Nurse Verification of Death Protocol

Protocol  Prov 09

15 May 2007
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Protocol For Community Nurse Verification of Expected Death

1 Background

Dealing with the death of a patient in a caring, compassionate and professional manner is often the last service that can be provided for an individual and may ease the suffering of those who are bereaved.

The legal position in English law requires a registered medical practitioner who attended the patient during their last illness, and within 14 days of the death, to issue a certificate detailing the cause of death if they are aware of this. There is no legal requirement for a doctor to confirm that death has occurred, nor imposes a statutory duty to report the fact. However, there is common law requirement on all persons, including medical practitioners, to report to the coroner, where death has occurred unexpectedly, or in suspected suspicious circumstances.

The Nursing and Midwifery Council state that registered nurses may confirm or verify that expected death has occurred provided that there is local policy/protocol in place, and that they have received appropriate training and been assessed as competent, and accept their accountability when performing this role.

Nurses therefore will undertake this role when the needs of living patients permit, and as quickly as can be reasonably accommodated within their usual working hours.

2. Expected Death

For the purposes of this protocol, an expected death can be defined as a death where the patient’s demise is anticipated, and where active interventions to prolong life are deemed to be futile, and consequently, the medical practitioner will be able to issue a medical certificate as to the cause of death. This information will have been clearly documented either in the patient’s home care records, within the documentation of the Integrated Care Pathway for End of Life Care (Liverpool Care Pathway) or on the appropriate Out of Hours form (Appendix 1).

3. Predictable Death

It is recognised that a patient may have a long term condition that can be considered to be the cause of their death, however, the death may occur suddenly, and therefore unexpectedly. Such a death will be considered to be predictable and may be suitable for nurses to verify, provided the medical practitioner is able to ascertain that there are no suspicious features associated with the patient’s death.

In the case of a predicted death, it is necessary that the medical practitioner will have established the events of the death, and therefore excluded any possible need for referral to coroner / post-mortem, and will have agreed with both the nurse and the patient’s family (if possible), that nurse verification in this case is appropriate. Where this has occurred at weekends / out of hours, the appropriate form will be completed by the doctor and faxed to the nurse before the nurse undertakes a visit to verify death (Appendix 1).
However, where this is not possible, the nurse will complete the form with information following verbal communication with the medical practitioner concerned, and this will include the name of the doctor agreeing that the circumstances of death are clear and that the death is therefore suitable for nurse verification.

4. Fig 1:

Death is predictable and/or expected

Yes

Decision made for no active medical intervention

Yes

Documentation is clear

Yes

Nurse Verifies Death

In these circumstances, suitably trained, competent registered nurses will verify that death has occurred and will follow the outlined process.
5. Unexpected Death

For the purposes of this protocol, unexpected deaths can be defined as any death where there is no clear documented evidence that the visiting medical practitioner has stated that death is predictable and/or expected as a result of the patient’s prolonged illness or long term condition, and that further medical interventions and any resuscitative attempts are deemed to be futile. Therefore nurses will NOT verify death, and will immediately report the death to the medical practitioner, in the following circumstances:

- Where there is no clear documented evidence as stated above
- Death of a child (person under 18 years)
- Death as a result of an accident or untoward incident (this will include falls, even where the patient has a terminal prolonged illness, and drug errors)
- Where there is a suspected industrial disease (e.g. Mesothelioma), with the exception of where the death has occurred within a hospice setting and where there is documented evidence of both a tissue diagnosis and details of asbestos exposure.
- Where suicide is suspected
- Overdose (including accidental) or where excess alcohol has been taken
- Where the cause of death is unknown
- Where there may be a concern relating to either professional or carer neglect/competence
- There are any unusual or disturbing features
- Where the nurse in his/her judgement is uncertain

Please Note: If the medical practitioner has not seen the deceased in the 14 days prior to death, then the case will be discussed with the doctor and nurses will not verify this death.

6. Process for Nurse Verification of Death

It is implicit that all nurses undertaking this extended role will have:

- Received suitable training and been assessed as competent to verify death
- Accepted professional responsibility and accountability in this role
- Full working knowledge of protocol

Life will be assessed to be extinct where brain stem death has occurred. Features of this are loss of:

- Pupillary reflexes (Contraction in response to light)
- Spontaneous breathing
- Pulse / heart sounds

Thus:

1.) Before undertaking verification of death the nurse will:

- Ascertain that the death is predicted /expected as per above
- Discuss the procedure with any present relatives/carers
2.) The most important test is for lack of heart and breath sounds over at least one minute. Therefore nurses will:
   - Watch the patient for at least one minute to ensure there is no spontaneous respiration
   - Listen to the chest with a stethoscope to confirm there are no heart or respiratory sounds for at least one minute
   - Confirm that there is no carotid pulse for at least one minute

**Please note, the above can be done concurrently**
   - Confirm that there is no pupil reaction to bright light

3.) On confirming the above the nurse will document verification on the proforma (Appendix 2), a copy of which will be retained for the home care records, and a copy faxed to GP surgery so that certification of death can take place.
   - The time of death
   - The time of death verification

All documentation must be clearly dated, signed and full name printed on records.

4.) The nurse will only remove any parenteral drug administration equipment when verification of death has been completed.

5.) The patient’s usual medical practitioner must be informed, via faxed copy of proforma (Appendix 2) within 24 hours of the death. Additionally, the relevant surgery /OOH service must also be verbally informed of facts of death, as soon as is practicable. The information must include the place and relevant times of death, the full name and qualification of the nurse confirming the death, and any persons present at the moment of death.

6.) Nurses will undertake whatever last offices procedures are appropriate, remembering that family members/carers may find involvement in this process therapeutic. The focus of such care is to ensure the dignified removal of the deceased, to prepare the body for viewing by those close to the deceased, and to prevent leakage of bodily fluids from the deceased which may place professionals (undertakers and healthcare professionals) at risk from cross infection. The deceased will be treated with dignity and respect at all times.

**Please Note:**

Community nurses will not be able to provide this service within registered nursing homes, but will provide verification of death in care homes (i.e. one that does not have a nursing registration and therefore is not required to have qualified registered nurses on the premises).

This role is within the remit of registered nurses, following appropriate training and proven competence, and should be considered to be appropriate care provision for residents in this care setting. Additionally, nursing homes are legally required to provide details of the cause of death and the death certificate number within a reasonable time. Verification of death by the home’s qualified staff facilitates appropriate care cohesion, as practices can expect to receive this information as soon as is practicable.

Subsequently, registered nursing homes will be required to ensure that their qualified nurses have the suitable training and competence to undertake the role.

Author: Lesley James - Strategic Nurse Manager 15th May 2007
Appendix 1

Predicted Death and Weekends/OOH

Patients details

Persons present at moment of death

Phone Number:

**Underlying Condition Associated with Predicted Death**

**Circumstances of Death**

**Family Aware of nurse verification**

Yes / No

**GP agrees that patient death is suitable for nurse verification**

Yes / No

Signed  

(Doctor referring)

Date
Appendix 2

Verification of Death Proforma

Patient's details

Other persons present at moment of death

Date of Death

Time of Death

Verification Process:

Date

Time

Listen and observe for breathing for one minute

Heartbeat listened for, for one minute

Feel for carotid pulse for one full minute

Pupils are un-reactive to light

Amount left in Syringe Driver (if appropriate)

Body observed for unexplained bruising, petechial haemorrhaging and colour / extent of skin mottling

Signature of registered nurse verifying death

Print Name:

Designation:

GP Name

Contacted: Yes/No

OOH contacted (if applicable)

Yes/No

Funeral Director

Telephone Number

If known, patient to be:

Buried/ Cremated

Other professionals contacted:
### Policy Impact Assessment – Screening Tool

**Name of Directorate:** Provider Services

**Date of Assessment:** 2nd October 2007

**Policy being assessed:** Protocol – Nurse Verification of Death

**Assessment Carried out by:** Lesley James

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<th>Policy Title</th>
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