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**Unexpected Death of Adults Policy**

**[Date of Issue]**

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# Introduction

Unfortunately, death is an unavoidable event that healthcare professionals and workers encounter regularly. The main difference is whether the death is expected or unexpected. An unexpected death is where death occurs suddenly or earlier than expected, as opposed to a death that is anticipated, or expected.

# Policy Statement

[Company Name] is committed to ensuring that clients receive a high quality and appropriate response to death, including care after death, whether this be expected or unexpected.

# Scope

This policy and its procedures apply to all staff working for or with [Company Name].

The Registered Manager has overall responsibility for supporting staff in applying this policy and ensuring that the content remains current and in line with the standards for best practice.

# Unexpected Death

Although difficult to qualify, unexpected death can still occur even where a client has a terminal diagnosis or is expected to die within a certain time frame.

The sudden or unexpected death of a client can be traumatic for the healthcare worker who discovers them in their home and/or the relatives. It will come as a shock, and so [Company Name] will support staff and clients' relatives in as far as they can with a supportive and caring culture.

# Verification and Certification of Death

Verification of death can be referred to as confirmation of death. This is the process of identifying that a person has died. Prior to the Covid19 pandemic, only staff that were trained and competent could verify and expected or unexpected death, e.g., a nurse, doctor, or paramedic. The Department of Health and Social Care have since issued guidance in an **emergency** to improve the timeliness of verification and to reduce spread of infection. The guidance reflects that an individual who is independent of the family, such as care workers, can access remote clinical support if they have not been trained in verification of death, whereby the guiding professional will officially verify the death. Further guidance can be found at:

<https://www.gov.uk/government/publications/coronavirus-covid-19-verification-of-death-in-times-of-emergency/coronavirus-covid-19-verifying-death-in-times-of-emergency#annex-1>

It is the responsibility of [Company Name] to ensure that all evidence within this policy is regularly reviewed to keep up to date with current guidelines.

Clinical support can be obtained from a professional through calling the client’s GP (during core practice hours) or 111 (outside of core practice hours).

Certification of death must be undertaken by a doctor who is licensed to practice with the General Medical Council (GMC). The doctor will complete a medical certificate which details the cause of death to an individual and will also notify the local coroner of any unexpected death. An unexpected death is one that is:

* Not anticipated or related to a known illness that has been previously identified
* Unnatural
* Unexplained

**Principles of practice**

Prior to a client’s death and following discussion between the appropriate medical practitioner and nursing or healthcare staff – if it has been decided that further intervention would be inappropriate, and death is expected to be imminent, designated staff who are trained and competent may confirm or verify the death. Wherever possible, the relatives should be made aware of the client's deteriorating condition, and this must be documented the client's care plan.

However, where the death is unexpected, staff have the responsibility to initiate resuscitative measures, if they are in the individual's best interests and unless an agreed advance statement has been made that resuscitation is not to occur. It is imperative that such documents are viewed during the client’s assessment process and documented within the client’s care plan, detailing where the documents can be found for all appropriate staff to access and view.

**In the event of an Unexpected or Sudden Death, Staff should:**

* Dial 999 and ask for the ambulance service.
* Follow the client’s care or support plan information, relating to resuscitation of the client. Appropriately trained staff should commence cardiopulmonary resuscitation (CPR) where directed.
* This must not be in contravention of any written 'Advance Care Plan' refusing life-sustaining treatment.
* Ambulance crew or police will advise on actions to be taken, including whether any items can be removed, e.g., an analgesic patch.
* Contact relatives and inform them that you have reason to believe that their family member has died, but that because it was unexpected or sudden, you are waiting for the ambulance and police to visit. Inform them that they are welcome to come to the home if they wish or that you will contact them again after the emergency services have attended.
* Inform the Registered Manager at [Company Name] of the situation**.**
* Ensure that the client is not moved and that nothing surrounding the client is moved (areas should be treated as a crime scene).
* The Registered Manager will inform the Care Quality Commission (CQC) within 24 hours of the death. The CQC Notification of Death form can be found at: <https://www.cqc.org.uk/guidance-providers/notifications/death-person-using-service-notification-form>
* The Registered Manager must complete an internal incident review, referring to [Company Name]’s Incident Management policy, and collate all evidence relating to the unexpected death.
* Once the police have completed their investigation, they may allow items to be moved; the client's home/room should be made tidy if appropriate.
* Appropriate action should be taken to safeguard personal belongings until relatives or representatives have visited.
* Once all documentation has been completed regarding the unexpected death, the client’s records must be placed in locked storage, in chronological order (with their name and date of death on the outside) and kept in accordance with the Record Keeping policy.

**[Responsibilities of the Nurse] (**Amend as appropriate- Domiciliary Care usually has healthcare carers/staff)

**Record keeping** is an essential part of the verification of an unexpected death process, and there is an expectation that the client’s records must reflect the process that has been undertaken by the staff member who has performed the verification of an unexpected death process.

Records should show details of the verification of the unexpected death process undertaken (including remote support given over the telephone), with the time, date, and any other recorded observations. Also include the time and date the doctor was informed. All documentation should be written clearly, concisely and collated to form part of the incident process.

**Education and Training**

* [Company Name] will ensure that education and training are made available, and staff should ensure that they are confident, competent, knowledgeable, and skilled enough for undertaking this role.
* Training will have taken place for the member of staff at [Company Name]
* Education is based on broad principles for practice as identified through regulatory bodies and government guidance.
* Topics might include accountability, current legislation, and the necessary skills and knowledge to determine death's physiological aspects.
* [Company Name] will ensure that competent and trained staff with have all the necessary equipment to undertake a verification of death, including: a stethoscope, pen torch, correct paperwork for documentation. The staff member will also require access to a watch or clock that visibly displays the seconds.

**Additional Staff Support**

It is important that staff’s wellbeing is supported after an unexpected death occurs of a client. [Company Name] will ensure that appropriate services such as internal clinical supervision and/or 1:1’s are offered to their staff and/or guidance to seek external support such as local counselling groups which should be made available to staff should they require this.

**Deaths and the Role of the Coroner**

Under English law, the coroner is an independent judicial office holder, paid for by the relevant local authority. They must be either a lawyer or a GP, sometimes both. Their role is to inquire into specific types of death. Where an inquest is held, they have a duty to establish the cause of death as far as this is possible. They are not allowed to determine criminal liability or responsibility; the criminal court would decide this.

Coroner's officers work under the coroner's direction and liaise with bereaved families, police, doctors, witnesses, and funeral directors.

**Reported Deaths**

Registrars of births and deaths, doctors, and police can all report unexpected deaths to a coroner in specific circumstances.

# Monitoring

Regular auditing will be undertaken by [Company Name] to ensure that best practice is maintained, and that the policy is effective, in date, and that no errors are present. The Registered Manager will be responsible for the audit of the policy.

# Related Policies

* Consent Policy
* Deteriorating Person Policy
* Dignity and Privacy Policy
* Emergency Situations Community Policy
* Incident Management Policy
* Information Governance and Record Keeping Policy
* Lone Worker Policy
* Pressure Ulcers Policy
* Quality Assurance Policy
* Resuscitation Basic Policy
* Staff Supervision Policy

# Legislation and Guidance

**Guidance**

* Nice Guidelines, Quality Standard (QS144) published December 2017 Care of dying adults in the last days of life. <https://www.nice.org.uk/guidance/qs144>
* Department of Health and Social Care (2020). Corona Virus (Covid19): verifying death in times of emergency <https://www.gov.uk/government/publications/coronavirus-covid-19-verification-of-death-in-times-of-emergency/coronavirus-covid-19-verifying-death-in-times-of-emergency#annex-1>
* Care Quality Commission. Death of a person using the service- notification form.
* <https://www.cqc.org.uk/guidance-providers/notifications/death-person-using-service-notification-form>
* End of life care for adults. NICE Quality Standard (QS13) published Nov 2011 updated September 2021 <https://www.nice.org.uk/guidance/qs13>
* Skills for Care - Common Core principles and Competences for social care and health workers working with adults at the end of life <http://www.skillsforcare.org.uk/Topics/End-of-Life-Care/End-of-life-care.aspx>
* One Chance to get it Right – Leadership Alliance for the Care of Dying People. (5 Priorities of Care) <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf>
* UK Health Security Agency: Covid-19: How to work safely in domiciliary care in England. <https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-covid-19-supplement>
* Guide to coroner services and coroner investigations – a short guide <https://www.gov.uk/government/publications/guide-to-coroner-services-and-coroner-investigations-a-short-guide>
* Notification of death Regulations 2019 <http://www.legislation.gov.uk/uksi/2019/1112/made>

# Summary of Review

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