Death of a Resident and the Verification of Death by a Registered Nurse Policy

Introduction

Quality statements are the commitments that providers, commissioners and system leaders should live up to. Expressed as ‘we statements’, they show what is needed to deliver high-quality, person-centred care.

When they refer to 'people' we mean people who use services, their families, friends and unpaid carers. This includes:

- people with protected equality characteristics
- those most likely to have a poorer experience of care or experience inequalities.

Elizabeth Finn Homes (EFH) will commit to the following quality statements for:

Safe systems, pathways and transitions

We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Safe environments

We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care.

Infection prevention and control

We assess and manage the risk of infection. We detect and control the risk of it spreading and share any concerns with appropriate agencies promptly.

How staff, teams and services work together

We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services.

Kindness, compassion and dignity

We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.

Treating people as individuals

We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

Person-centred care

We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

Governance, management and sustainability

We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

Scope

This procedure states EFH approach to the death of a resident and verification of that death. It also details the actions required following the verification of death including notification to statutory bodies including CQC.

This policy and procedure are provided for the regulated activity of accommodation for persons who require nursing or personal care.

Equality Statement

EFH is committed to equal rights and the promotion of choice, person-centred care and the promotion of independence. This policy demonstrates our commitment to creating a positive culture of respect for all individuals. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to reflect the Human Rights Act 1998 to promote positive practice and value the diversity of all individuals.

Policy Statement

This policy should be read in conjunction with EFH End of Life Policy

Confidentiality of a resident's records remains after their death.

The policy sets out roles for both staff and other professionals on the death of a resident.

Certification of death can only be undertaken by a medical practitioner. At the time of writing the death certification system in England and Wales is under review. From April 2024 new death certification reforms come into practice, this means that there will be an independent review of all deaths in England and Wales without exception. This will be either by a medical examiner or coroner. For further information see 'Introduction of medical examiners and reforms to death certification.'

Verification of death can be undertaken by a number of healthcare professionals including nurses, doctors and paramedics.

During COVID-19 the government has provided guidance by which non-healthcare professionals can assist a GP or similar in verifying death using a defined pathway remotely. At the time of writing this remains in English law.
This helps avoid long delays in waiting for verification before the deceased person can be moved when medical practitioners are unavailable.

If non-medical professionals are not comfortable or equipped to verify, they should not experience any pressure to verify deaths.

Information within the policy includes who should be notified on the death of a person in our care, including CQC.

This policy is provided to ensure staff have the information to understand their role and that of others at the death of a resident.

Under the supervision of a registered professional:

- Check the identity of the person, for example photo ID.
- Record the full name, date of birth, address, NHS number and, ideally, next of kin details.
- The time of death is recorded as the time at which verification criteria are fulfilled.

Staff members should follow the appropriate policies associated with 'First Aid,' 'Basic Life Support' and 'Do Not Attempt CPR/ReSpect' where they find a collapsed resident.

If a staff member finds a resident has died, their first response should be seek assistance, get them to dial 999 and request an ambulance. The body should not be moved or handled (other than where CPR has been attempted) in any way before the medical services arrive.

The Policy

It is EFH aim to provide all residents and their family with a high-quality service which supports them to live an active, safe and independent life.

As it is our aim to support people to live their best life for as long as possible, EFH and its staff will support residents at the end of their life and where it is their wish for them to die in their home.

It is hopefully a rare occurrence that an unexpected death of a resident takes place whilst they are receiving a service from this organisation, but this policy sets out how we will support them if this should happen.

This policy sets out the actions that EFH will take to maintain the dignity and respect for the individual and their family, and the actions it will take to ensure all of its obligations are fulfilled in a caring and supportive manner.

It is important that staff are aware of how and when to respond to requests for information in order to minimise distress and adhere to any cultural beliefs or preferences that the resident, their family, or representative have expressed as part of their care and support plan.

Staff must remember that the death of a resident requires that information is protected, and that confidentiality is still in place relevant to the wishes of the resident, e.g. if medical information was not to be shared with family, this still applies after their death.

Staff and EFH will co-operate fully with multi-agency partners to ensure all lawful requirements are met and will assist, where appropriate, when asked or directed by a lead agency to support or provide information relevant to investigations, e.g. Coroners' Office.

All communication will be dealt with in a sensitive professional manner that promotes the privacy and dignity of the resident, their family and/or representative.

Verification of death is performed by professionals trained to do so in line with their employers' policies (for example medical practitioners, registered nurses or paramedics). Staff may be asked to support a GP or other appropriate professional to remotely verify a death with clinical support.

Expected Deaths, e.g. End of Life or Palliative Care

Guidance has been provided by the government and the BMA, which sets out where non-clinical staff can support professional staff to verify death remotely. This was introduced during the COVID-19 emergency and continues after the pandemic.

The Department of Health and social care guidance says that:

'It's also to be exercised by other non-medical professionals, usually and normally independent of family members, who are verifying death using remote clinical support. This helps avoid long delays in waiting for verification before the deceased person can be moved when medical practitioners are unavailable, which can be distressing for their families and those close to them.

All registered professionals must follow their professions' code of practice and conduct. These require professionals to acknowledge the limits of their professional competence and only undertake practice and accept responsibility for those activities in which they are competent.

An expected death is the result of acute or gradual deterioration in the patient's health and often due to advanced disease and terminal illness.'

It is relevant to all adult deaths in all settings (healthcare, social care and domiciliary settings and circumstances), with the exception of when a case must be reported to the coroner.

Process of Verification with Remote Clinical Support

See guidance from the BMA (British Medical Association) 2022, 'Guidance for Remote Verification of Expected Death (VoED) Out of Hospital.'

- Check the identity of the person, for example photo ID.
- Record the full name, date of birth, address, NHS number and, ideally, next of kin details.
- The time of death is recorded as the time at which verification criteria are fulfilled.

During core practice hours, call the person's registered general practice.

Outside core practice hours, call NHS 111 where a clinician will provide remote support to work through the verification process. See 'Annex: Guidance for remote clinical support for verification of death).'

Process of the verification of death by a registered nurse

All Registered Nurses (RN) are required to exercise professional judgement when using organisational policies.

The circumstances that define an expected death within EFHL are:

- Death is expected and not accompanied by any suspicious circumstances.
- The "Do not attempt cardiopulmonary resuscitation" (DNACPR) document is signed and in line with current guidance.
- Death occurs in the Elizabeth Finn Home
- It includes where the resident dies under the Mental Health Act including Liberty Protection Safeguards (formally known as DOLs)
- The resident has been seen by a GP within the previous 14 – 28 days depending on the Homes local arrangement with their GP practice.(All RNs responsible for verification should be aware of the local policy upon verification of death training)

Definitions

Recognition of death

It is recognised through competency-based training that staff will recognise when death has occurred.

Verification of the fact of death

EFH uses documentation to record the fact of death which is in line with national guidance, and its associated responsibilities of identification of the deceased, notification of infectious illnesses and implantable devices. This is recognised as the official time of death.

EFH staff will document on Access and Clinical in a timely manner using form 2.17

Certification of death

Certification of death is the process of completing the "Medical Certificate of the Cause of Death" (MCCD) by a medical practitioner in accordance with the births and deaths Registration Act 1953, underpinning the legal requirements for recording a persons death. Currently in order to issue a MCCD, a doctor must have attended a resident in their last illness and either seen the resident in the 14-28 days preceding death or seen the body after death.

Expected death

An expected death is the result of an acute or gradual deterioration in a residents health status usually due to advanced progressive incurable disease. The death is anticipated, expected and predicted. It is anticipated in these circumstances thatg advance care planning and the consideration of a DNACPR will have taken place. The death can be verified even if a doctor has not seen the resident in the previous 14-28 days.

Sudden or unexpected death

An unexpected death is no anticipated or related to a period of illness that has been identified as terminal. Where death is completely unexpected and the healthcare professional is present there is a requirement to begin resuscitation. The national Resuscitation Council has issued clear guidance for the circumstances where a resident is discovered dead and there are signs of irreversible death.

If the death is unexpected (i.e. sudden) then the person in charge should inform the doctor immediately. The doctor will ask questions about aspects of the illness or the care given, these should be answered appropriately.

The body must not leave the premises until death is certified by a doctor.

Sudden or unexpected death within a terminal period

A resident with a terminal diagnosis can have a sudden death,e.g. embolism. Death can be verified by an RN in these circumstances if a DNACPR form is completed and the circumstances are discussed with a GP. The death can be verified even if the GP has not seen the resident in the previous 14-28 days.

Do not attempt cardiopulmonary resuscitation (DNACPR)

Cardiopulmonary Resuscitaion (CPR) is a medical treatment that endeavours to restart cardio-respiratory function. The advance decision not to attempt CPR or ReSPECT and allow natural death is underpinned by national guidance.

Responsibilities

- All RNs must read and understand this policy and guidance and received appropriate training and be deemed competent.
- The RN carrying out this procedure must inform the GP of the the residents death (both in and out of hours using NHS111), using agreed local systems and document the the date and time this was carried out in ICAREprogress note / Professional Visit Form.
- The RN carrying out this procedure must inform the the funeral director / mortuary of any infections, radioactive implants, implantable devices and whether an ICD is still active.
- It is the right of the verifying RN to refuse to verify a death and to request the attendance of a responsible doctor/police if there is an unusual situation.

Scope of Professional Practice

The Nursing and Midwifery Council (NMC) code ‘Standards for Conduct, Performance and Ethics (2008)’ places specific responsibilities on Registered Nurses to maintain professional knowledge and competence. To practice competently within these guidelines Registered Nurses must possess the knowledge, skills and abilities required for lawful, safe and effective practice without direct supervision. Nurses are required to acknowledge the limits of their professional competence and only undertake practice and accept responsibilities for those activities in which they are competent.

EFH provides verification of death training and competencies.

These are to be completed by all Registered Nurses when they commence employment with EFH and then every two years. Having attended the training and completed the competencies a Registered Nurse may perform independent verification.

Action required by the RN

Action	Rationale
Check for completed DNACPR documentation.	To ensure agreement of process.
Adopt universal infection control precautions. *In the event of COVID-19 PPE must be worn at all times and this information relayed to all parties involved in the deceased.*	To ensure protection of RN.
Check that the NHS number of the residents clinical records and deceased correlate	To correctly identify deceased.
Identify from the clinical notes, any infectious diseases, radioactive implants, implantable medical devices.	To enable correct information to be passed on to ensure others involved in the care of the deceased are protected.
The individual should be observed by the person responsible for verifying death for a minimum of five (5) minutes to establish that irreversible cardio-respiratory arrest has occurred.	
For at least one minute, ensure absence of a central pulse on palpation.	To ensure there are no signs of cardiac output.
For at least one minute, ensure absence of heart sounds on auscultation.	To ensure there are no signs of cardiac output.
Absence of respiratory effort by observation over the five minutes.	To ensure there are no signs of respiratory output.
After five minutes of continued cardio-respiratory arrest the absence of pupillary responses to light should be tested.	To ensure there is no cerebral activity.
After five minutes of continued cardio-respiratory arrest the absence of motor response to trapezius squeeze should be tested.	To ensure there is no cerebral activity.
Any spontaneous return of cardiac or respiratory activity during this period of observation should prompt a further five minutes observations.	
Lie the resident flat. Leave all tubes, lines, drains, medication patches and pumps, etc. in situ (switching off flows of medicine and fluid administration if in situ), and spigot off as applicable and explain to those present why these are left.	To ensure the patient is flat ahead of rigour mortis and all treatments are stopped.
The RN verifying the death needs to complete the local verification of death form. Time of death is recorded as when verification of death is completed (i.e. not when the death is first reported).	For legible documentation and legal requirements.
The RN must notify the doctor of the death (including date / time) by secure email or their locally agreed procedure	To ensure consistent communication.

Referral to the Coroner

A doctor may report the death to a coroner in the following circumstances:

- Cause of death is unknown.
- Death was violent or unnatural.
- Death was sudden and unexplained.
- Deceased was not visited by a medical practitioner during their final illness.
- Medical certificate is unavailable.
- Deceased was not seen by the doctor who signed the medical certificate within 28 days prior to death or after they died.
- Death occurred during an operation or whilst still under the effects of anaesthetic.
- Medical certificate suggests the death may have been caused by an industrial disease or industrial poisoning.

In the Event of a Death

In the event of a death of a resident, the following process should be adhered to and staff should be supported and assisted throughout.

Regardless of the experience of staff in working with the dying, it is important to recognise the distress, shock, or trauma that can follow, especially where the death is sudden or unexpected.

If a staff member visits a resident's room in the middle of the night for a routine check or is the first to visit their room in the morning, and finds the resident has collapsed and non-responsive, their first response should be to dial 999 and request an ambulance.

Commence CPR (Unless the death is expected or there is a DNACPR or other advanced planning in place requiring that CPR not be performed)

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It is important to remember that the death has to be medically certified, so no assumptions should be made regarding the status of the resident. The body should not be moved or handled in any way before the medical services arrive.
The senior manager should be informed. This includes the night duty, where the death is discovered overnight. Full details should be recorded and an incident form completed.

The medical services will lead and liaise with the management, as required upon their arrival, e.g. they may ask that the staff stay until the undertaker or next of kin arrives or the police may request that they stay even if their shift has finished.

Where staff are really distressed or anxious, a member of the management may be asked to relieve them, and consideration should be given to the cover arrangements necessary for the rest of their schedule.

Management will liaise with the lead agency, e.g. GP, until all formalities are settled and will keep detailed records of any dialogue. The file will then be closed in the usual way.

Consideration should be given to requests to any funeral attendees from EFH. This will take into account such things as how long the resident was with us, their regular care workers etc, and the availability of cover.

All deaths are reported to the Senior Clinical Leadership team.

EFH will investigate all deaths and investigate any trends or lessons learned.

EFH documents all deaths on the CQC notifications Matrix.

EFH reports analysis of deaths to the EFH Safeguarding Board.

EFH will notify the Care Quality Commission (CQC) by email as soon as is reasonably practicable after the death of a resident during their service provision as required under the Care Quality Commission (Registration) Regulations 2009: Regulation 16.

Post-mortems

The coroner may decide that a post-mortem is needed to find out how the person died. This can be done either in a hospital or mortuary. The coroner's post-mortem cannot be objected to. However, if asked, the coroner must tell the next of kin (and the GP of the deceased) when and where the examination will take place.

The coroner may decide that the cause of death is clear, in which case:

The doctor signs a medical certificate.
The medical certificate is taken to the registrar.
The coroner issues a certificate to the registrar stating that a post-mortem is not needed.

After the Post-mortem

The coroner will release the body for a funeral when they have completed the post-mortem examinations and no further examinations are needed. If the body is released with no inquest, then the coroner will send a form ('Pink Form — form 100B') to the registrar stating the cause of death. The coroner will also send a 'Certificate of Coroner, form Cremation 6' if the body is to be cremated.

If the Coroner Decides to Hold an Inquest

A coroner must hold an inquest if the cause of death is still unknown, or if the deceased either possibly died a violent or unnatural death or died in prison or police custody.

EFH staff may be requested to attend / give evidence at an inquest. EFH will complete an internal investigation into any death that the coroner decides will go to an inquest. Legal advice may be sought.

This information is provided as family and friends may need additional information after a recent death of a loved one.

Cremation Forms

The doctor will complete form B of the cremation form (the first section) if requested and need not have issued the death certificate in order to do so; however, the doctor must satisfy the criteria in the section 'certification of death.'

It is the responsibility of the doctor who completes form B to contact another doctor in order to complete form C, the latter must not have known the individual and not be a partner of the hospice or doctor.

The completed cremation form should be left in the Manager's office for collection.

The undertakers should be informed if the individual was fitted with a cardiac pacemaker.

The suicide of an individual must be reported to the coroner.

EFH will notify the Care Quality Commission (CQC) by email as soon as is reasonably practicable after the death of a resident during their service provision as required under the Care Quality Commission (Registration) Regulations 2009: Regulation 16.

Training

RNs will be expected to update their competency by reflection on practice annually and keep a record of this in their revalidation portfolio

Care staff are provided with an awareness of our EFH commitment to improving social impact at all suitable stages of their employment from induction onwards.

Seeking Feedback about

EFH will seek feedback from people, families, staff, involved professionals and volunteers about their experiences of end of life where it is appropriate to do so. We will seek feedback in person during conversations and via surveys and meetings. We will respond to feedback and tell people about changes and improvements we make as a result of their feedback.

References

https://www.rcn.org.uk/get-help/rcn-advice/confirmation-of-death

Review date	Next Review Date
May 2024	May 2027