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1.0	9.6.2018	Julie Barker	After initial consultation
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2.0	17.9.18	Julie Barker	Following further consultation with NEMS senior staff and various senior colleagues.
2.1	23.10.18	PG & ADLM & Dr Didcock	NEMS & Coroners Office amendments
2.2	08.09.18	Laura Adlem	Citycare
2.3 & 4	Dec-Jan	Julie Barker	Final Formatting following ICS EOL programme board ratification.

Contents

Clinician Guidance for Verification of Death in the Community

This guidance incorporates advice from the BMA, the RCGP, RCN and local Coroner.

It is recognised that sometimes there may be confusion over whether a death is expected, whether a coroner referral will be needed when a patient dies and whether there needs to be a GP to verify in person that a person has died prior to a person being removed from the place of death. These situations can give rise to inappropriate conveyances, referrals and delays in managing the administration and family needs.

In order to avoid unnecessary distress this guidance has been written and a pathway flow chart devised. The majority of the guidance relates to the management of patients whose death is expected. However it also includes guidance concerning unexpected or sudden deaths.

Please read in association with the guidance below about when to involve the Coroners office and the associated circumstances tables with regard to involving other agencies e.g. the police (see Appendix A).

1. Identifying the dying patient

It is important that all clinicians and care providers have been trained in and are confident to recognise when a person may be dying. Certain symptoms and signs are easily recognised:

- Loss of appetite.
- Extra tiredness - taking to bed.

- Dry mouth and difficulty swallowing.
- Cold mottled skin - sometimes clamminess - especially the fingers.
- Reduced level of consciousness.
- Erratic, rattly breathing

National guidance about care of the dying patient can be found on our End of Life website: http://www.epaccs.com/end-of-life-care-guide/red-stage/preferred-priorities-for-care/

Further information about the final stages of life can be found within the following guidance document; End of Life: a guide - A booklet for people in the final stages of life and their carers which is located on the Marie Curie website:

http://www.mariecurie.org.uk/documents/patients-carers-families/publications-and-guides/end-of-life-guide.pdf

It is important that the person and their family are sensitively informed at the earliest opportunity.

2. Once the dying phase has been recognised (whether registered on EPaCCS or not).

If the person was not already identified as 'End of Life' or their key professional was not expecting death at this time it is very important to ask for an immediate GP or senior nurse assessment. If the person has suddenly collapsed in this situation and there is no advance care plan or DNACPR form in place it is important to commence resuscitation measures immediately and call 999.

Where the signs are part of an ongoing deterioration (ie expected) , please contact the GP surgery at the earliest opportunity via the surgery (or if deteriorating rapidly via 111/NEMS). The GP/nurse should assess the patient, stop any medications or interventions that are not purely for comfort care and ensure that anticipatory medications are in place to support the comfort of the patient. A plan for the ongoing management and support of the patient and their family should be in place and carer givers confident they understand it.

If appropriate, and after careful consideration and discussion, the death verification pre-authorisation form can be completed. (Appendix C).

Plan to review the person within 48 hours where necessary (yourself or colleague). If an OOH GP or ANP has confirmed that death is likely soon, a plan for their usual GP to review them at the earliest opportunity should be made.

The EPaCCS template should be updated to 'red' status.

3. After Death

The care/nursing home can verify death where confident to do so, if the GP or usual clinician has indicated that this is appropriate. Then the relative or carer inform 111 9*6 and contact the undertaker who can remove the person to a mortuary at a convenient time.

If there has been no clear GP pre-authorisation, the district nursing team (where they have been caring for the person), or the usual GP (or OOH 111) should be informed and should assess whether it would be appropriate to visit to assess and advise.

In Mid-Notts the PatientCall number (01623 781891) can be used to seek advice/action.

It i*s the responsibility of nursing home managers to ensure that their nursing staff are all trained to verify death. Contact Social Care administration, John Eastwood Hospice or your District nurse administration support team fo*r access to training.

If the death occurs at home where there should have been district nursing or hospice at home support, one of the nursing team should attend to verify death, disconnect devices, collect medications etc. The evening/overnight district nursing service can be called out of hours. The checklist can be signed and pre-authorisation form checked with regard to extra important information to be mindful of.

If there is no authorised person available to verify, contact the GP surgery or OOH NHS 111 at the earliest opportunity. The GP or OOH clinician should check the circumstances of death and need for family support (see Appendix D)

In the less usual situation where there has been no need for regular nursing input and a fully informed family member is happy to inform the Undertaker directly upon death of their relative after a GP/nurse pre-authorisation this would be acceptable. They should be asked to contact the GP surgery immediately or 111 if the surgery is not open to inform them of the death and to have an opportunity to ask advice if needed.

If *the MCCD cant be issued without involvement of the coroner's office it would still be acceptable to remove the body to the undertakers and contact the coroners office via emailed form as soon as possible* (refer to guidance below).

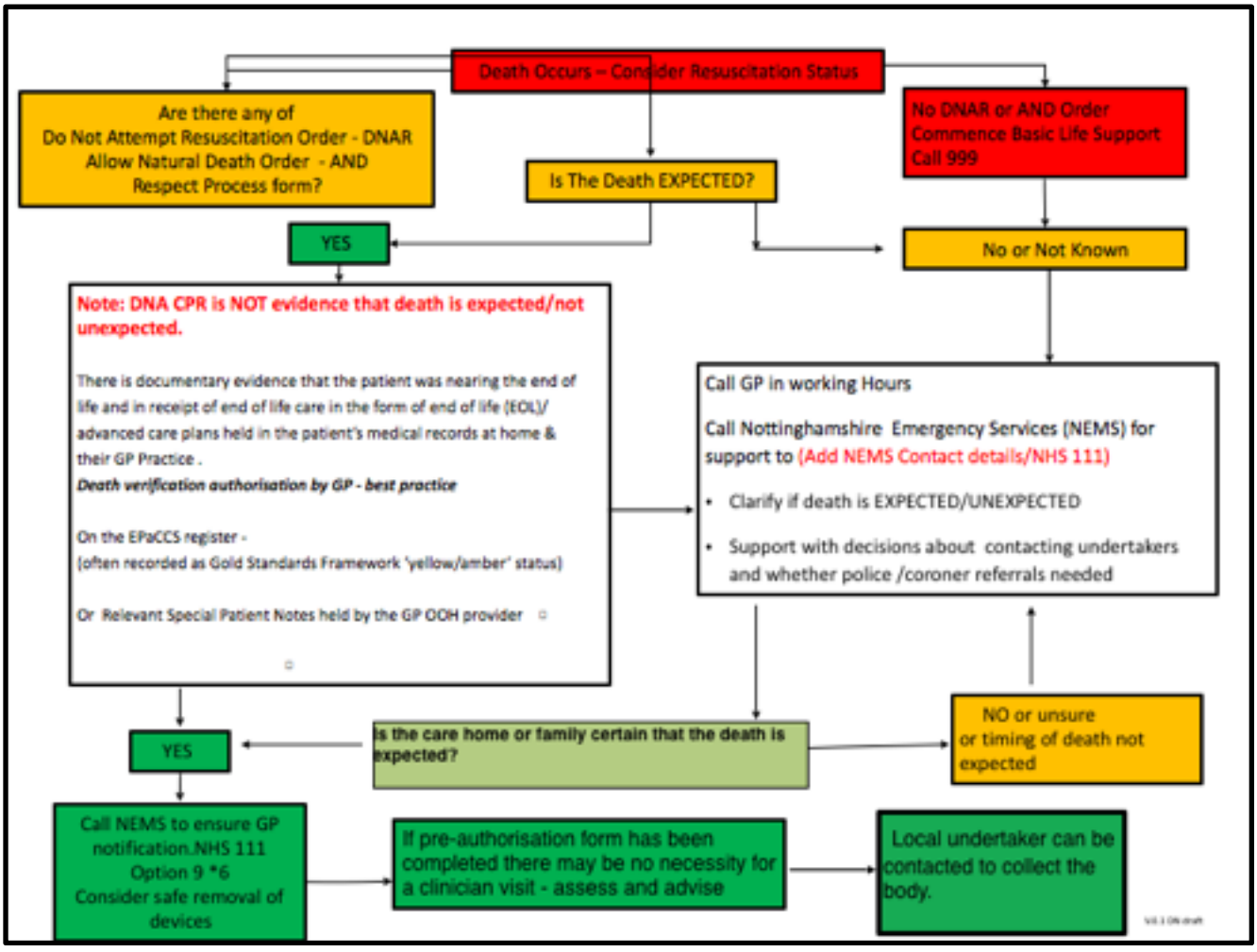
If there are concerns about the circumstances of death or any other reason to involve the coroner's office as per guidance, the body should not be moved until the police have made their assessment.

The patients' family should be informed about the expected delays for the MCCD to be avail-

able as follows:

1. Death reported to coroner who is happy for GP to issue MCCD 24-48 h
2. Death reported to the coroner who takes over the case - the coroner's officer will explain the process and timescales involved.

Flow Chart Expected Deaths in Community



References.

BMA current guidance: https://www.bma.org.uk/advice/employment/gp-practices/service-provision/confirmation-and-certification-of-death

Registered Nurse Verification of Expected Death (RNVoED) guidance 2016

Respect Process

Royal College of Physicians 'Talking about Dying' October 2018

Reporting deaths to the Coroner.

General Notes:

When a patient dies, it is the statutory duty of the doctor who has attended in the last illness to issue the Medical Certificate of Cause of Death (MCCD). There is no clear legal definition of "attended", but it is generally accepted to mean a doctor who has cared for the patient during the illness that led to death. The doctor should be familiar with the patient's medical history, investigations and treatment. The certifying doctor should also have access to relevant medical records and the results of investigations.

If the doctor has treated the patient in life and seen the patient after death, that doctor can issue the MCCD if he/she feels confident to do this. If the doctor has seen the patient within 14 days of death, it is not necessary to view the patient after death. If the doctor has never treated the patient in life, then an MCCD cannot be issued by that doctor and the death must be referred to the coroner unless another doctor is in a position to do so .

The doctor may complete a MCCD the death where he/she has:

- attended the deceased in life AND seen after death, OR
- attended to the deceased within 14 days of death, when it is not necessary to view the deceased after death.*

  * *Please note that in this second situation there is a legal requirement to have a clearance from the Coroner's office prior to completion of cremation document form Failure to do so is likely to result in the crematorium referee refusing to give clearance for the cremation to proceed.*

When a death is referred to the coroner, it is imperative that all relevant information is shared. The reporting doctor should be familiar with the patient's medical history, investigations and treatment and should have access to the records at the time of reporting.

"Old Age" may be given as the cause of death when the doctor caring for the patient has observed a gradual decline in general health and functioning and the patient is more than 80 years old. Severe Frailty will not be accepted as the sole cause of death; co-morbidities or adding old age will be accepted.

Deaths that should be referred to the Coroner

1. The cause of death is not known.

2. Cause of death may be due to trauma or unnatural cause eg Road traffic collision, possible suicide, poisoning, self-harm, fracture.

3. Cause of death may be related to an industrial disease eg pneumoconiosis, (deceased was a miner), mesothelioma, farmer's lung.

4. Patient had been in hospital for less than 24 hours.

5. Cause of death is due to a fall or there has been a fall in the three days prior to death.

6. At death, grade 3 or 4 pressure sore present, or more than one grade 2 pressure sore.

7. Surgery or invasive procedure involving general or local anaesthetic performed within the preceding 12 months (including endoscopies).

8. A medical procedure or treatment which may have caused or contributed to the death. For the avoidance of doubt, a medical procedure includes chemotherapy, radiotherapy, biological/hormonal therapies, stem cell and bone marrow transplants.

9. Alcohol or any prescribed or non-prescribed drug is mentioned as contributing to the cause of death in part 1 of the death certificate.

10. Death during pregnancy or within a year of giving birth.

11. All deaths that would be referred to the Child Death Overview Panel (CDOP) i.e. deaths of all minors under the age of 18 years. It is very important that all doctors are conversant with the "signs of life" protocols and guidelines for neonatal cases - if further guidance is required on this please consult with the Trust and/or our office. We have had cases in this category where child deaths have not been reported to HMC but were picked up by the Registrar and then referred to HMC, causing great distress to the families.

12. Death is associated with or occurs after a clinical incident.

13. Where allegations of negligence have been made against the hospital or others involved in the nursing or medical care of the deceased, regardless of whether it is considered such allegations have merit.

14. Death may be due to the neglect of others.

15. Any other unusual circumstances.

If there is any doubt about whether a Coroner's referral is required, the first point of contact should be the Consultant in charge of the care. The Consultant has the ultimate responsibility for decisions on referral. In General Practice, it is a good idea to discuss the case with a partner – if in doubt, refer to the Coroner.

The referral should be made on the online form accepted by the coroners office, together with a proposal for the cause of death if the reporting doctor is happy to issue the MCCD. The coroner's office generally return feedback for these within 48h.

Unexpected or Sudden deaths

If a person's death is not anticipated at that time but in retrospect, and with enough evidence from their clinical records and their family or carers to allow confidence that in retrospect it should have been expected, as long as there are no suspicious circumstances, a GP nurse or paramedic should verify death and the GP should report the death to the coroner for assessment and discussion about the MCCD.

Where the death is completely unexpected, the GP or a paramedic should verify death and the police must be informed and asked to assess. The body should not be moved until they have done so. (Refer of the Unexpected Deaths column below)

Appendix A

Death In the Community in Nottinghamshire Guidance for GP Out of Hours (OOH) providers, NEMS.

EXPECTED DEATH/DEATH IS NOT UNEXPECTED **Definition** There is documentary evidence that the patient was nearing the end of life and in receipt of end of life care in the form of end of life (EOL)/advanced care plans held in the patient's medical records at their GP Practice (often recorded as Gold Standards Framework 'yellow/amber or red' status) Or Primary Care Records Or Special Patient Notes held by the GP OOH provider Or on the EPaCCS register. **Note: DNA CPR is not evidence that death is expected/not unexpected.**	**UNEXPECTED DEATH** **Definition** No documentary evidence as in box opposite. **Note: DNA CPR is not evidence that death is expected/not unexpected.**
No need to inform the Police	Police must be informed

OOH service to be contacted if pre-authorisation form has not been completed. OOH clinician should make enquiries as to the expected nature of the death and to determine whether there are any further concerns requiring a visit to verify the death. The OOH clinician should also document relevant information and arrange to inform the patient's GP of their death. If the death is confirmed as expected and no concerns apparent the OOH clinician should request the care home staff to call the preferred funeral directors to collect the ceased, taking professional responsibility and accountability for the decision (providing their name and profession).	Appropriate qualified person may 'pronounce' or verify death e.g. GP/paramedic /nurse. This will include a nurse in a nursing home. If not available or family or carers request it, OOH clinician visits to verify death and provide advice.
If the OOH clinician has concerns or cannot satisfy themselves to take responsibility and accountability for the expected death, the OOH clinician should arrange to visit at the earliest, non-urgent, opportunity.	
Family funeral Director can be called to remove the body to their premises.	Police determine whether or not a Funeral Director can be called to remove the body or whether the body needs to be removed by the Co-Op for transportation to QMC mortuary.
GP OOH consultation notes sent back to the patient's own GP practice.	GP OOH consultation notes sent back to the patient's own GP practice.
HM Coroner is prepared to take calls on the emergency phone (weekends, bank holidays and weekdays between 5pm and 8am) to provide advice on any specific issue if required. Before making a call, please read the guidance relevant to your role/organisation. Remember that this is an emergency service and not for general enquiries.	

DOL + expected death/death not unexpected = no police ; Unexpected death , with or without DoL = police required.

Death In the Community in Nottinghamshire Guidance for EMAS

EXPECTED DEATH/DEATH IS NOT UNEXPECTED	**UNEXPECTED DEATH**
Definition There is documentary evidence that the patient was nearing the end of life and in receipt of end of life care in the form of end of life/advanced care plans held in the patient's medical records at their GP Practice (often recorded as Gold Standards Framework 'yellow/amber' status Or Primary Care Records Pre-authorisation form completed by GP Or Special Patient Notes held by the GP OOH provider Or on the EPaCCS register. **Note: DNA CPR is not evidence that death is expected/not unexpected.**	**Definition** No documentary evidence as in box opposite. **Note: DNA CPR is not evidence that death is expected/not unexpected.**
During normal GP surgery opening hours, contact the GP practice of the deceased to establish the position in terms of evidence.	
If you think that NEMS GP OOH service may hold this information, ring NEMS on 0115 8462397. This number is answered 24/7.	
If the deceased's own GP practice or NEMS hold documentary evidence that death was expected/not unexpected, there is no need to inform the Police.	Police must be informed – EMAS to remain on the scene until the police arrive
Family funeral director can be called to remove the body to their premises.	Police determine whether or not a Funeral Director can be called to remove the body or whether the body needs to be removed by the Co-Op for transportation to the QMC mortuary.

HM Coroner is prepared to take calls on the emergency phone (weekends, bank holidays and weekdays between 5pm and 8am) to provide advice on any specific issue if required. Before making a call, please read the guidance relevant to your role/organisation. Remember that this is an emergency service and not for general enquiries.

DOL + expected/not unexpected death = no police ; Unexpected death , with or without DoL = police required.

Death In the Community in Nottinghamshire - Guidance for GP Practices

EXPECTED DEATH/DEATH IS NOT UNEXPECTED **Definition** There is documentary evidence that the patient was nearing the end of life and in receipt of end of life care in the form of end of life/advanced care plans held in the patient's medical records at their GP Practice (often recorded as Gold Standards Framework 'yellow/amber or red' status ; Or Special Patient Notes held by the GP OOH provider Or Pre-authorisation form completed Or on the EPaCCS register. **Note: DNA CPR is not evidence that death is expected/not unexpected.**	**UNEXPECTED DEATH** **Definition** No documentary evidence as in box opposite. **Note: DNA CPR is not evidence that death is expected/not unexpected.**
No need to inform the Police	Police must be informed
GP/Nurse/Paramedic to 'pronounce' or confirm death or, if pre-authorisation form completed, family can contact the undertakers directly.	GP/Nurse/Paramedic to 'pronounce' or confirm death.
Family funeral director can be called to remove the body to their premises.	Police determine whether or not a Funeral Director can be called to remove the body or whether the body needs to be removed by the Co-Op for transportation to QMC mortuary.

A death may be certified by a medical attendant who treated the patient during their last illness. The doctor may issue a MCCD when he/she has seen the patient within 14 days of death **OR** if the doctor has treated the patient during their last illness and seen the patient after death. If there is no GP in the practice who has treated the patient in life, the death must be reported to the coroner. The death ought to be reported electronically in the first instance by completing the coroner's referral form and sending the form via secure e-mail to the coroner's office. http://www.nottinghamcity.gov.uk/coroners	The Coroner will give advice on whether the GP who has attended the patient can provide a medical certificate
HM Coroner is prepared to take calls on the emergency phone (weekends, bank holidays and weekdays between 5pm and 8am) to provide advice on any specific issue if required. Before making a call, please read the guidance relevant to your role/organisation. Remember that this is an emergency service and not for general enquiries.	

Appendix B

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) and The Respect Process Form

Guidance for care home staff

Cardiopulmonary resuscitation (CPR) is the emergency treatment to attempt to restart someone's heart beating and/or breathing. It may involve chest compressions and mouth to mouth breathing; it is an invasive procedure with a very low success rate particularly in those with significant health problems and poor performance status.

For most people cardiorespiratory arrest will occur as part of the natural dying process and a DNACPR decision is made to prevent inappropriate, futile attempts at CPR and allow the individual to have a dignified death.

The following is a summary of national and regional guidance to help care home staff in their day-to day care of residents with a valid DNACPR or Respect Process form.

Whilst DNACPR forms solely refer to a decision about resuscitation, the Respect Form is a broader advance care planning form that records a person's priorities and best interests, including treatments that may or may not be appropriate, including resuscitation decisions. As such, a Respect Form is very different to DNACPR and may indicate that a person should have a resuscitation attempt in certain or all circumstances.

Making the decision

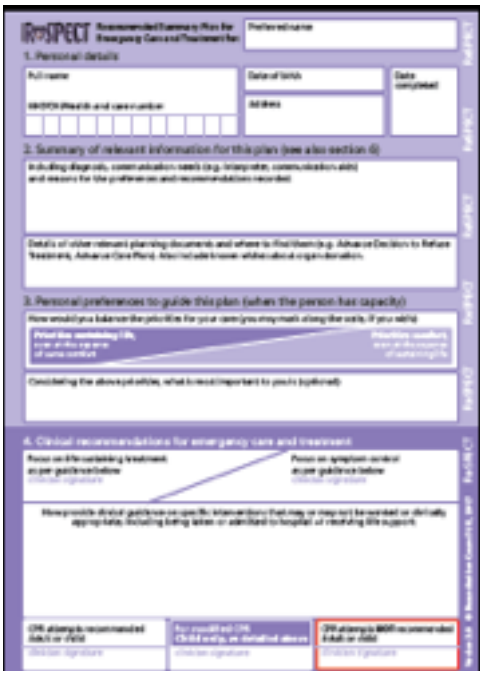
- A DNACPR decision is made by a clinician on an individual basis taking into account the state of health, chance of a successful outcome and the individual's wishes.
- The DNACPR decision should be discussed with the individual unless he or she does not have capacity to understand and retain the information or if it is believed the discussion would cause the individual physical or psychological harm.
- If the ***individual does not have capacity*** to discuss the DNACPR decision, any Advance Decision to Refuse Treatment (ADRT) made when the individual did have capacity should be taken into consideration. If there is no ADRT, the clinician should discuss the DNACPR decision with family and the multidisciplinary team. Capacity to understand, whey up information, retain it in the memory and communicate thoughts about it effectively should be assessed in accordance with the mental capacity act (MCA). Where it is judged that this capacity is lacking, the assessment should be carefully documented in the clinical and care records and on the form. A 2-part assessment should be done where there is any uncertainty.

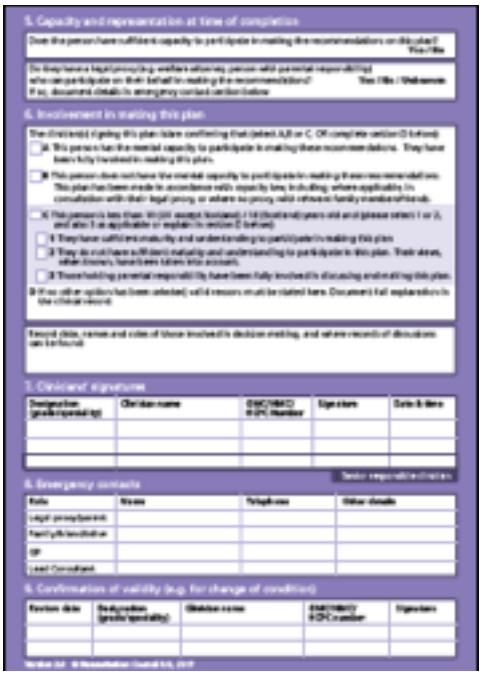
  Reference: https://www.scie.org.uk/mca/practice/assessing-capacity/

Recording the decision

- GPs, senior hospital doctors and nurses with appropriate training can complete the DNACPR form.
- Black and white DNACPR forms are valid, the clinician's original signature is required on the form.
- The completed form is placed at the front of the individual's notes where it is easily accessible.
- All care home staff should be made aware of the DNACPR decision.

DNACPR Form **ReSPECT Process Form**





Review of the decision

- The clinician may wish to review the DNACPR decision at frequent intervals especially if the individual's condition is expected to change. The frequency of review is determined by the response to a changing clinical situation for the patient .
- For most individuals in the community, a DNACPR decision will be appropriate until their death and review of this decision is not necessary. This should be clear within the document used to record the decision.
- Care home staff should prompt GPs to review the DNACPR decision if a pre-determined review date is approaching to prevent inappropriate CPR attempts due in out-of-date forms.

Transport of patients out of the care home

- Both forms belongs to the individual and should accompany them to hospital appointments, admissions etc to prevent inappropriate CPR attempts during transport. If an emergency admission is being considered for a person with a Respect form, if the form indicates that the person does not wish hospital admission, this should be respected and an urgent review requested by their GP or out of hours service
- If using ambulance transport, inform the ambulance service that the individual has a valid DNACPR or Respect Form at the time of booking.
- Ensure the ambulance crew are aware of the DNACPR form but it should remain with the individual and return back to the care home with them.
- If the ambulance crew raise any concerns about transportation of a resident, it is their responsibility to discuss their concerns with their manager immediately.

Emergency situations

- A decision not to attempt CPR only applies to CPR and a DNACPR decision should not compromise the care for any individual.
- If deterioration is anticipated, there should be a clear medical plan to follow and the out of hours medical service should be made aware of that plan and the DNACPR decision.
- If deterioration is unexpected, eg sudden collapse, it may be appropriate to call the GP or an emergency ambulance – inform the call handler of the clinical situation but also that the individual has a valid DNACPR or Respect form. Ensure this form available to the ambulance crew on arrival.
- In Mid Notts, urgent advice from an experienced nurse is available 24/7 by ringing PatientCall: 01636 781891 # 2. They can arrange for an urgent visit by a doctor or nurse.

Appendix C

Pre Authorisation Template

Name D.O.B NHS number

I anticipate that the above named person is approaching the end of their life within the next few days or weeks and it is appropriate for the undertaker to remove the person from their place of care once dead.

GP or RGN signature……..

Name (print)……Role……Date……

*The GP or RGN should update the patient's clinical record with regard to assessment and authorisation at the earliest opportunity and update EPaCCS register **RED** last days page.*

Preference for Burial or Cremation:……..

* Name of Preferred Undertaker……..

Address…….

Contact number ……

* **IMPORTANT :If the undertaker is situated out of the registered GP's practice area, please highlight this asap to the GP so that a plan for viewing the body PRIOR to removal can be made. Where necessary a local undertaker can be asked to look after the person until their GP has been able to view their body.**

* Action for care staff to facilitate GP to view body when cremation is needed and the undertaker is out of area

……
……
……

Are there any issues requiring that the persons death should be reported to the

Coroner's office? (Please refer to guidance document). **YES /** NO

If Yes, please advise the person's family of this as it will affect how soon the MCCD will be issued. They should be advised ask the GP practice when the medical certificate of cause of death (MCCD) can be available.

Any other Information (eg personal, cultural, social or faith based considerations relevant to care of the deceased person)):

Expected death - checklist for carers.

This form should be completed then given to the Undertaker and remain with the deceased person.

If there is any uncertainty about the correct actions to take, please contact GP surgery or District Nursing if they have been assisting with care or if outside surgery hours, ring NHS 111 to ask advice.

ABSENCE OF SIGNS OF LIFE

Breathing - stopped for at least 5 minutes

Responses - no response to verbal or physical stimuli e.g. pinching ear lobe.

Skin - exposed parts of the body begin to cool down and limbs stiffen

Pupils - become larger and don't respond to light

Nursing & Carers:

Switch devices off and remove the device e.g. syringe driver (for return to source). Contents disposed of in accordance with controlled drugs policy.

Any catheter can also be removed.

Prostheses: (specify if known) pacemaker, implantable defibrillator, limb.

Jewellery on Patient:

Family members present:……

Life extinct at: Date …….Time ……

Verified by: Name ……..… Designation:…….

Signature:……. …….

Witnessed By: Name …… Designation:……

Signature:……

Appendix D

NEMS Guide Checklist - Verification of Expected Death

(adjusted to recognise nurses guidance).

- Verification of death is NOT a legal requirement in English Law, but has become custom and practice.
- The ability to verify death does not need mandatory training however nurses work to RGN guidance which does specify training (Registered Nurse Verification of Expected Death (RNVoED) guidance 2016).
- Nursing homes are obliged to provide a nurse for verification of deaths.

WE MAY NOT NEED TO VISIT CARE HOMES OR NURSING HOMES

BUT THE FOLLOWING INFORMATION MUST BE DOCUMENTED:

1. Confirm the death is expected (use all background clinical data to ascertain this information e.g. EPaCCS, pre-authorisation template, Respect Form etc).
2. Ask the staff if they have any concerns regarding the death.
3. Record the time and place of death and the name of any person present.
4. When was the deceased last seen alive if no one was present at the time of death?
5. When was the deceased last seen by a doctor?

A VISIT WOULD BE INDICATED IF:

- There is doubt regarding any of the questions above if they are not being robustly/fully answered.
- Presence of relatives/others who would benefit from our attendance for any other reason e.g. distress.

IF A VISIT IS NOT OFFERED PLEASE ADVISE THE STAFF AT THE HOME TO CONTACT THE UNDERTAKERS AND ADVISE STAFF THAT YOU ARE TAKING ACCOUNTABILITY AND RESPONSIBILITY FOR THE DECISION NOT TO VISIT