POLICY FOR THE VERIFICATION OF DEATH BY REGISTERED HEALTHCARE PROFESSIONALS

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<tr>
<th>Amendments</th>
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<td></td>
<td>April 2012</td>
<td>All</td>
<td>Update on original nurse verification policy to include all medical staff and the implementation of a new verification of death form.</td>
<td>Resuscitation Committee.</td>
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<td></td>
<td>November 2016</td>
<td>All</td>
<td>Full policy review</td>
<td>Resuscitation Committee.</td>
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Compiled by: Paul Darling-Wills, Resuscitation Services Manager
Susan Harris, CSNP Team Leader
Dr Peter Wilkinson, Consultant Cardiologist

Ratified by: Trust Board

Date ratified: April 2012

Date reviewed: November 2016

Next review date: November 2019

Target Audience: All staff

Impact Assessment Carried Out by: Paul Darling-Wills, Resuscitation Services Manager
Susan Harris, CSNP Team Leader

Policy Owners: Paul Darling-Wills, Resuscitation Services Manager
Dr Peter Wilkinson, Consultant Cardiologist
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1. INTRODUCTION

Death entails the irreversible loss of those essential characteristics which are necessary to the existence of a living human person and, thus, the definition of death should be regarded as the irreversible loss of the capacity for consciousness, combined with irreversible loss of the capacity to breathe. This may be secondary to a wide range of underlying problems in the body, for example, cardiac arrest.

For people suffering cardiorespiratory arrest (including failed resuscitation), death can be diagnosed when a registered medical practitioner, or other appropriately trained and qualified individual, confirms the irreversible cessation of neurological (pupillary), cardiac and respiratory activity.

2. PURPOSE

The purpose of this document is to provide guidance on verification of death. This task can be undertaken by all registered doctors and in situations were there is an organisational policy such as this, after appropriate training and assessment, it can also be undertaken by registered nurses (only where death is expected).

3. BACKGROUND

When a person dies, a number of steps need to be completed to allow legal registration of the death and for a funeral to take place:

VERIFICATION OF DEATH
This first step, verifying death has no formal legal term and is referred to by different phrases including Recognition of Life Extinct (ROLE), verification of death, pronouncing death, confirming death. For the purposes of this policy the term “verification of death” will be used.

CERTIFYING THE MEDICAL CAUSE OF DEATH
When a patient dies it is the statutory duty of the doctor who had attended in the last illness to issue the Medical Certificate of Cause of Death (MCCD) There is no clear legal definition of “attended”, but it is generally accepted to mean a doctor who has cared for the patient during the illness that led to death and so is familiar with the patient’s medical history, investigations and treatment. The certifying doctor should also have access to relevant medical records and the results of investigations. There is no provision under current legislation to delegate this statutory duty to any non-medical staff. In hospital, there may be several doctors in a team caring for the patient. It is ultimately the responsibility of the consultant in charge of the patient's care to ensure that the death is properly certified. Any subsequent enquiries, such as for the results of post-mortem or ante-mortem investigations, will be addressed to the consultant.
4. PROFESSIONAL REQUIREMENTS

All doctors registered with the General Medical Council can verify death. Nurses can undertake this task within certain parameters. The advice on verifying death given to nurses by the Nursing and midwifery Council (NMC, 2008) is that “In the event of death, a registered nurse may confirm or verify death has occurred, providing there is an explicit local protocol in place to allow such an action. Nurses undertaking this responsibility must only do so providing they have received appropriate education and training and have been assessed as competent. The code says:

You must have the knowledge and skills for safe and effective practice when working without direct supervision
You must recognise and work within the limits of your competence
You must keep your knowledge and skills up to date throughout your working life
You must take part in appropriate learning and practice activities that maintain and develop your competence and performance. They must also be aware of their accountability when performing this role”

5. TRAINING AND COMPETENCES FOR NURSING STAFF

1. A registered nurse who has undergone a programme of training to develop their Scope of Professional Practice to include this skill, and can provide evidence of this may carry out this procedure. This nurse should be at Band 6 or above.

2. There are 5 exclusions for verifying death, please see exclusion criteria (appendix 1)

3. Death must have been expected.

4. A written record must have been made in the medical notes regarding the management plan for resuscitation and active treatment. A current red bordered “Do Not Attempt Cardiopulmonary Resuscitation” (DNACPR) form must have been completed.

5. The verifying nurse will record in the patient’s notes (medical and nursing):
   - Date
   - Time of estimated death (information from ward staff) and time of verification of death
   - Relatives informed (state name of relative)
   - Signature and written name of verifying nurse

6. The verification of death record sheet recording the examination undertaken and verifying death MUST be completed and put in the patient’s notes.

7. The registered nurse will undertake supervised training in verifying death and provide evidence of this.

8. The first death which a nurse is asked to verify must be confirmed by a doctor.

9. A written standard of competence will be completed (appendix 2), signed by the registered nurse, the assessor and their line manager.

10. A copy will be placed in the individual’s personal file and a copy should be included in the nurses’ professional profile.

6. CLINICAL ASSESSMENT TO VERIFY DEATH
In order to verify death, cessation of circulatory and respiratory systems and cerebral function must be confirmed and documented on the verification of death record sheet and included in the patient’s notes.

Certain situations can make the clinical confirmation of death more difficult, in particular drowning, hypothermia and drug overdose. In these situations active resuscitation should continue until an experienced doctor has verified life extinct.

There are some special circumstances, including brain-stem death in ventilated patients, where ITU consultants will be involved in verifying death under more detailed protocols.

**Death MUST always be verified using the following criteria:**

**If resuscitation is attempted, you must wait five minutes from the time of cessation before verification of death is started. (During this time the patient should be kept attached to an ECG monitor)** If no resuscitation is attempted verification may be commenced immediately.

1. Absence of heart sounds on auscultation over one full minute
2. Absence of a carotid pulse on palpation over one full minute
3. Absence of breath sounds on auscultation and no chest movement seen over one full minute
4. Absence of pupillary responses to light
5. Absence of corneal reflex (supra-orbital pressure)

**The time of death is recorded as the time at which these criteria are fulfilled.**

The use of direct intra-arterial pressure monitoring and echocardiography is recommended if available.

If no resuscitation has been initiated (i.e. expected death) then verification can be commenced immediately. (no need to wait 5 minutes before verification is started)

It is obviously inappropriate to initiate any intervention that has the potential to restore cerebral perfusion after death has been confirmed.

The verification of death record sheet, recording the examination undertaken and verifying death **MUST** be completed and placed in the patient’s notes. (appendix 3)

**7. ACTION TO BE TAKEN AFTER A DEATH**

Following the verification of death, the practitioner needs to determine the next step, which will depend on the circumstances of the death. Although most deaths, even sudden deaths, are not suspicious, it is important that the professional who has verified death considers the general circumstances of the death.

**SUSPICIOUS CIRCUMSTANCES**

If there are concerns about the death, the body and the area around it should be secured and not disturbed, senior management/consultant should be contacted in the first instance and then the Police. They will direct how the death should then be handled.
8. DISSEMINATION AND IMPLEMENTATION

This policy will be made available on the Trust intranet. Directors, Clinical Directors, Divisional Heads, Business Centre Managers and Ward managers are responsible for ensuring that all staff are made aware of this policy’s existence and receive instruction if necessary.

9. MONITORING OF COMPLIANCE

The Trust Resuscitation Group will monitor the implementation of this policy and will make an annual review of the policy to ensure that all relevant statements are being adhered to and make any minor changes as necessary. Monitoring of adherence to current guidelines will be assessed at cardiac arrests. Any gaps / incidents will be discussed at the resuscitation group meetings, an exception report to risks to the organisation will be completed and submitted if necessary.

10. EQUALITY IMPACT ASSESSMENT

See appendix 4

11. ARCHIVING ARRANGEMENTS

This is a Trust-wide document and archiving arrangements are managed by the Quality Department, who can be contacted to request master/archived copies.

12. REFERENCES AND BIBLIOGRAPHY

A Code of Practice for the Diagnosis and Confirmation of Death

_Academy of Medical Royal Colleges_; October 2008

Confirmation of death for registered nurses

_Nursing & Midwifery Council_; April 2008

Guidance for doctors certifying cause of death

_Office for National Statistics’ Death Certification Advisory Group_; April 2005
APPENDIX 1

EXCLUSION CRITERIA

1. Any unexpected death.
2. Death following an untoward incident, fall or error.
3. Death that has occurred as a result of malpractice or negligence.
4. Death of a person under 18 years of age.
5. Any suspicious death.
**APPENDIX 2**

**Competency:** Verification of Expected Death

**Standard Statement:** The Registered Nurse will be competent in the verification of an expected death in adults

*The Registered Nurse can:*

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<th>4</th>
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<td></td>
<td>Discuss the local procedure with regard to verification of expected death.</td>
<td>Demonstrate correct procedure for verification of expected death.</td>
<td>Discuss rationale for the procedure.</td>
<td>Display prior knowledge of the patient and his/her illness.</td>
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<td></td>
<td>Ensure relatives are informed of death.</td>
<td>Ensure access to deceased is provided upon request.</td>
<td>Document date and time of death in the patient's medical &amp; nursing records. Complete record of verification of death.</td>
<td>Inform medical staff of patient death as per local procedure.</td>
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**Comments:**

The Registered Nurse undertaking this competency is at Band 6 or above. (currently only members of the CSNP team will practice this competency)

The Registered Nurse is able to provide written evidence in the form of their reflective log for their assessment.

Instruction by a doctor on the verification of death needs to form part of the evidence provided by the nurse for their assessment.

Supervision of the procedure by a Doctor on at least one occasion

Each individual nurse undertaking this responsibility is reminded that they are accountable for their own actions

Ratified by Nursing & Midwifery Committee
APPENDIX 3

VERIFICATION OF DEATH RECORD SHEET

Patient name:  
Hospital Number:  
Date:  

PROCEDURE

If resuscitation is attempted, wait five minutes from the time of cessation of resuscitation before verification of death is started. (During this time the patient should be left attached to an ECG monitor).

<table>
<thead>
<tr>
<th>CIRCULATORY</th>
<th>RESPIRATORY</th>
<th>CEREBRAL</th>
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<tr>
<td>Absence of a carotid pulse on palpation over one full minute.</td>
<td>Absence of breath sounds on auscultation over one full minute</td>
<td>Absence of pupillary responses to light</td>
</tr>
<tr>
<td>Absence of heart sounds on auscultation over one full minute.</td>
<td>Absence of chest movement seen over one full minute</td>
<td>Absence of corneal reflex (supra-orbital pressure)</td>
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</table>

The time of death is recorded as the time at which these criteria are fulfilled.

I have confirmed the death of the patient named above following the Guidelines for Verification of Death.

Date:       Time:  
Signature:  
Print Name:  
Bleep / ext number:

GMC / NMC number:

NURSING VERIFICATION

☐ I have concerns about the circumstances of this death and have contacted the Doctor named below.

Or

☐ The circumstances of this death do not appear suspicious and have informed the Doctor named below that death has occurred.

DOCTOR INFORMED

Name of Doctor:  
Nurse name:  

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Patient Care  
First Ratified  
April 2012  
Next Review  
November 2019  
Issue 2  
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Equality Impact Assessment Summary

**Name:** Paul Darling-Wills, Resuscitation Services Manager  
**Policy/Service:** Policy for the Verification of Death by Registered Healthcare Professionals

### Background
- Description of the aims of the policy  
- Context in which the policy operates  
- Who was involved in the Equality Impact Assessment

This policy enables all medical staff to verify death and enables competent Registered Nurses to verify the expected death of adult inpatients. Currently the only nurses performing verification of death are members of the Clinical Site Nurse Practitioner Team (CSNP).

In respect to nursing staff, all deaths verified under this policy must have been expected and a current Do Not Attempt Resuscitation decision must be in place.

Equality Impact Assessment carried out by Paul Wills, Resuscitation Services Manager.

### Methodology
- A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age)  
- The data sources and any other information used  
- The consultation that was carried out (who, why and how?)

Review of the policy failed to identify any adverse or potentially adverse impacts for any equalities groups.

### Key Findings
- Describe the results of the assessment  
- Identify if there is adverse or a potentially adverse impacts for any equalities groups

The policy does not involve any adverse or potentially adverse impacts for any equalities groups.
Conclusion

- Provide a summary of the overall conclusions

There are no identified adverse or potentially adverse impacts for any group of patients.

Recommendations

- State recommended changes to the proposed policy as a result of the impact assessment
- Where it has not been possible to amend the policy, provide the detail of any actions that have been identified
- Describe the plans for reviewing the assessment

None.

Guidance on Equalities Groups

<table>
<thead>
<tr>
<th>Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)</th>
<th>Religion or belief (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration)</th>
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<tr>
<td>Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)</td>
<td>Sexual orientation including lesbian, gay and bisexual people (consider whether the policy/service promotes a culture of openness and takes account of individual needs)</td>
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<tr>
<td>Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)</td>
<td>Age (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior)</td>
</tr>
<tr>
<td>Culture (consider dietary requirements, family relationships and individual care needs)</td>
<td>Social class (consider ability to access services and information, for example, is information provided in plain English?)</td>
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