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Care After Death: Registered Nurse Verification of Expected Adult Death (RNVoEAD) Guidance

(Sixth Edition)

National Nurse Consultant Group Palliative Care

Royal College of Nursing

Royal College of General Practitioners

national association for hospice at home

Contents

Version Control

Date	Version	Reason
2 April 2024	6.0	References to COVID all removed. Role of the Medical Examiner added in (applicable from April 2024). Paragraph on Non Invasive Ventilation added in.
18 April 2023	5.1	Page 10; **Motor / Cerebral Response** After five minutes of continued cardio-respiratory arrest, test for the absence of motor response with the trapezius squeeze or the absence of cerebral activity with supra orbital pressure, which is considered best practice. To ensure there are no signs of motor or cerebral activity.

Introduction

The aim of this guidance is to provide a framework for the timely verification of expected adult deaths by experienced (assessed as competent), registered nurses (RN)[1]. It is anticipated that local areas will develop their policies based on the guidance, but sensitised to the local area, enabling staff to care appropriately for the deceased, supporting and minimising distress for families and carers at any time of the day, night, or week. This guidance has been developed in line with the person and family centred care recommended in national documents.[2]

Timely verification – within one hour in a hospital setting and within four hours in a community setting[3] – is supportive to bereaved families, and is necessary prior to the deceased being moved to either the mortuary or funeral directors,

Families should be advised that there might be a difference between the time of the last breath and the official time of death[4].

This guidance ensures that the death is dealt with:

- in line with the law and coroner requirements[5] (see Appendix 1)
- in a timely, sensitive, and caring manner
- respecting the dignity, religious and cultural needs of the patient and family members as far as is practicable
- ensuring the health and safety of others, e.g. from infectious illness, radioactive implants, and implantable devices.

A competency assessment tool (see Appendix 2) accompanies this guidance for RNs to demonstrate their practical skills, knowledge and understanding for verifying an expected adult death. RNs already competent in verification of an expected adult death are not expected to repeat the competency assessment, rather to familiarise themselves with the changes within this guidance and adopt the changes into their practice.

There has been an e-learning module for the Registered Nurse Verification of Expected Adult Death[6] developed by e-Learning for Health and this may provide a useful resource. Local areas may want to adopt a pragmatic approach to training. If the RN does not feel confident after completing training, they could undertake the verification of death with the remote support and guidance of a more experienced colleague[7].

This guidance may be used to inform training for other registered healthcare professionals who are regulated by a professional body who, under statutory regulation, are recognised by the Professional Standards Authority[8].

Scope of the guidelines

Inclusion criteria

The guidance applies to RNs, deemed competent, working within their care setting to verify the death of all adults (over the age of 18), and where the following conditions apply:

- Death is expected and not accompanied by any suspicious circumstances.
- An individualised conversation between the patient and a healthcare professional agreeing to the DNACPR decision has previously been undertaken and recorded in the patient's clinical notes.
- Where the person is found deceased without a DNACPR conversation documented and there are signs of irreversible death (e.g. rigor mortis), verification of death by the RN can be carried out.
- Death occurs 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).

Exclusion criteria

Any expected adult death believed to have occurred in suspicious circumstances.

Definitions

Recognition of death

It is recognised that relatives, nursing home staff and others can recognise that death has occurred.

Verification of the fact of death

Verification of the fact of death documents the death formally in line with national guidance.[9] The time of verification is recognised as the official time of death. Associated responsibilities include identification of the deceased, and notification of any infectious diseases and/or implantable devices[10].

We recognise that doctors call this process 'confirmation of death', and is the term used in Scotland, and that paramedics call this process 'recognition of life extinct'. Nurses will continue to use the term 'verification of death' and we will all mutually review terminology at a future point.

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 person's death.[11] The Coronavirus Act 2020[12] and information for Death certification processes: information for medical practitioners after the Coronavirus Act 2020 expires[13] in March 2022 allows for the issue of a MCCD where

the medical practitioner has seen the deceased within 28 days prior to death (rather than 14 days), and includes seeing the patient via a video link, OR after death. If the medical practitioner has not seen the person prior to death, then they will need to view the deceased directly and not via video link.

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 even if the doctor has not seen the patient in the previous 28 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 the death is completely unexpected, and the healthcare professional is present then there is an expectation that resuscitation will commence [14].

There is further clear guidance from the Resuscitation Council UK for circumstances where a patient is discovered dead and there are signs of irreversible death.[15] In such circumstances, the RN may make an informed clinical judgement not to commence CPR, for example clear signs of rigor mortis. The RN must be able to articulate and document clearly their actions and reasoning.

Medical Examiner (ME)

From April 2024, the role of the Medical Examiner (ME) will be extended to include an oversight of all proposed causes of death. There will also be a new MCCD to include the details of the ME who is scrutinising the cause of death, the deceased' ethnicity and details of any medical devices or implants.

Do not attempt cardio-pulmonary resuscitation (DNACPR)

Cardiopulmonary 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 [16]. A DNACPR can be completed by an appropriately trained and competent practitioner, including RNs, and should take place with the individual's consent. Where the person is unable to participate in the decision, for example through lack of capacity or unconsciousness, the healthcare team may make the decision in the person's best interest, involving those important to the patient.

Responsibilities

Medical

- The doctor will be available, if necessary, to speak to the family after death of the patient. This should be arranged at the soonest mutually convenient time and could be a telephone or virtual discussion.
- The responsible doctor or a delegated doctor will endeavour to be available to explain the cause of death they have written on the medical certificate of cause of death (MCCD), alongside the Medical Examiner (ME) process.
- Notification of infectious diseases, statements relevant to cremation and MCCDs are the responsibility of the medical practitioner.

Nursing

- All RNs must have read and understood this guidance, received appropriate training and be deemed competent.
- The RN should know the medical legal responsibilities, i.e. notification of infectious diseases, statements relevant to cremation, MCCDs and the electronic transfer of these to the registrar and the need for families to register the death in person.
- The RN carrying out this procedure must inform the doctor of the patient's death (both in and out of hours), using agreed local systems and document the date and time verification was carried out in the clinical record.
- The RN must instigate the process for deactivation of the Implantable Cardiac Defibrillator (ICD)[17], where applicable.
- The RN carrying out the verification of death must notify the funeral director or mortuary of any confirmed or suspected infections, radioactive implants, implantable devices and whether an ICD is still active.
- It is the right of the verifying nurse to refuse to verify a death and to request the attendance of the responsible doctor, or police if there is any unusual situation.

Procedure Guide

Personal Protective Equipment (PPE)

To maintain the safety of the RN carrying out the verification of death, these guidelines should be used in conjunction with local policy and universal infection control precautions.

Equipment (cleaned in accordance with local procedure):

- Pen torch
- Stethoscope
- Watch with second hand

- Disposable plastic apron
- Disposable gloves
- Disposable plastic waste bags
- Alcohol hand gel

Risk Assessment

The RN verifying the death should undertake a risk assessment with regards to the environment and potential infection status.

- Clinical Notes: these should be accessible to the RN in clinical settings, or care homes ahead of the process of verifying death. This may not be the case in the patient's own home.

Procedure

ACTION	RATIONALE
Adopt standard infection control precautions.	To ensure protection of the RN from cross-contamination.
Check identification of the patient against available documentation, for example, clinical records, NHS number.	To correctly identify the deceased.
Where a DNACPR is not available or in place, ensure clear clinical judgement that the death is irreversible.	To articulate and document decision not to commence CPR.
Identify any suspected or confirmed infectious diseases, radioactive implants, implantable medical devices. **See the 'Notification of Infectious Diseases' section in Appendix 1.*	To enable correct information to be passed on to ensure others involved in the care of the deceased are protected.
Where applicable, instigate the process for deactivation of Implantable Cardiac Defibrillator (ICD), if not already deactivated.	To ensure the timely deactivation of ICD.
Lie the patient flat.	To ensure the patient is flat ahead of rigor mortis.
Leave all tubes, lines, drains, medication patches and pumps, etc. in situ (switching off flows of medicine and fluid administration if in	To ensure all treatments are stopped prior to the verification of death examination.

ACTION	RATIONALE
situ), and spigot off as applicable and explain to those present why these are left at this time.	These may be removed after the verification of death examination and only if the death is not being referred to the coroner[18]
VERIFICATION OF DEATH EXAMINATION **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.** ***NOTE a change in the order of examination to minimise contamination of equipment.*** **NB:** In the rare case of a patient in the community having non-invasive ventilation (NIV), and the patient has died, the NIV will cause the chest to continue to rise and fall, mimicking respiratory effort from the patient. However, you would anticipate that all other signs of life are absent. It is recommended that the ventilator be switched off and continued checking for a pulse, alongside auscultating for the presence of a heartbeat, occurs. Following this, the verification process should be followed, ensuring all checks are conducted over the 5-minute period. **If there are any doubts or concerns over verifying the death, it is advisable to liaise with the GP or other medical practitioner.**	
Central Pulse For at least one minute, ensure absence of a central pulse on palpation.	To ensure there are no signs of cardiac output.
Heart Sounds For at least one minute, ensure absence of heart sounds on auscultation.	To ensure there are no signs of cardiac output.
Respiratory Effort Absence of respiratory effort by observation over the five minutes.	To ensure there are no signs of respiratory effort.
Neurological Response Using the pen torch, test both eyes for the absence of pupillary response to light.	To ensure there is no sign of cerebral activity.
Motor/ Cerebral Response After five minutes of continued cardio-respiratory arrest, test for the absence of motor response with the trapezius squeeze or the absence of cerebral activity with supra orbital pressure, which is considered best practice.	To ensure there are no signs of motor or cerebral activity.

ACTION	RATIONALE
Any spontaneous return of cardiac or respiratory activity during this period of observation should prompt a further five minutes of observations.	
In hospital, ensure the patient is identified correctly with two name bands in situ completed with: name, date of birth, address, or NHS number.	To ensure the patient is identifiable.
Dispose of waste in line with local policy for waste management of clinical waste.	To ensure correct management of clinical waste in patient's own homes.
Perform hand hygiene following removal and disposal of PPE.	Follow local infection prevention and control standards in correct management of contaminated PPE.
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.
The RN verifying the death must acknowledge the emotional impact of the death and ensure the bereaved family and friends are offered information about "the next steps".	To ensure the family are supported during this difficult time.
The RN verifying death should understand the potential / actual emotional impact of bereavement on surrounding patients and residents in a communal setting and prompt colleagues and paid carers to provide appropriate support.	To ensure surrounding patients and residents are supported during this difficult time.
The RN verifying death should understand the potential / actual emotional impact of bereavement for colleagues and paid carers and guide them towards appropriate support.	To ensure colleagues and paid carers are supported during this difficult time.

Auditing and Monitoring

RNs will be expected to update their competency by reflection on practice annually and keep this in their portfolio.

Evidence of audit – both organisational in terms of the processes of care after death including RNVoEAD, and the experience of bereaved relatives in line with national guidance.[19]

Appendix 1

Deaths requiring coroner investigation

Deaths requiring referral to the coroner's office for investigation are when: [20]

- the cause of death is unknown
- there is no attending practitioner(s) or the attending practitioner(s) are unavailable within a prescribed period
- the death may have been caused by violence, trauma, or physical injury, whether intentional or otherwise
- the death may have been caused by poisoning
- the death may be the result of intentional self-harm
- the death may be the result of neglect or failure of care
- the death may be related to a medical procedure or treatment
- the death may be due to an injury or disease received in the course of employment or industrial poisoning
- the death occurred while the deceased was in custody or state detention, whatever the death.

A person who dies from a notifiable infectious disease, e.g. COVID-19, is not a reason to refer the death to the coroner. [21]

Notification of infectious diseases

Notifiable diseases are nationally reported in order to detect possible outbreaks of disease and epidemics as rapidly as possible, and it is important to note: [22]

- Diagnosis of suspected (and/or confirmed) COVID-19 is a notifiable infectious disease.
- Registered medical practitioners have a statutory duty to inform their local health protection team of a diagnosis of a suspected notifiable infections disease, and without waiting for laboratory confirmation, at time of diagnosis.
- All laboratories where diagnostic testing is carried out must notify the UK Health Security Agency, previously Public Health England, of any confirmation of a notifiable infectious disease.

Appendix 2

Assessment of Competence for Registered Nurse Verification of Expected Adult Death

Name of registered nurse:

Name and signature of trainer:

Date of training:

Assessor guidance

- The competencies are a mixture of practical skills, knowledge and understanding.
- All criteria must be achieved during training to achieve competency.
- Registered nurses (RNs) will self-assess at the completion of the training that they feel competent to perform this skill independently. Competence can be achieved at the first assessment, which can occur as part of the training.
- It is recommended that RNs reflect on this skill within their clinical practice at least annually during the appraisal process.

	Assessment of Competence	Competent
	Criteria	**YES / NO**
Standard 1: The registered nurse is aware of their role and associated guidance		
	Guidance for staff responsible for care after death.	
	Guidance re RN verification of expected adult death.	
Standard 2: The registered nurse is aware of the following definitions		
	Who can recognise a death?	
	Who can verify a death?	
	Who can certify a death?	
	What is an expected death?	
	What is a sudden or unexpected death?	
	Individualised agreement to DNACPR documented in the clinical notes.	
	What is the definition of the official time of death?	
	Deaths requiring coroner involvement.	
	Notification of infectious diseases	

	Assessment of Competence	Competent
	Criteria	**YES / NO**
Standard 3: The registered nurse is aware of the medical and nursing responsibilities		
	The medical responsibilities.	
	The nursing responsibilities.	
Standard 4: The registered nurse understands the procedure for verification of a patient's death		
	Demonstrates universal infection control precautions	
	The patient is identifiable from available documents.	
	There is a completed DNACPR form, or equivalent. Where there is not a DNACPR form, demonstrate clear clinical rationale that the death is irreversible.	
	Infections, implantable devices, and radioactive implants are identified, for example, from the medical notes.	
	To instigate the process for deactivation of Implantable Cardiac Defibrillator, if not already deactivated.	
Standard 5: The registered nurse is able to follow the procedure and carry out a patient examination to verify death		
	Position the patient for examination and verification of the fact of death.	
	Knows what to do with tubes, lines, drains, patches and pumps.	
	Understands that the patient must be observed for a minimum of five minutes to establish that irreversible cardio-respiratory arrest has occurred.	
	Ensures absence of a central pulse on palpation.	
	Ensures absence of heart sounds on auscultation.	
	Ensures absence of respiratory effort by observation over the five minutes.	
	Ensures both eyes are tested for the absence of pupillary response to light.	
	Ensures that after five minutes of continued cardio-respiratory arrest the absence of motor response to trapezius squeeze is tested.	

	Assessment of Competence	Competent
	Criteria	**YES / NO**
	Ensures that any spontaneous return of cardiac or respiratory activity during this period of observation would prompt a further five minutes observations.	
	Knows how to correctly label the deceased for identification.	
Standard 6: The registered nurse completes appropriate documentation in a timely way		
	How to complete the local verification of death form.	
	How to record the time of death.	
	How to notify the doctor.	
Standard 7: The nurse knows how to support and provide appropriate information to the bereaved family and friends		
	Understands the potential/actual emotional impact of a bereavement on the family and friends	
	Can demonstrate how they would support the bereaved at the time of death.	
	Understand the potential / actual emotional impact on surrounding patients and residents in communal setting	
	Can demonstrate how they would support surrounding patients / residents without breaching confidentiality.	
	Understands the potential/ actual emotional impact of a bereavement for colleagues and paid carers.	
	Can demonstrate how they would support colleagues and paid carers	
	Knows the support information available for bereaved family and friends.	
	Knows how to signpost relatives to where to collect paperwork and the next steps.	

Competency statement

I …… (Name) feel competent to perform RNVoEAD unsupervised.

Signed……. Designation…….. Date……

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(all links checked March 2024)

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