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

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Introduction

In these unprecedented times of the COVID-19 pandemic, we are aware that this guidance is subject to local policy and changing circumstances and may be adapted as the situation evolves. Infection prevention and control evidence related to COVID-19 and person-centred care is rapidly evolving, and further updates may be made to this guidance in response to this.

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 / 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, We recognise that this timeframe may not be achievable under current COVID-19 pandemic circumstances, in these cases it may be; appropriate to offer guidance to families regarding the positioning of the deceased person and the maintenance of a cool environment.

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[6]
- ensuring the health and safety of others, e.g. from infectious illness including COVID-19, radioactive implants, and implantable devices[7]

A competency assessment tool (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 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. We acknowledge that in these difficult times there is

a need to train staff swiftly. There has been an e-learning module for the Registered Nurse Verification of Expected Adult Death[8] developed by e-Learning for Health and this may provide a useful resource. Local areas may want to adopt a pragmatic approach for the duration of the pandemic with RNs completing a self-assessment of the competencies, with a return to normal practice once the crisis is over. If the RN does not feel confident due to lack of practical experience, they could undertake the verification of death with the remote support and guidance of a more experienced colleague[9].

Changes in this Special Edition in response to COVID-19

In direct response to the COVID-19 outbreak, and the need for clarity, Hospice UK has reviewed the 3rd Edition guidelines for RNVoEAD and produced a Special Edition. We are now updating this Special Edition to include the latest guidance[10]. It includes these additions:

- **Infection Control precautions:** Personal Protective Equipment (PPE) should be worn when carrying out verification of death on all adults, including those suspected of, or confirmed to be, COVID-19 positive, and by following UK Infection Prevention and Control (IPC) guides for safe PPE selection (Appendix 3), and for donning and doffing PPE in non-aerosol generated procedures[11] (Appendix 4).
- **Revised Procedure:** the use of PPE for verification has been updated, and the order of the examination for verification of death has changed to protect the practitioner and minimise infection risk of contamination of equipment and PPE (see Procedure Guidelines).
- **Medical Certificate of the Cause of Death (MCCD):** can be issued where a medical practitioner has seen the deceased up to 28 days prior to death (previously 14 days) and includes via video link or in person after death.
- **Referral to a Coroner**: a person suspected of, or confirmed with, COVID-19 at the time of death is not a reason on its own to refer the death to the coroner (see Appendix 1).
- **Notifiable Diseases:** Diagnosis of suspected (or confirmed) COVID-19 is a notifiable infectious disease and must be reported to the Health Protection team by the medical registered practitioner at the time of the suspected diagnosis (see Appendix 1).

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. This includes when the person has died expectedly from or with COVID-19.
- 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, prison, 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.[12] 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[13].

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.[14] The Coronavirus Act 2020[15] now 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

video link (such as skype), 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. Any medical practitioner can issue a MCCD without having personally attended the deceased, including in the person's home, provided they are sufficiently able to ascertain the cause of 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 even if the doctor has not seen the patient in the previous 28 days. Confirmed or suspected COVID-19 does not by itself make the death sudden or unexpected; but could if the death were considered unexpected.

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 [16].

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.[17] 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.

There is new guidance from the Resuscitation Council UK in relation to CPR on suspected or confirmed COVID-19 patients, including the use of PPE and managing airways: 'PPE, including face mask and eye protection should be worn when carrying out resuscitation, and mouth-to-mouth or pocket mask airways management should not be undertaken. An oxygen mask, cloth or towel (depending on what is available) should be placed over the person's face to help reduce possible air contamination'.[18]

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[19]. 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.

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. In the current circumstances, this may not always be possible, and explanation may be given by another registered health professional.
- 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 and 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, and MCCDs
- 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 this was carried out in the clinical record.
- The RN must instigate the process for deactivation of the Implantable Cardiac Defibrillator (ICD)[20].
- The RN carrying out the verification of death must notify the funeral director /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 / 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 applied to all verifications of expected adult death irrespective of any COVID-19 status (i.e. not suspected, suspected, confirmed), by donning surgical mask, eye protection, gloves and apron as a minimum when carrying out the verification of death procedure.[21]

Equipment (cleaned in accordance with local procedure):

- *Pen torch
- *Stethoscope
- *Watch with second hand
- Surgical face mask
- Eye protection
- Disposable plastic apron
- 2 pairs of clean disposable gloves
- Single use, small clean disposable sheet
- 2 small disposable waste bags
- Alcohol hand gel

**For visits to patient's own home, this equipment should be suitably cleaned prior to entering the home and prior to leaving.*

The RN may need a 'clean buddy' in order to help with infection control procedures.

Risk Assessment (see Appendix 3 for COVID-19 safe PPE selection)

The RN verifying the expected adult death should undertake a risk assessment with regards to all PPE selection:

- Eye protection/Face visor: Where there is a risk of contamination to the eyes from splashing secretions including body fluids, a surgical mask with visor or surgical mask and goggles should be worn, along with a single-use gown.[22]
- Disposable apron/gown: plastic aprons must be worn for all iterations to protect staff uniform from contamination. Fluid-resistant gowns should be worn where there is a high risk of extensive splashing of secretions or body fluids, and where a plastic apron would not be sufficient.

- Equipment: Ensure stethoscope and pen torch are thoroughly cleaned with a disinfectant wipe
- Clinical Notes: 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.
- Home Visits:
    - If verification is to take place in a patient's home, take soap, disposable towels, and alcohol hand gel to ensure suitable hand hygiene.
    - Where there are other members of the household present, a distance of at least 2 metres (6 feet) must be maintained between you. Where possible, ask the family member(s) to leave the room, explaining why.
    - Ensure two small waste bags are taken into the patient's home. Any waste should be disposed of in the first bag, then double bagged prior to leaving the home. Advise relatives that it should be left for 72 hours and then placed in the general waste.

Procedure

ACTION	RATIONALE
Adopt standard infection control precautions: Perform hand hygiene prior to donning selected PPE (see Appendix 4).	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 deceased.
Check for documented individualised agreement to DNACPR or equivalent in the clinical notes. Where a DNACPR is not available or in place, ensure clear clinical judgement that the death is irreversible.	To ensure agreement of process. To articulate and document decision not to commence CPR.
Identify any suspected or confirmed infectious diseases*, radioactive implants, implantable medical devices. NB: COVID-19 may not have been documented in the notes. **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.

ACTION	RATIONALE
Where applicable, ask a relative to ensure that a window is opened in the patient's home for ventilation	To allow circulation of fresh air and reduce viral load.
Where applicable, instigate the process for deactivation of Implantable Cardiac Defibrillator (ICD), if not already deactivated.	To ensure the timely deactivation of ICD.
Open clean disposable sheet onto a cleaned surface, place suitably cleaned stethoscope and pen torch onto the clean disposable sheet. (For home visits, this may be a dressing pack containing the required gloves, apron, waste bag and sheet).	In readiness for the verification.
Lie the patient 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 at this time.	To ensure the patient is flat ahead of rigor mortis. To ensure all treatments are stopped prior to the verification of death examination. These may be removed after the verification of death examination and only if the death is not being referred to the coroner[23]
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***	
Heart Sounds Using the stethoscope, listen for heart sounds through the clothing/nightclothes. Place stethoscope on clean sheet.	 To ensure there are no signs of cardiac output. Ready for cleaning.
Neurological Response Using the pen torch, test both eyes for the absence of pupillary response to light. Place pen torch on clean sheet.	 To ensure there is no sign of cerebral activity. Ready for cleaning.
Respiratory Effort Observe for any signs of respiratory effort over the five minutes. NB Do not place your ear near to the person's nose or mouth to listen for breathing.	 To ensure there are no signs of respiratory effort. To avoid any risk of contamination.

ACTION	RATIONALE
Central Pulse Palpate for a central pulse and if necessary, through the clothing/night clothes.	To ensure there are no signs of cardiac output.
Motor Response After five minutes of continued cardio-respiratory arrest, test for the absence of motor response with the trapezius squeeze. Carry out the trapezius squeeze through the clothing/night clothes.	To ensure there are no signs of no cerebral activity. To minimise movement of the person and reduce contamination.
Any spontaneous return of cardiac or respiratory activity during this period of observation should prompt a further five minutes of observations.	
Take off first pair of gloves and dispose of in the small waste bag whilst leaving on the remaining PPE. Perform hand hygiene and don clean pair of disposable gloves. Clean the stethoscope and pen torch with disinfectant wipes and place in a clean bag.	To discard contaminated gloves safely prior to cleaning the equipment To ensure hands are clean prior to donning clean gloves to decontaminate equipment. Follow local infection control procedure for decontamination of equipment.
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.
Remove gloves and dispose of into the waste bag.	To safely dispose of contaminated gloves.
Remove PPE in the correct order (see Appendix 4) including hand hygiene and place in waste bag.	To eliminate cross-contamination from the equipment to anyone else.
Dispose of waste in line with local policy for waste management of clinical waste.	To ensure correct management of infective 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.

ACTION	RATIONALE
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.[24]

Appendix 1

Deaths requiring coroner investigation

Deaths requiring referral to the coroner's office for investigation are when: [25]

- 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 on its own to refer the death to the coroner. [26]

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: [27]

- 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 Public Health England of any confirmation of a notifiable infectious disease.
- Registered medical practitioners are required to report COVID-19 positive deaths to NHS England.

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?	

	Assessment of Competence	Competent
	Criteria	**YES / NO**
	Deaths requiring coroner involvement, *noting COVID-19.*	
	Notification of infectious diseases, *noting COVID-19.*	
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		
	Risk assessment of PPE and equipment requirement prior to attending the bedside, or home.	
	Demonstrates universal infection control precautions, appropriate donning of PPE, equipment decontamination, and correct hand hygiene procedure, and in the correct sequence. *Note precautions relating to COVID-19.*	
	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.	
	Where applicable, a window is opened for ventilation.	
	To instigate the process for deactivation of Implantable Cardiac Defibrillator, if not already deactivated.	
	Stethoscope and pen torch are placed on the clean disposable sheet ready for use.	
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.	

	Assessment of Competence	Competent
	Criteria	**YES / NO**
	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 heart sounds on auscultation.	
	Ensures both eyes are tested for the absence of pupillary response to light.	
	Ensures absence of respiratory effort by observation over the five minutes.	
	Ensures absence of a central pulse on palpation.	
	Ensures that after five minutes of continued cardio-respiratory arrest the absence of motor response to trapezius squeeze is tested.	
	Ensures that any spontaneous return of cardiac or respiratory activity during this period of observation would prompt a further five minutes observations.	
	Ensure stethoscope and pen torch are placed on the sheet ready for cleaning.	
	Demonstrates universal infection control precautions by correctly doffing first set of gloves, performing hand hygiene, and donning second set of gloves to clean stethoscope and pen torch.	
	Knows how to correctly label the deceased for identification.	
	Demonstrates universal infection control precautions by correctly doffing PPE with correct hand hygiene procedure and knows how to dispose of the waste.	
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.	

	Assessment of Competence	Competent
	Criteria	**YES / NO**
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, *noting the impact of COVID-19 at this time*.	
	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, *and in relation to a COVID-19 related death.*	
	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, *including in a COVID-19 related death.*	
	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……

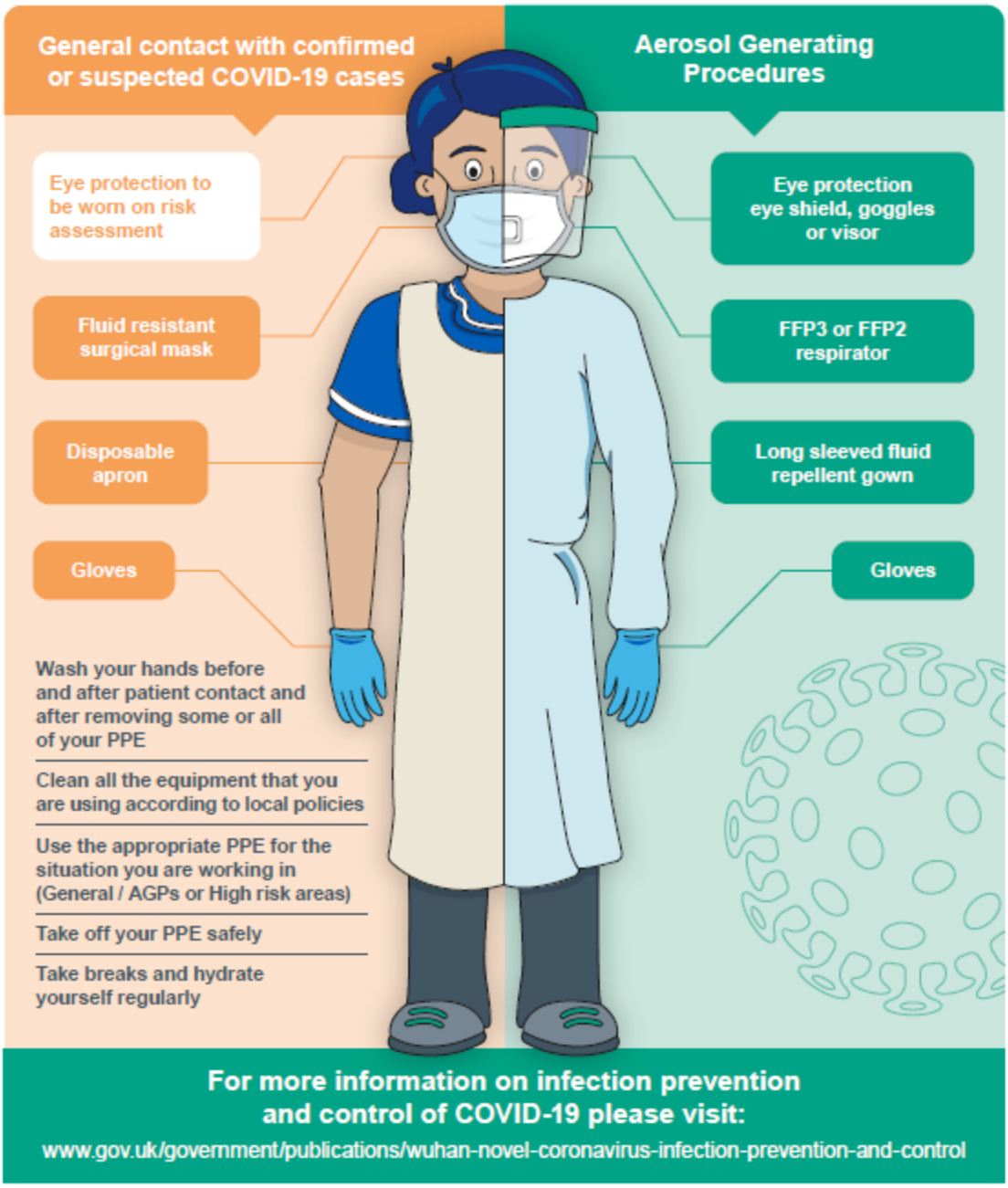
Appendix 3

Visual Guide to safe PPE

Public Health England

COVID-19 Safe ways of working

A visual guide to safe PPE



Appendix 4

Guide to donning and doffing PPE[28]

Public Health England

This guidance is issued jointly by the Department of Health and Social Care (DHSC), Public Health Wales (PHW), Public Health Agency (PHA) Northern Ireland, Health Protection Scotland (HPS), Public Health Scotland, Public Health England, and NHS England as official guidance.

Guide to donning and doffing standard Personal Protective Equipment (PPE) for health and social care settings

Donning or putting on PPE

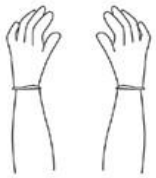
Before putting on the PPE, perform hand hygiene. Use alcohol handrub or gel or soap and water. Make sure you are hydrated and are not wearing any jewellery, bracelets, watches or stoned rings.

1. Put on your plastic apron, making sure it is tied securely at the back

2. Put on your surgical face mask, if tied, make sure securely tied at crown and nape of neck. Once it covers the nose, make sure it is extended to cover your mouth and chin.

3. Put on your eye protection if there is a risk of splashing

4. Put on non-sterile nitrile gloves.



5. You are now ready to enter the patient area.

Doffing or taking off PPE

Surgical masks are single session use, gloves and apron should be changed between patients.

1. Remove gloves, grasp the outside of the cuff of the glove and peel off, holding the glove in the gloved hand, insert the finger underneath andpeel off second glove.

2. Perform hand hygiene using alcohol hand gel or rub, or soap and water.

3. Snap or unfasten apron ties the neck and allow to fall forward.

Snap waste ties and fold apron in on itself, not handling the outside as it is contaminated, and put into clinical waste.

4. Once outside the patient room. Remove eye protection

5. Perform hand hygiene using alcohol hand gel or rub, or soap and water.

6. Remove surgical mask.

7. Now wash your hands with soap and water.

Please refer to the PHE standard PPE video in the COVID-19 guidance collection:
www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-non-aerosol-generating-procedures
If you require the PPE for aerosol generating procedures (AGPs) please visit:
www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures

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