Northumberland NHS
Care Trust

POLICY NUMBER
NP04

VERIFICATION OF EXPECTED DEATH IN A COMMUNITY SETTING

Policy Information

Policy Title	Verification of Expected Death in a Community Setting
Policy Reference Number	NP04
Responsible Director	Director of Care Development
Contact Person	Clinical Director (Nursing)
Planned Review Date	December 2008

Policy Approval History

Version Number	Date Last Approved by the Board	Date Last Modified by Responsible Director
1	December 2004	Reviewed November 2005
	December 2006	

Implementation Process

Distribution	To all nursing staff via General / Operational Managers
Implementation Actions	All staff to note content and follow practice recommendations
Implementation Date	December 2004

Policy Amendment History

No amendments to the original policy document.

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Verification of expected death in the community

1. Introduction

1.1 GP Out of Hours cover within Northumberland is provided by Northern Doctors Limited. These arrangements apply to evenings and nights and also to weekends. Increasing demands on the service and a reduction of the numbers of GPs available out of hours means that requests for assistance must be prioritized.

1.2 In the past, district nurses, when notified by relatives of a patient's death and being aware of this death as being an expected result of prolonged illness have visited the home to confirm death informally and notified the on-call GP. Due to pressures on GP out of hours services and the obvious need to prioritise care to those in most urgent need there can be a delay between time of death and the time the patient is seen by a doctor and death formally verified. Similarly the relatives may have a natural wish to wait until their GP is available in daytime hours for formal verification and certification rather than have another unfamiliar doctor visit at a time of great stress. The delays involved in both these situations can lead to difficulties in particular when patients may have parenteral medication sited for pain relief. The disconnection of such devices before verification of death has legal implications in the event of the coroner's department being involved in the case. However, normal practice for nurses working in the community being called to an expected death would be to remove such devices in order to maintain the dignity of patients and relieve stresses on carers at a difficult time.

1.3 This policy relates to expected death only. In the event of a community nurse being advised of a sudden collapse or unexpected death immediate emergency treatment / resuscitation should be instigated and an ambulance or medical aid called.

2. Legal position

2.1 The law requires that:

"a registered medical practitioner, who has attended a deceased person during his last illness, is required to give a medical certificate of the cause of death 'to the best of his knowledge and belief, and to deliver that certificate forthwith to the Registrar. The certificate requires that the doctor state the last date on which he saw the deceased person alive, and whether or not he saw the body after death.

He is not obliged to view the body, but good practice requires that if he has any doubt about the fact of death, he should satisfy himself in this way."

Para 5.01 Report of the Committee on the Death Certification and Coroners Home Office **(1971)**

3. Nurse verification of death

3.1 Registered nurses, working to this policy, have the authority to verify expected death.

3.2 For the purposes of this policy, expected death can be defined as death following on from a period of illness which has been identified as terminal, where district nurses have been involved in providing palliative care and where no active intervention to prolong life is ongoing. The district nursing services and the patients GP will be visiting regularly to provide medical and nursing support.

3.3 The patient's GP will normally have indicated that the nurse has authorisation to verify the death. This may either be done on an individual patient basis (using the form Appendix 02) or the Practice may have provided blanket authorisation (in writing) for a category of patients. Where blanket authorisation has been given this should be communicated to other community nursing colleagues including out of hours services. Where a patient is on the End of Life pathway this includes authorization to verify expected death.

Nurses must **not** verify any other deaths which were not expected, or where a post mortem or routine referral to the coroner's office is indicated or where the death relates to:

- the death of a child
- deaths of unidentified persons
- deaths of people not under obvious care
- deaths which occur within 24 hours of onset of illness or where no firm clinical diagnosis has been made
- deaths following post-operative or post invasive procedures
- deaths which follow an untoward incident, fall or drug error
- deaths which occur as a result of negligence or malpractice
- any unclear or remotely suspicious death

In these cases the GP or on-call locum has a responsibility to refer the death to the Coroner.

4. Procedure for verifying expected death

4.1 The nurse should:

- Note the exact time of death where possible. In the case of nurses being contacted by relatives and attending as soon as possible after death, time of death should be established as closely as possible from relatives.
- Check the patient's pupil reactions using a flashlight in both eyes and observe for eye movement
- Listen for heart sounds or respiration using a stethoscope for 1 minute
- Check for respiratory effort, radial and carotid pulse for 1 minute
- Enter into the patient's home nursing record that death was verified (indicating the absence of pupillary reaction, heart and respiratory sounds). The records must clearly show the date and time of death, as well as the time of verification. Appendix 01 provides a form which may be used for this purpose

  All records must be clearly signed and the registered nurse's name printed in full after each entry. The record of the nurse's visit should be formally communicated to the patient's GP as soon as possible. Appendix 01 may be faxed to the GP as formal notification

4.2 In all cases the doctor should produce a medical certificate of the cause of death within 24 hours of the patient's death, except at weekends and bank holidays when the certificate should be produced on the next working day.

4.3 Parenteral drug administration equipment or any life prolonging equipment should not be removed prior to verification of death.

5. Nurse who may work to this policy

5.1 Only experienced registered nurses working within the Scope of Professional Practice (NMC, 1992) may verify death.

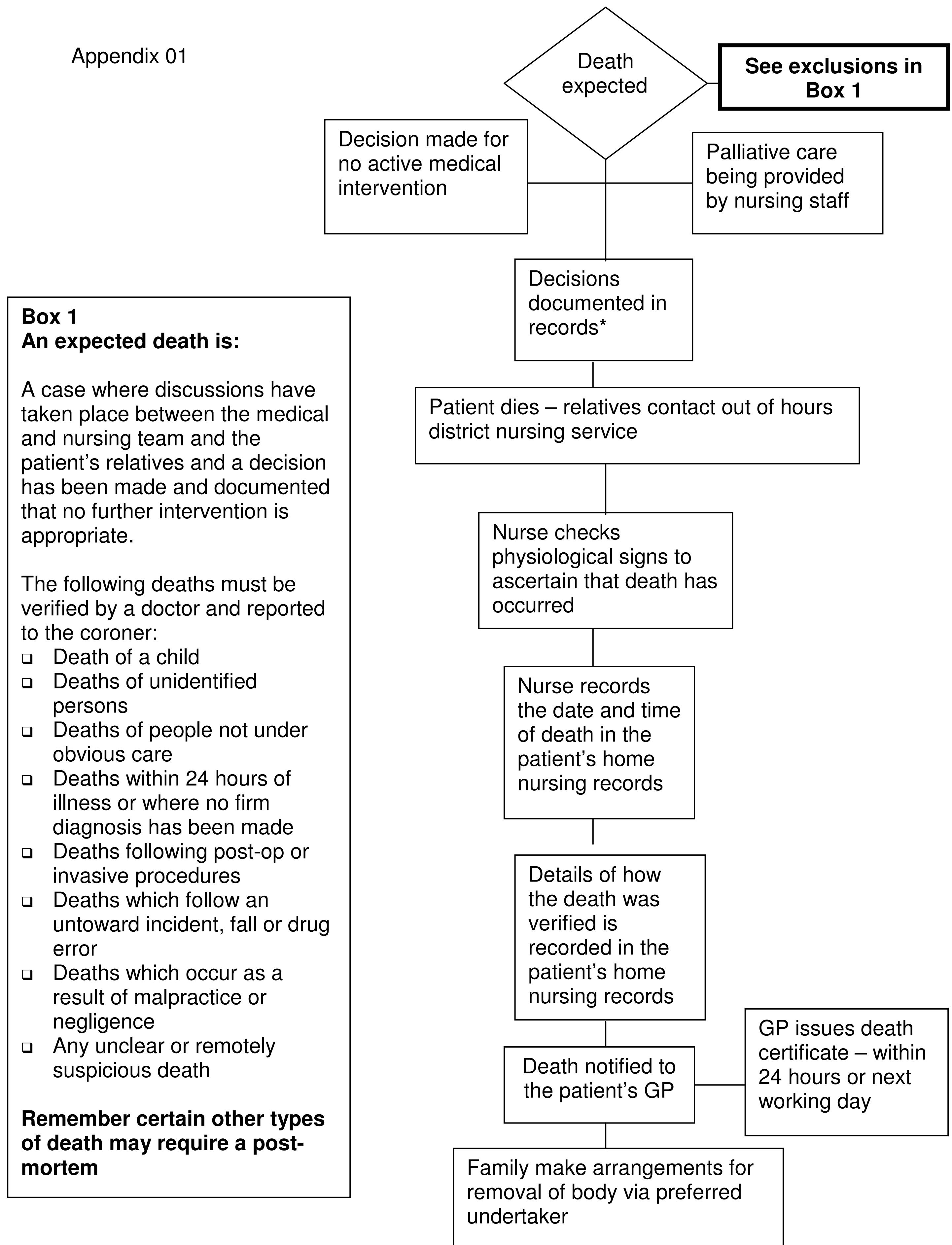
5.2 All registered nurses working to this policy must have undergone additional training to provide them with the knowledge to enable them to determine the physiological aspects of death. Additionally, she/he should be aware of the legal issues and related accountability which relates to this extended scope of professional practice.

6. References

Home Office (1971) *Report of the Committee on Death Certification and Coroners.* Home Office: London.

Nursing and Midwifery Council (1992) *Scope of Professional Practice.* NMC: London

Appendix 01



*blanket authorisation may be provided by some practices

Appendix 02

Northumberland NHS Care Trust

Patient's name	Date of Birth						

VERIFICATION OF EXPECTED DEATH

I, Dr ________________, being the General Practitioner / Doctor in Charge of the care of ___________________________ am aware that this patient's death is imminent and expected and hereby give my permission of the nurse in charge at the time to verify the death in my absence in accordance with Care Trust Policy

Signature: ________________________

Print Name: ________________________

Date: ________________________

This section does not need to be completed if the Practice has provided written authorisation for a category of patients – where this is the case the Registered Nurse in charge of the patient care should tick this box and sign above ☐

RECORD OF VERIFICATION

Cessation of:

CIRCULATION		**RESPIRATION**		**CEREBRAL**	
No radial pulse for 1 minute		No respiratory effort for 1 minute		No eye movements	
No carotid pulse for 1 minute		Using stethoscope no chest sounds for 1 minute		Pupils fixed and dilated both eyes	
Using stethoscope no heart sounds for 1 minute				Pupils not responsive to light both eyes	

I have verified the death of the patient named above following the Care Trust's policy

Death verified on: ☐☐☐☐☐☐ at (time): ☐☐☐☐ use 24 hr

Signature: ____________________ Designation: ____________________

Print Name: ____________________

NP04 Verification of Expected Death in a Community Setting Policy

This sheet should be used to record the names of staff members to verify that they have read and understood the policy document.

Name (please print)	**Job Title**	**Date**	**Signature**