Brent NHS
Teaching Primary Care Trust
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POLICY REGARDING VERIFICATION OF DEATH FOR PATIENTS IN TRUST Community HOSPITALS

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POLICY REGARDING VERIFICATION OF EXPECTED DEATH FOR PATIENTS IN COMMUNITY HOSPITALS

1. POLICY STATEMENT

First level Registered Nurses within the Trusts bedded services are permitted to perform the role of verifying the death of a patient in cases when the patient's death is imminent.

This Policy makes the distinction between an imminent and expected death and a sudden, unexpected death. It allows a Registered Nurse to verify death only in the circumstances of an imminent and expected death.

It does not allow a nurse at any time to certify a death.

Certification of death is a medical responsibility and must be performed by a doctor within 24 hours after a nurse has verified a patient's death.

Nurses and doctors must be aware of individual cultural and religious requirements of individual patients (eg the body of a Jewish patient certification of death must be completed within 24 hours of time of death)

After verification of death the patient's body can be taken to the mortuary or a chapel of rest and the doctor can then certify the body there within the specified time.

2. RATIONALE

Where a death is imminent and expected and medical personnel are not continuously on site, it is appropriate to minimise delay, in order that other patients and relatives are not further distressed.

3. CRITERIA FOR PERFORMING THE ROLE

Training in 'Verification of Death' must be undertaken by all nursing staff required to execute this task.

Each nurse required to do so, has the responsibility for ensuring their own competence, which must be agreed / signed off by their local tutor.

The expectation of the patient's death must, wherever possible, be discussed jointly between the medical, nursing staff, patient and relatives/ carers.

Where appropriate, a 'Do Not Resuscitate' DNR order must be completed by the medical team and stored in the medical section of the patient notes. {See RP 33 and DTC 18 (Parkside adopted)}.

The medical personnel should also document an indication that death is expected / imminent, when this is decided.

4. PROTOCOL FOR VERIFICATION OF DEATH

4.1 An assessment of the patient must be carried out in the following way to verify death.

The requirements of this are to:

- check pupils for absence of reaction to light
- check patient for absence of carotid or femoral pulses
- check that there are no heart sounds
- check that there are no chest or breath sounds
- check that there is no reaction to pain or reflexes

If **all** of the above are absent the nurse may verify that the patient as died.

4.2 Following the verification of death the nurse must:

- inform the doctor on call
- inform the relatives if not present
- document the following in the medical and nursing notes, including the following information:

i. Date and time of death.

ii That the patient was examined (by name and full signature) and the following signs were absent:

a. pupil reaction to light
b. palpable pulses
c. heart and breath / chest sounds
d. reflex response to stimulus

- arrange for the transfer of the patient to the mortuary

5. EXCEPTIONS TO THE POLICY

Nursing staff are not covered by the policy to verify death in unexpected circumstances

These include:

1. Where the client has no recent DNR agreement.
2. Where there is cause to believe that there is a suspicion of unnatural death.
3. Where there has been a serious untoward incident (see RP 15), e.g. Death following a fall, Drug error

In such circumstances a doctor must always be called

Appendix 1

Additional Information
A doctor may be required to complete a form of certification for a dead person in one of four circumstances:

1. To verify the fact of death. For this, the body must not have been moved to any setting in which survival would be compromised, e.g. a locked space not visited by any staff, or a refrigerator, or an undertaker. However, under an appropriate policy cover a nurse can verify the fact of death. Once the fact of death has been verified, the body can be refrigerated, including at an undertaker.

2. To certify the cause of death. A doctor who has cared for the person in their final illness is the only one who can complete this certificate. But that doctor does not have to see the actual body, only to know the fact of death as verified by another doctor or health professional.

3. To complete the Part 1 of the Cremation Certificate. For this, the doctor must have cared for the person in their final illness and see the body.

4. To complete the Part II of the Cremation Certificate. For this, the doctor must be entirely independent from the team that cared for the person in their final illness, but must see the body and talk to the doctor who completed Part I. Undertakers typically have GPs local to their mortuary organised to complete Part IIs when required.

References

Risk Policies RP 15, 33
Drugs and Therapeutics Committee policy DTC 18 (Old Parkside Policy awaiting review)

Professional Nursing Forum
September 2004