Cornwall Hospice Care
Caring for our community
Mount Edgcumbe Hospice St. Julia's Hospice
Registered Charity No. 1113140

NHS
Cornwall Partnership
NHS Foundation Trust

Verification of Death by Registered Nurse Guidance

(Version 10: Updated 7th April 2020)

ONLY FOR USE DURING THE COVID-19 PANDEMIC

Introduction

The overall aim of this guidance is to provide a framework to support registered nursing staff to verify adult death.

The guidance ensures that the death is dealt with:

- In line with local policy and current death legalities
- In a timely, sensitive and caring manner
- Respecting the dignity, religious and cultural needs of the patient, family and carers
- Ensuring the health and safety of others e.g. from infectious illness, radioactive implants and implantable devices

Inclusion criteria:

The guidance applies to registered nurses, deemed competent to verify the death of adults (over the age of 18), under the following circumstances:

- Expected deaths
- Sudden or unexpected deaths with a terminal period
- Deaths occurring in a private residence, hospice, residential home, nursing home or hospital
- It includes where the patient dies under the Mental Health Act including Deprivation of Liberty Safeguards (DoLS)
- A Treatment Escalation Plan (TEP) with a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order is recorded for the patient.

Nursing and Midwifery Council

Nurses undertaking this responsibility must do so in line with the professional standards as set out in the Nursing and Midwifery Council (2015):

The Code: Professional standards of practice and behaviour for nurses and midwives:

- Prioritise
- Practise effectively
- Preserve safety
- Promote professionalism and trust

https://www.nmc.org.uk/standards/code/

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NMC Standards of proficiency for registered nurses
(Annexe B – Nursing Procedures, section 10)

10. Use evidence-based, best practice approaches for meeting needs for care and support at the end of life, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

10.1 observe, and assess the need for intervention for people, families and carers, identify, assess and respond appropriately to uncontrolled symptoms and signs of distress including pain, nausea, thirst, constipation, restlessness, agitation, anxiety and depression

10.2 manage and monitor effectiveness of symptom relief medication, infusion pumps and other devices

10.3 assess and review preferences and care priorities of the dying person and their family and carers

10.4 understand and apply organ and tissue donation protocols, advanced planning decisions, living wills and health and lasting powers of attorney for health

10.5 understand and apply DNACPR (do not attempt cardiopulmonary resuscitation) decisions and verification of expected death

10.6 provide care for the deceased person and the bereaved respecting cultural requirements and protocols.

https://www.nmc.org.uk/standards/standards-for-nurses/standards-of-proficiency-for-registered-nurses/

Definitions & Legal considerations

Verification of the fact of death:

Formal verification, including clinical assessment to confirm that death has taken place and the associated responsibilities of identification of the deceased, notification of infectious illnesses and implantable devices. This is recognised as the official time of death.

Certification of death:

Certification of death is the process of completing the 'Medical Certificate of 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 person's death. Currently, in order to issue a MCCD, the doctor must have attended the patient in their last illness and either seen the patient in the 14 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 patient's health status, usually due to advanced progressive incurable disease. The death is anticipated, expected and predicted. It is anticipated in these circumstances that advance care planning and the consideration of DNACPR will have taken place. The death can be verified by the nurse even if the doctor has not seen the patient in the previous fourteen days.

Sudden or unexpected death within a terminal period:

A patient with a terminal diagnosis can have a sudden death e.g. from an embolism. Death can be verified by a registered nurse in these circumstances, provided the DNACPR order is in place. The death can be verified by the nurse even if the doctor has not seen the patient in the previous 14 days.

Sudden or unexpected death:

An unexpected death is not 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 patient is discovered dead and there are signs of irreversible death.

Do not attempt cardio-pulmonary resuscitation (DNACPR):

Cardio Pulmonary Resuscitation (CPR) is a medical treatment that endeavours to restart cardio respiratory function. The advance decision not to attempt CPR and allow a natural death is underpinned by comprehensive national guidance.

Circumstances when a death should be reported to the Coroner as documented within The Notification of Deaths Regulations 2019.

a. The death was due to:

- poisoning, including by an otherwise benign substance
- exposure to or contact with a toxic substance
- the use of a medicinal product, the use of a controlled drug or psychoactive substance
- violence, trauma or injury
- self-harm
- neglect, including self-neglect
- the person undergoing a treatment or procedure of a medical or similar nature
- an injury or disease attributable to any employment held by the person during the person's lifetime

b. The registered medical practitioner suspects that the person's death was unnatural but does not fall within any of the circumstances listed above.

c. The registered medical practitioner despite taking reasonable steps to determine the cause of death considers that the cause of death is unknown.

d. The registered medical practitioner suspects that the person died while in custody or otherwise in state detention – includes hospitals where the deceased was detained under the mental health legislation (including instances when the deceased is on a period of formal leave).

e. There was no attending medical practitioner required to sign a medical certificate of death in relation to the deceased person. (Only an attending medical practitioner who attended the deceased during his/her last illness before his/her death can complete an MCCD, without reference to a senior coroner. Under the registration of births and deaths regulations 1987, any MCCD that has not been completed by an attending medical practitioner who has seen the deceased wither in the 14 days prior to the date of death, or after death, must be reported to the coroner by the registrar). Please note the new provision given the COVID-19 pandemic: The MCCD can be issued if the Doctor is able to state the cause of death to the best of their knowledge. The issuing Doctor does not need to have attended the patient themselves but a medical practitioner must have attended the deceased within 28 days before death (expanded timescale) or after death.

f. The attending medical practitioner is not available within a reasonable time of the person's death to sign the certificate of cause of death

g. The identity of the deceased person is unknown.

The expectation is that all deaths that require reporting to the coroner will be in writing. The Coroner has introduced e-reporting to facilitate this.

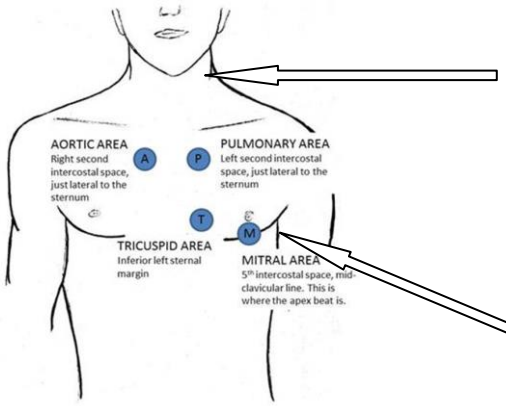
Clinical Examination and Documentation

Equipment required: Pen torch, Stethoscope, watch with second hand

Procedure:

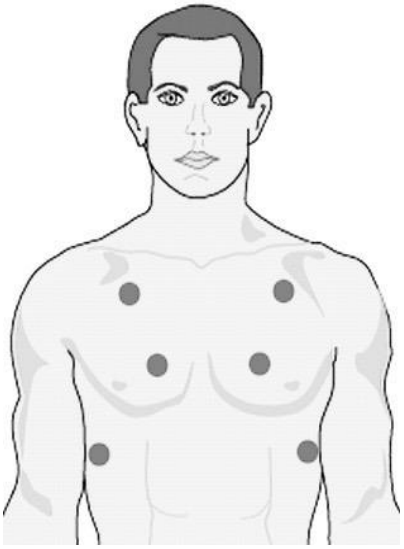
- Check for completed TEP with DNACPR order recorded
- Adopt infection control precautions
- Confirm the identity of the patient
- Note any infectious diseases, radioactive implants, implantable medical devices
- Undertake clinical assessment as follows:

Observe the patient for a minimum of five minutes to establish that irreversible cardio-respiratory arrest has occurred.

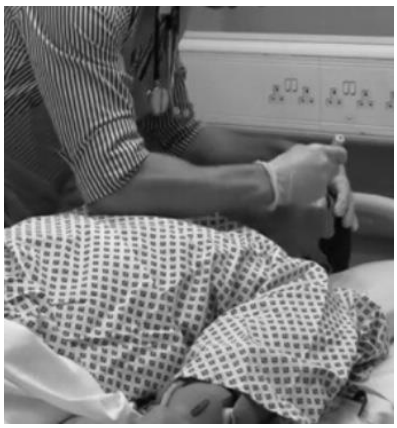


For at least one minute ensure absence of a central pulse on palpation to ensure there are no signs of cardiac output

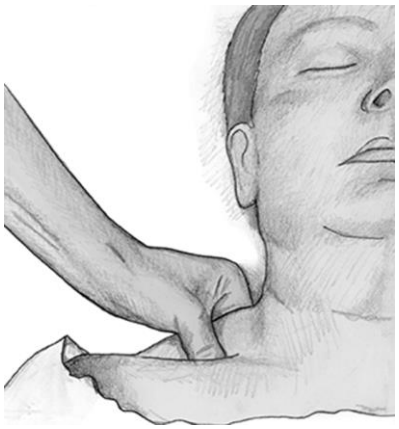
For at least one minute ensure absence of heart sounds on auscultation to ensure that there are no signs of cardiac output



Auscultate breath sounds for a minimum of one minute.
Observe for absence of respiratory effort 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 are tested to ensure there is no cerebral activity.



After five minutes of continued cardio-respiratory arrest the absence of motor response to trapezius squeeze is 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

Complete the Verification of Death Form; the time of death is recorded as when verification of death is completed (i.e. not when the death is first reported).

Care after Death

For an expected death, any drug administration equipment such as syringe drivers, and any other access devices attached to the patient such as a catheter should be removed and recorded.

For deaths requiring coroner referral await further instruction before removing tubes, lines and devices. Switch off flows of medicine and fluid administration, and spigot off urinary catheters if applicable.

For suspicious deaths do not move the body, leave all intravenous cannulae and lines in situ and intravenous infusions clamped but intact (this includes syringe drivers with controlled drugs). Leave urinary catheter in situ with the bag and contents. Do not wash the body.

The nurse should ensure appropriate communication is delivered in a sensitive and respectful manner when informing relatives of a person's death.

The religious or cultural wishes of the deceased and their family should be respected where possible, ensuring any legal obligations are met.

Any spiritual/cultural needs should be addressed, and proceed with personal care after death (last offices) if the coroner/police are not involved. Allow family present the opportunity to participate (if appropriate).

If applicable, facilitate the deceased's wishes for tissue / body donation. Record if any jewellery, dentures or other possessions remain on the deceased. Document if there is any infectious diseases, radioactive implants, implantable devices.

Complete the Hazard Notification Form in preparation for transfer.

Those handling bodies should be aware that there is likely to be a continuing risk of infection from the body fluids and tissues of cases where coronavirus (SARS-CoV2) infection is identified, through either a clinical diagnosis or laboratory confirmation.

The usual principles of Standard Infection Control Precautions (SICPs) and Transmission-Based Precautions (TBPs) apply for bodies that are suspected or confirmed to be infected with coronavirus (SARS-CoV2). No additional precautions are needed unless Aerosol Generating Procedures (AGPs) are being undertaken. For more information please refer to https://www.gov.uk/government/publications/covid-19-guidance-for-care-of-the-deceased/guidance-for-care-of-the-deceased-with-suspected-or-confirmed-coronavirus-covid-19

Body bags are not required in terms of COVID-19 risk, but may be required for other, practical Reasons; such as maintaining dignity or preventing leakage.

On the 5th March 2020 COVID-19 was added to the list of notifiable disease, this change was made by adding it to the health protection (notification) regulations 2010. The change in law requires GPs in England to report all cases of COVID-19 to Public Health England. Visit the Gov.uk website for more information on how to report notifiable diseases

PLEASE NOTE THAT DURING THE CORONVIRUS PANDEMIC CHANGES TO NORMAL PRACTICE WITH RESPECT TO VERIFICATION OF DEATH, TRANSFER OF THE DECEASED AND THE CERTIFICATION PROCESS WILL OCCUR. PLEASE ENSURE YOU ACCESS THE LATEST GUIDANCE & SUPPORTIVE INFORMATION AS IT BECOMES AVAILABLE THROUGHOUT THIS PERIOD OF TIME.

(Refer to page 10 & 11 for further information)

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Verification of Death by Registered Nurse Flow Chart Process

(Subject to change during the coronavirus pandemic)

Are there any signs, or suggestions, that this death may be from anything other than natural causes? Are there any suspicious circumstances, any unusual or disturbing features or concerns?

NO

Confirm that the patient has a TEP with DNACPR order

- Observe the patient for a minimum of 5 minutes to establish that cardio-respiratory arrest has occurred.
- Palpate central pulse for at least one minute
- Auscultate heart sounds at least one minute
- Observe respiratory effort by observation over the five minute period & auscultate breath sounds for a minimum of one minute.

After 5 minutes of continued cardio-respiratory arrest:

- Confirm absence of pupillary responses
- Test response to trapezius squeeze to confirmed absence of motor response

Complete Verification of Death Form

YES

Preserve the scene and call the police. Do not move the body, leave all intravenous cannulae and lines in situ and intravenous infusions clamped but intact (this includes syringe drivers with controlled drugs). Leave any catheter in situ with the bag and contents. Do not wash the body.

Do circumstances require mandatory referral to coroner?

YES

Arrange for transfer of the deceased via the duty undertaker / coroners officer via 101 Leave tubes, lines and devices. Switch off flows of medicine and fluid administration, and spigot off urinary catheters if applicable.

NO

Undertake last offices, remove lines, equipment. And arrange transfer of the deceased to the chosen undertaker. Complete the Hazard Notification. For in-patient units complete 2 patient ID bands (wrist and ankle) and 2 RIP identification cards.

Notify the patient's GP/Doctor. Undertake after death analysis reflection and staff debrief.

Provide support and understanding to family / significant others throughout all stages and provide written information on the procedure to be followed after death, including how to collect the medical certificate cause of death (MCCD), where to register the death, and the role of the funeral director and bereavement support agencies. Ensure written information is given in a supportive way.

COVID-19 SUMMARY GUIDELINES

The Chief Coroner has issued guidance to Coroners about the approach to COVID-19: https://www.judiciary.uk/wp-content/uploads/2020/03/Chief-Coroner-Guidance-No.-34-COVID-19_26_March_2020-.pdf

In summary:

- The majority of COVID-19 deaths are not required to be reported to the coroner. COVID-19 is capable of being a natural cause of death.

- COVID-19 is an acceptable direct or underlying cause of death for the purposes of completing the Medical Certificate of Cause of Death (MCCD).

- COVID-19 as cause of death (or contributory cause) is not a reason on its own to refer a death to a coroner.

Further guidance has been issued summarising the position on completing the Medical Certificate of Cause of Death and the relaxation of provisions given the COVID-19 pandemic: https://www.judiciary.uk/wp-content/uploads/2020/03/Chief-Coroners-Office-Summary-of-the-Coronavirus-Act-2020-30.03.20.pdf

In summary:

- The MCCD can be issued if the Doctor is able to state the cause of death to the best of their knowledge. The issuing Doctor does not need to have attended the patient themselves but a medical practitioner must have attended the deceased within 28 days before death (expanded timescale) or after death.

- "Attendance" before death can be visual, including by video-link/skype but not solely audio such as a telephone call. Attendance after death must be in person.

- In Cornwall the Pre Notified Death Form can be reviewed by telephone review.

- In relation to cremations – the requirement for a confirmatory certificate is suspended – this means only one medical certificate is required, which can be completed by ANY medical practitioner. Doctors will be required to complete 'part 1' as per previous paper work. There will be no requirement for 'part 2.'

Registering a death:

For Doctors:

- Issue usual MCCD as before
- Scan and send to mc.cds@cornwall.gov.uk ensuring the whole certificate is captured
- Send original to Registrar, Dalvenie House, New County Hall, Truro, TR1 3AY

For Families:

- Go to Cornwall Council's website: https://www.cornwall.gov.uk/advice-and-benefits/deaths-funerals-and-cremations/registering-a-death/
- Complete online form requesting a telephone appointment or call the customer services team on 0300 1234 181 between the hours of 8:30am – 6:00pm Monday to Friday
- Registrar then contacts family direct by phone

The Acting Senior Coroner for Cornwall has also issued further guidance for doctors: https://www.cornwall.gov.uk/media/43011322/guidance-for-doctors-during-coronvirirus-pandemic.pdf

Pre-Notified Death Forms (PNDF) update - referenced from the above guidance:

"The period of validity of a Pre-Notified Death Form is to be extended from 14 days to 28 days. This is consistent with the notice provisions for completing an MCCD contained with the Coronavirus Act.

To extend the validity of a PNDF, there is no longer a requirement for a doctor personally to attend upon a patient. Where a patient is at home, a telephone call to a member of the family providing care will suffice. Similarly, where a patient is in a Care or Nursing Home, a telephone call to Matron or an Allied Health Professional will be sufficient.

Doctors are expected to check that a patient's status is unchanged or worsening i.e. there is an expectation of imminent death. A record of the telephone call confirming the identity of the persons involved and the date it took place should be entered in the notes".

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Verification of Death Form

Full Name:	Date of Birth:
Patient's GP or Ward Doctor:	NHS Number:
Pre-notification of death form in place: Yes / No (expected death)	TEP with DNACPR in place: Yes / No

Clinical Examination and Observation	**Tick box confirm**
The patient has been observed for a minimum of five minutes to establish that irreversible cardio-respiratory arrest has occurred.	☐
Palpate central pulse for at least one minute: Absence of carotid pulse confirmed.	☐
Auscultate heart sounds for a least one minute: Absence of heart sounds confirmed.	☐
Auscultate breath sounds for one minute and observe for the absence of respiratory effort over the five minutes: Absence of respiratory effort confirmed.	☐
After five minutes of continued cardio-respiratory arrest test pupillary response to light: Absence of pupillary responses confirmed.	☐
After five minutes of continued cardio-respiratory arrest test response to trapezius squeeze: Absence of motor response confirmed.	☐

Name, signature and designation of verifier:

Date death verified: **Time death verified:** **Place of death:**

Medical practitioner notified: Yes / No	**Coroner referral required: Yes / No**

Those present at the time of death:

Next of kin informed: Yes / No

Dentures in situ: Yes / No	Jewellery in situ: Yes / No
Pacemaker in situ: Yes / No	Implantable Cardiac Defibrillator (ICD) in situ: Yes / No
Radioactive implants: Yes / No	Notifiable infection present or suspected: Yes / No

Hazard Notification form completed? Yes / No

TRANSFER OF CARE

Inpatient setting: Patient transferred to: Patient identification check completed: Yes / No Nurse print name: Signature: Undertaker print name: Signature: Date & time of transfer:	**Community setting:** Document details regarding transfer arrangements:

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Hazard Notification Form

1	Name of deceased		
2	Date and time of death		
3	Source (hospital, ward or other)		
4	Infection Risk from the deceased		
4a	Does the deceased present an infection risk? (ring as appropriate)		
	Yes	Suspected	Non suspected
4b	If yes what are the likely routes of transmission? (ring all that apply)		
	Airborne	Droplet	Contact
4c	Infection (If permitted to disclose)		
4d	Provide any relevant information to enable the deceased to be handled safely		
5	Condition of the deceased		
5a	Is the deceased leaking body fluids? Please provide details		
5b	Have accessories that present a risk of sharps injury been removed?		
5c	If yes, have the puncture points been covered or sealed?		
5d	If no, please provide details and location		
5e	Does the deceased have an implantable device?		
	No	Yes and switched off	Yes but not switched off
5f	If yes, please provide details and location		
5g	Was the deceased receiving radiotherapy? (if yes, please provide details)		
6	Signed		
	Print Name		
	Organisation		

This information needs to be handled sensitively and securely to ensure confidentiality of the deceased's personal information. It should be shared only with those who need it to handle the deceased safely (as required by the Health and Safety at Work etc Act 1974). This form provides one means of sharing the pertinent information

Guidance Notes to support completion of Hazard Notification Form

The information needs to be handled sensitively and securely to ensure confidentiality of the deceased's personal information. It should be shared only with those who need it to handle the deceased safely (as required by the Health and Safety at Work etc Act 1974). This form provides one means of sharing the pertinent information.

1. Providing sufficient information on infection risks from handling the deceased will enable the appropriate precautions to be taken. Where infection is the primary cause of death, please ring 'Yes' for Q4a. Infection may not be the primary cause of death but if the deceased was suffering from an infection, please ring 'Yes' or 'Suspected' for Q4a. Where there are no indications that the deceased was suffering from an infection, or where the deceased was on a course of antimicrobial medication that would minimise the infection risk, please ring 'None suspected' for Q4a and proceed to section 5, 'Condition of the deceased'.

2. When handling the deceased, standard infection control precautions (SICPs) are considered the minimum protective measures to be used. In Q4b provide information on how exposure to infection may occur. This will help those handling the deceased to consider adopting additional control measures (transmission-based precautions or TBPs) appropriate to the route by which they can be exposed and transmission can occur.

3. If the infection is known it is helpful, though not essential, to provide specific details in Q4c of the infectious agent, to inform the risk assessment and assist with possible treatment should exposure occur. This information may only be disclosed with prior permission of the deceased or their family.

4. In Q4d provide any information relevant to infection risk that may assist in deciding whether and how the deceased should be handled during viewing, preparing (hygienic preparation), embalming, post-mortem examination or exhumation. For example, indicate why a body bag has been used, whether a body bag is necessary, and details of any counter-indications that may prevent specific activities (e.g. embalming) being performed. It may be appropriate to consult Appendix 1 of '*Managing infection risks when handling the deceased*' for further information.

5. In section 5 provide information on the condition of the deceased that would be helpful in deciding whether and how they should be handled. It highlights important issues, eg sharp medical devices or implantable devices (e.g. pacemakers), their location and whether they need to be removed.

6. In hospital cases, the doctor and/or nursing staff with knowledge of the deceased's condition is asked to sign section 6 of this form. Where a post-mortem examination has been undertaken, the pathologist (or qualified anatomical pathology technologist) is asked to sign. In non-hospital situations (e.g. community setting), the doctor and / or nursing staff with knowledge of the deceased's condition is asked to sign.

References

3rd Edition of Care After Death: Registered Nurse Verification of Expected Adult Death (RNVoEAD) guidance November 2019

COVID-19 Guidance for infection prevention and control in healthcare settings

https://www.gov.uk/government/publications/covid-19-guidance-for-care-of-the-deceased/guidance-for-care-of-the-deceased-with-suspected-or-confirmed-coronavirus-covid-19

Guidance for registered medical practitioners on the Notification of Deaths Regulations

The Notification of Deaths Regulations 2019

Managing infection risks when handling the deceased
https://www.hse.gov.uk/pUbns/priced/hsg283.pdf

https://www.judiciary.uk/wp-content/uploads/2020/03/Chief-Coroner-Guidance-No.-34-COVID-19_26_March_2020-.pdf

Daily bulletin 03.04.2020 cftcommunications@nhs.net

https://www.judiciary.uk/wp-content/uploads/2020/03/Chief-Coroners-Office-Summary-of-the-Coronavirus-Act-2020-30.03.20.pdf

https://www.cornwall.gov.uk/media/43011322/guidance-for-doctors-during-coronvirirus-pandemic.pdf

https://www.cornwall.gov.uk/advice-and-benefits/deaths-funerals-and-cremations/registering-a-death/