Leicestershire Partnership NHS Trust

Verification and Certification of Death Policy

Clinical Policy

Key Words:	Verifying death; confirming death	
Version:	2	
Adopted by:	Quality Assurance Committee	
Date Adopted:	20 August 2019	
Name of Author:	Jonathan Dexter Sue Swanson	
Name of responsible Committee:	Clinical Effectiveness Group	
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Target audience:	Registered Nurses across LPT services	
Type of Policy	Clinical	
Which Relevant CQC Fundamental Standards?	Safe care and treatment	

Version Control

Version number	Date	Comments (description change and amendments)
Version 1	Feb 2016	Updated Guidance: This policy replaces the Verification of Adult Expected Death by a Registered Nurse or Emergency Care Practitioner (ECP) who holds State Registration as either a Paramedic or Nurse (NP015 Leicestershire County and Rutland Policy 2010)
Version 1.3	June 2016	To include verification of expected death by registered nurses for children.
Version 1.4	July 2016	Amendments from guidance to policy standards
Version 1.5	August 2016	Separation of verification of expected death within children's; adult mental health; learning difficulties and community care services from verification of death within community in patient areas for CHS.
Version 1.6	August 2016	Addition to patient's home in section 4.5 /4.6 and 4.7
Version 1.7	August 2016	Addition of definition of invasive procedure.
Version 1.8	August 2016	Inclusion of ANP and medical certification guidance.
Version 1.9	August 2016	Expansion of the certification to community hospital nurses and ANPs
Version 1.10	Sept 2016	Amendments to include Emergency Health Care Plans and guidance for Childrens nurses
Version 1.11	Sept 2016	Inclusion of certification of death to policy title and content
Version 1.12	June 2019	Amendments include removal of DOLs and informing the Coroner from Appendix 2. Update of Due Regard screening template and addition of Data Privacy Impact Assessment screening tool.

For further information contact:

Nurse Consultant - Advanced Practice / Clinical Education Team, Charnwood Mill.

Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all.

This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area.

This applies to all the activities for which LPT is responsible, including policy development and review.

Due Regard

This policy has been screened in relation to paying due regard to the general duty of the Equality Act 2012 to eliminate unlawful discrimination, harassment, victimisation; advance equality of opportunity and foster good relations.

There is no likely adverse impact on staff or patient/service users from this policy.

The Due regard assessment template is Appendix 6 of this document.

Definitions and abbreviations used within this policy

Verification of death	Physiological assessment to confirm the fact of death.
Certification of death	The process of completing the 'Medical Certificate of Cause of Death' (MCCD).The MCCD can only be completed by a registered medical practitioner.
Expected death	Where discussions have taken place between the medical and nursing team, the patient and the patient's relatives, and a decision has been made and documented that no further intervention is appropriate.
DNAR-CPR Form	Do Not Attempt Cardio- Pulmonary Resuscitation form (East Midlands) is a formal declaration that cardio-pulmonary resuscitation should not be attempted.
DoLS	Deprivation of Liberty Safeguard
ANP	Advanced Nurse Practitioner
GP	General Practitioner
NMC	Nursing and Midwifery Council
PRPs/EHCP	Personal Resuscitation Plans/Emergency Health Care Plans are agreed plans that families, children and professionals sign up to about the interventions that the child will receive with regards to the different health presentations.
RN	Registered Nurse
Post invasive procedure	After a procedure that; makes a cut or hole to gain access to patient's body or; gains access to a body cavity without requiring a cut or; use of electromagnetic radiation.

1 Purpose

1.1 To provide a framework within which registered nurses may safely verify a death, without an unnecessary and potentially distressing delay and sets out the process to enable the safe verification of death.

1.2 This policy should be read in conjunction with:

- Care of the Deceased Policy and Guidelines (LPT 2017).
- Guideline NG31 'Care of dying adults in the last days of life' (NICE 2015).
- Priorities of Care for the Dying Person (Leadership Alliance for the Care of Dying People 2014)
- Verification of expected death in childhood: Guidance for children's palliative care services (Together for Short Lives 2012).

2 Summary

2.1 The policy sets out the parameters and procedures for registered nurses in the verification of death and how deaths are certified.

3. Introduction

3.1 This policy has been developed to determine the scope of nursing practice regarding the verification of patient death, and the prompt certification of death to enhance continuity of end of life care for patients, their families, relatives and significant others.

3.2 In line with the Priorities of Care for the Dying Person (Leadership Alliance for the Care of Dying People 2014); Verification of expected death in childhood (Together for Short Lives 2012); and NICE guidance (2015) on care of dying adults in the last days of life, it is appropriate for registered nurses to be able to formally verify the expected death of their patients, and thus improve the quality of care to families at this difficult time, which will include the permission to remove the body to an undertaker.

3.3 Verification of death sometimes referred to as pronouncing death or confirming death is the procedure of determining whether a person is actually deceased. All deaths should be subject to verification that life has ended.

3.4 The verification of death must be recorded (appendix 1). Death can be verified by all doctors and in defined situations, with appropriate training and competence, by registered nurses (NMC 2015; Secretary of State for the Home Department 2003).

3.5 Verification of death is separate to the certification process.

3.6 Certification of Death is the process of completing a Medical Certificate of Cause of Death (MCCD) and can only be carried out by a medical practitioner. This certificate details the cause of death and enables the deceased's family to register the death and make funeral arrangements.

3.7 All deaths must be reported to the medical doctor responsible for the patient's care so that appropriate actions can be completed such as completion of the MCCD, reporting the death to the coroner.

3.8 If the patient is of a faith with specific time or preparation requirements for funeral services, we must ensure we are aware of these and can plan for them. Please refer to the Rapid Release of Body Policy

4. Registered Nurse Verification of Death Parameters

4.1 This policy applies:

- To registered nurses working in LPT with the appropriate training.
- To patients in receipt of LPT services.
- When a DNAR-CPR / PRP/EHCP form is in place that indicates DNAR- and not some basic resuscitation.

4.2 This policy **does not** apply:

- In cases of sudden or unexpected death (sudden or unexpected death is defined as a natural, unexpected fatal event that occurs where such an abrupt outcome could have not been predicted) ,when the patient is a child; or an adult within their own home; or an adult under Adult Mental Health or Learning Difficulties services. In these circumstances verification of death must not be carried out by the registered nurse.

- The death is **sudden, unexpected, or circumstances give cause for concern**, the registered nurse must immediately report the death to medical staff and complete related incident reporting procedures.

- If the death occurred within 24 hours of admission to a community based bed (including nursing and residential care) unless there is a definitive diagnosis or specific end of life care plan such as a personalised care plan 'deciding right form' plus a signed DNAR-CPR form in place.

- If death has occurred as a result of an untoward incident, fall or drug error.

- If death occurs post-operatively or post invasive procedure

- If there are any suspicious circumstances related to the death.

- When the deceased was detained under the Mental Health Act (this is regarded as a 'death in custody').

- When the deceased has died in custody, as part of a custodial sentence.

- Where resuscitative measures had been initiated prior to the patient's death such as CPR.

- When an expected death has occurred at the patient's home and the registered nurse is not present or expected to imminently attend, then verification would be completed by the most appropriate Medical Practitioner, such as GP or out of hours GP service.

- Where there is a need for the urgent release of the deceased body by some relatives for burial only outside normal working hours.

4.3 The policy **does** apply:

- When the patient is a child; or an adult is within their own home / care home; or an adult under Adult Mental Health or Learning Difficulties services the registered nurse will only verify death if the death is expected. Within LPT there will be those patients whose death becomes inevitable. An expected death can be defined as *'a death where a patient's demise is anticipated in the near future and the doctor will be able to issue a medical certificate as to the cause of death (i.e. the doctor has seen the patient within the last 14 days before the death and this is not a case reportable to the coroner* (Home Office 1971).

- When an expected death has occurred within the patient's home, and a registered nurse is in attendance, it is appropriate for the registered nurse to verify the death.

- When an expected death has occurred at the patient's home and a registered nurse is imminently due to attend, then it is appropriate for that registered nurse to verify the death when they arrive.

- When a death has occurred in a community hospital (CHS Directorate), it is appropriate for the registered nurse to verify the death.

4.4 **Certification of Death:** Nurses are **not** able to certify a death. The process for activation of the certification process within community hospitals by the nursing or ANP staff is detailed in appendix 2 of this policy.

5.0 Process Chart

Following a death, the nurse must confirm the identity of the patient against the healthcare records

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The nurse must determine if the patient's death and the circumstances of the death are compatible with nurse verification parameters (refer to section 4).

↓

Check medical history details (drugs, cataracts, false eyes)

↓

Inform family / carers that you are about to commence the physical examination of the patient to ascertain that death has occurred

↓

Assess and confirm **all** of the following criteria:

- No carotid / radial pulse after palpation for a full minute.
- No heart sounds for a full minute, determined by use of stethoscope.
- No respiratory effort, determined by observation, for a full minute.
- No chest sounds for a full minute, determined by use of stethoscope.
- No eye movements.
- Pupils are fixed and dilated.
- Pupils do not react to light, determined by shining torchlight into a patient's eye and observing for any change in shape or size; this should be repeated in both eyes.
- No response to painful stimuli, such as squeezing the trapezius muscle or flexing the end knuckle of each finger.

↓

Record the results of the above observations within the patient healthcare records. Verification of Death Record Sheet is available for use (appendix 1).

↓

If assessment is inconclusive then repeat 5 minutes later.
If death is confirmed: record date, time and name of registered nurse who verified the death in the patient healthcare records.

↓

Remove any lines / catheters and carry out last offices as appropriate. (Community Hospital staff to activate the certification process).

↓

If appropriate liaise with family to enable arrangements for patient's body to be moved by the preferred undertaker / chapel of rest.

↓

Notify the GP / relevant clinician of the patient's death as soon as possible (within one working day)

6.0 Duties within the Organisation

6.1 The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

6.2 Trust Board sub-committee, Quality Assurance Committee, has the responsibility for approving this policy.

6.3 Directorate Directors and Heads of Service are responsible for ensuring that policy is embedded throughout the directorate / services.

6.4 Managers and Team leaders are responsible for:

- The implementation of this policy.
- Ensuring that registered nurses are trained in the skill of verification of expected death within LPT.
- Ensuring that line managers are supported in monitoring compliance with this policy.
- Investigating incidents / concerns / complaints regarding registered nurses fulfilment of this policy.

6.5 Registered Nurses are responsible for:

- Maintaining the standards in this policy and accepting accountability for their own practice.
- Maintaining their skills and competence to verify death of patients within the parameters stated in the policy.
- Participating in the investigation of incidents / concerns / complaints regarding registered nurses fulfilment of this policy.
- Completing of documentation appropriate to the care setting.
- Reporting of incidents and near misses relating to verification of death.
- Undertaking / cooperating with audits of practice within the clinical setting.

7.0 Training needs

7.1 There is a need for training identified within this policy. In accordance with the classification of training outlined in the Trust Learning and Development Strategy this training has been identified as role development training.

7.2 All registered nurses undertaking verification of death will have completed the trust's verification of death training. Children's Nurses will have completed a recognised and approved course as detailed in 'Together for Short Lives' guidance.

7.3 A record of the training will be recorded on uLearn.

8.0 Monitoring Compliance and Effectiveness

Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
All registered nurses verifying death have completed the relevant training.	7.0	Appraisal. Training records.	Line Manager	Annual
All registered nurses trained are performing verification of death within the policy parameters.	4.0	Discussion at appraisal between line manager and staff member / clinical supervision.	Line Manager	Annual
Review of incidents / complaints / concerns by divisions to identify concerns around verification of death.	6.0	Collection of data via the safeguard system and complaints / concern reports.	Service Line Governance Groups (by exception reporting to Clinical Effectiveness Committee within highlight report).	Quarterly

9.0 Standards/Performance Indicators

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
CQC – Safe care and treatment	Evidenced by ensuring verification of expected death is carried out sensitively, with dignity and respect by registered nurses.
	Evidenced by the provision of appropriate training for registered nurses, together with supervision registers and appraisals.

10.0 References and Bibliography

- BMA Guidance (2013) accessed via www.bma.rog.uk
- CQC Fundamental Care standards (2015) accessed via https://www.cqc.org.uk/content/regulations-service-providers-and-managers-relevant-guidance#end of life care/support-at-work/gp-practices/service-provision/confirmation on 31.12.2015
- Home Office (1971) *Report of the committee on Death Certification and Coroners*. CMND 4810. London Her Majesty Stationary Office.
- Leadership Alliance for the Care of Dying People (LACDP) (2014) *Priorities of Care for the Dying Person*. June 2014 accessed via www.nhsiq.nhs.uk/endoflifecare on 14.4.16
- National Institute for Health and Care Excellence (NICE) (2015) Guideline NG31 *'Care of dying adults in the last days of life'*. London
- Nursing and Midwifery Council (NMC) (2015) *The Code 'professional standards of practice and behaviour for nurses and midwives'* Nursing and Midwifery Council. London
- Secretary of State for the Home Department (2003) *Death Certification and Investigation in England, wales and Northern Ireland-The Report of a Fundamental Review* 2003.Cm 5831. London. Her Majesty Stationary Office.
- Skills for Health (2010) standard CHS54 '*Verify an expected death'* accessed via https://tools.skillsforhealth.org.uk/competence/show/html/id/2231/ on 16.02.2016
- Together for Short Lives (2012) *The verification of expected death in childhood. Guidance for children's palliative care services*. Together for Short lives. Bristol.

Appendix 1

Leicestershire Partnership NHS
NHS Trust

Verification of Death Record Sheet

Date…….. **Time**……

Patient's Name …… **Date of Birth**……

General Practitioner……

Date Last Seen by GP/Consultant……

Response confirmed;

1. No response to painful stimuli
2. Absence of carotid/radial pulse after palpation for 1 minute
3. Absence of heart sounds, determined by stethoscope, after minimum of 1 minute
4. Absence of respiratory activity, determined by observation and assessment with stethoscope, after minimum of 1 minute
5. Fixed, dilated pupils, which do not react to light

Assess and confirm **all** of the following criteria:

Place of Death

……..

I saw this patient on …… at …… hours and identified that death had occurred.

Time of Death ……. **Time Verified**……..

VERIFIER

Print Name …….. **Signature**……..

Contact Tel Number…… **Position**……

Work Base……

I have authorised the removal of the body by the undertaker and made appropriate arrangements for the medical professional to be informed to discuss certification of death with the patients family / carers.

Please retain 1 copy within the patient's records and send a copy to the General Practitioner. Inform other agencies involved with providing services for this patient.

Appendix 2

Guidance Relating to Certification of Death within Community Hospitals

Certification of Death

Certification of death is the process of completing the 'Medical Certificate of Cause of Death' (MCCD) and currently must be completed by a medical practitioner see Appendix 2. In the event of an unexpected death refer to appendix 3.

The requirements for the completion of a MCCD are outlined in section 46B of the Burial and Cremation Act 1964. A medical certificate of cause of death (MCCD) enables the deceased's family to register the death. This provides a permanent legal record of the fact of death and enables the family to arrange disposal of the body, and to settle the deceased's estate. Information from death certificates is used to inform national statistics, so it is important to ensure the certificate is completed accurately.

General Medical Council guidance is clear that the 'responsible doctor' should complete the death certificate without delay, and must comply with the English legal requirements for reporting deaths to a coroner[i]. Section 46B does not require the doctor who attended the patient during their illness to examine the body before providing a death certificate. Although a doctor who attended the patient during the illness is not required to examine the body after death, there are other good reasons for routinely examining the body. These include: to satisfy oneself that the identity of the deceased is Confirmed, to ensure that all relevant information has been checked, and to console and support the family and answer any questions. The medical practitioner must:-

- Complete the death certificate as soon as practical and within the timeframe required by law and be ready for collection by the relatives/funeral director
- If the medical practitioner has not seen the patient BUT the diagnosis, clinical prognosis and DNAR-CPR form for the patient has been clearly documented then a discussion between the coroner and clinician for the community hospital should occur
- The clinician completing the death certificate is also responsible for completion of part 1 of the cremation form where applicable

Completion of a death certificate by another doctor

Section 46B (3) of the Act recognises that the 'doctor who attended the person during the illness' may be unavailable in a timely manner. It defines the circumstances under which an alternative doctor (who did not attend during the illness) can then complete a death certificate. This only relates to cases in which the death was a natural consequence of an illness. The alternative doctor should make reasonable inquiries to ensure that the attending doctor is not withholding certification because they are not satisfied as to the cause of death. The circumstances in which another doctor may sign the death certificate are:

- Where the appropriate doctor is '*unavailable*'. This is defined as '*dead, unknown, missing, of unsound mind, or unable to act by virtue of a medical condition*'.
- Where the doctor who attended the patient during the illness is unlikely to be able to provide a death certificate within 24 hours of the death.
- Where the doctor who attended the patient during their illness has not given a death certificate and 24 hours or more has passed since the death.
- While the Act allows this 'fall-back' option, it places more rigorous demands on the substitute certifier, who must:

a) look at the medical records made by the doctor who last attended the patient during the illness;
b) consider the circumstances of the patient's death; and
c) examine the patient's body.

Who is the responsible doctor?

When a patient dies it is the statutory duty of the doctor who has attended in the last illness to issue the 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 and so is 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. There is no provision under current legislation to delegate this statutory duty to any non-medical staff.

In hospital, it is ultimately the responsibility of the consultant in charge of the patient's care to ensure that the death is properly certified. Any subsequent enquiries, such as for the results of post-mortem or ante-mortem investigations, will be addressed to the consultant.

If no doctor who cared for the patient can be found, the death must be referred to the coroner to investigate and certify the cause.

If the attending doctor has not seen the patient within the 14 days preceding death, **and** has not seen the body after death either, the registrar is obliged to refer the death to the coroner before it can be registered. In these circumstances, the coroner may instruct the registrar to accept the attending doctor's MCCD for registration, despite the prolonged interval. In contrast, a doctor who has not been directly involved in the patient's care at any time during the illness from which they died cannot certify under current legislation, but he should provide the coroner with any information that may help to determine the cause of death. The coroner may then provide this information to the registrar of deaths. It will be used for mortality statistics, but the death will be legally 'uncertified' if the coroner does not investigate through an autopsy, an inquest, or both.

Deaths to refer to the Coroner

Deaths which involve the following should be discussed with the corners officer to determine if further action is required (see appendix 5):

- Accident
- Suicide
- Violence
- Neglect (by self or others)
- Industrial disease
- Deaths for which the cause is not known
- Patients who have had a naso-gastric tube placed during their hospital admission
- Surgery within last 12 months

Cremation Forms

Cremation forms can only be completed by a registered medical practitioner with a licence to practise with the General Medical Council[ii]. Two doctors are required to complete the certificates – one acting as the referee *in some areas part 1 and 2 are referred to as form 4 and 5 see appendix 4.

Regulation 17 of the Cremation Regulations requires the medical certificate (form Cremation 4) to be completed by a registered medical practitioner with a license to practice with the General Medical

Council. This includes those who hold a provisional or temporary registration with the General Medical Council.

Regulation 17 of the Cremation Regulations also provides for the confirmatory medical certificate (form Cremation 5) to be completed by a fully registered medical practitioner of at least 5 years' standing. This means a registered medical practitioner who has been fully registered under the Medical Act 1983 for at least 5 years and who has held a licence to practice for at least 5 years within the meaning of the Medical Act 1983.

There is no legal requirement that the doctor completing form 4 of the cremation form is the same doctor that has certified death, although in practice it often is the same person.

To complete the Cremation form, you should have attended the deceased during their last illness. The minimum period of hospital care sufficient to meet the requirement should normally be 24 hours. When the period is less than 24 hours you must inform a coroner.

The doctor completing Cremation form 5 must examine the body to confirm life is extinct and to check for implantable devices such as cardiac pacemakers.

We expect the medical practitioner signing form Cremation 4 to have treated the deceased during their last illness and to have seen the deceased within 14 days of death.

The form Cremation 5 medical practitioner cannot be a partner or work colleague of the form Cremation 4 medical practitioner or a relative of the deceased; the two medical practitioners must be truly independent of one another, i.e. not on the same team in hospital or a locum at the same surgery.

Equally, if the medical practitioner completing form Cremation 4 was not the deceased's usual medical practitioner or general practitioner, because the deceased died in hospital, then it is not appropriate for the deceased's GP to sign form Cremation 5. This is because it cannot be said that the deceased's GP is truly independent from the care that the deceased received during life.

Forms Cremation 4 and Cremation 5 do not need to be completed where the death has been referred to a coroner, or the application relates to the cremation of body parts, to a stillborn baby or to the exhumed remains of a deceased person who has already been buried for a period of one year or more.

Further information can be found in the Cremation (England and Wales) Regulations 2008

Completion of forms Cremation 4 (Medical Certificate) and Cremation 5 (Confirmatory Medical Certificate) (replaced forms B and C)

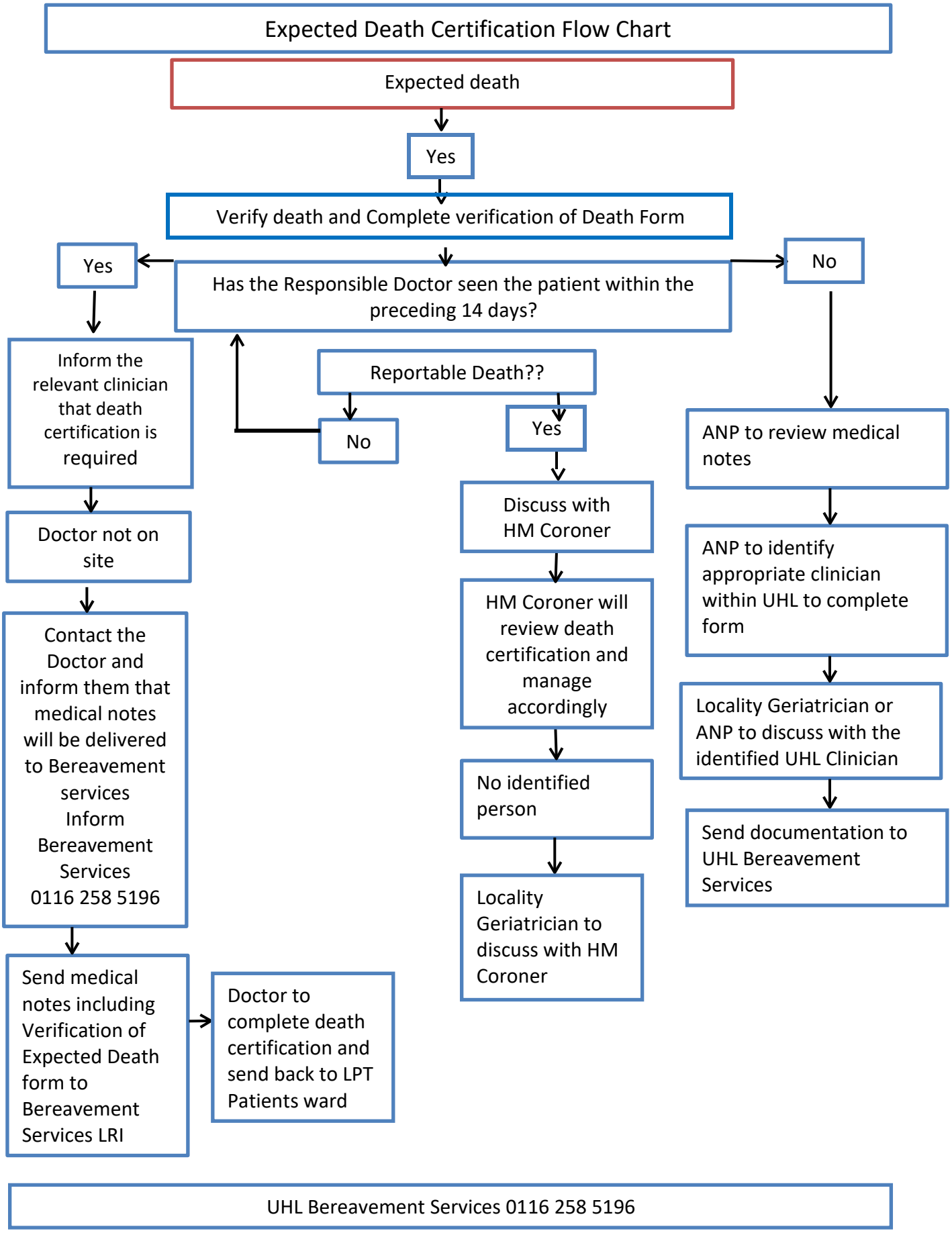
The most frequently occurring errors in completing these forms are: -

- Failure to complete all questions in full
- Deletion of questions
- Incorrect completion of forms
- Illegible handwriting; and
- Discrepancies between the forms as to the date and time of death.

Abbreviations for causes of death are unacceptable where the abbreviation is unclear, unusual or ambiguous; in such cases, the medical referee is likely to make further enquiries of you. You should sign the form with a full signature, not an abbreviation. You cannot use a stamp.

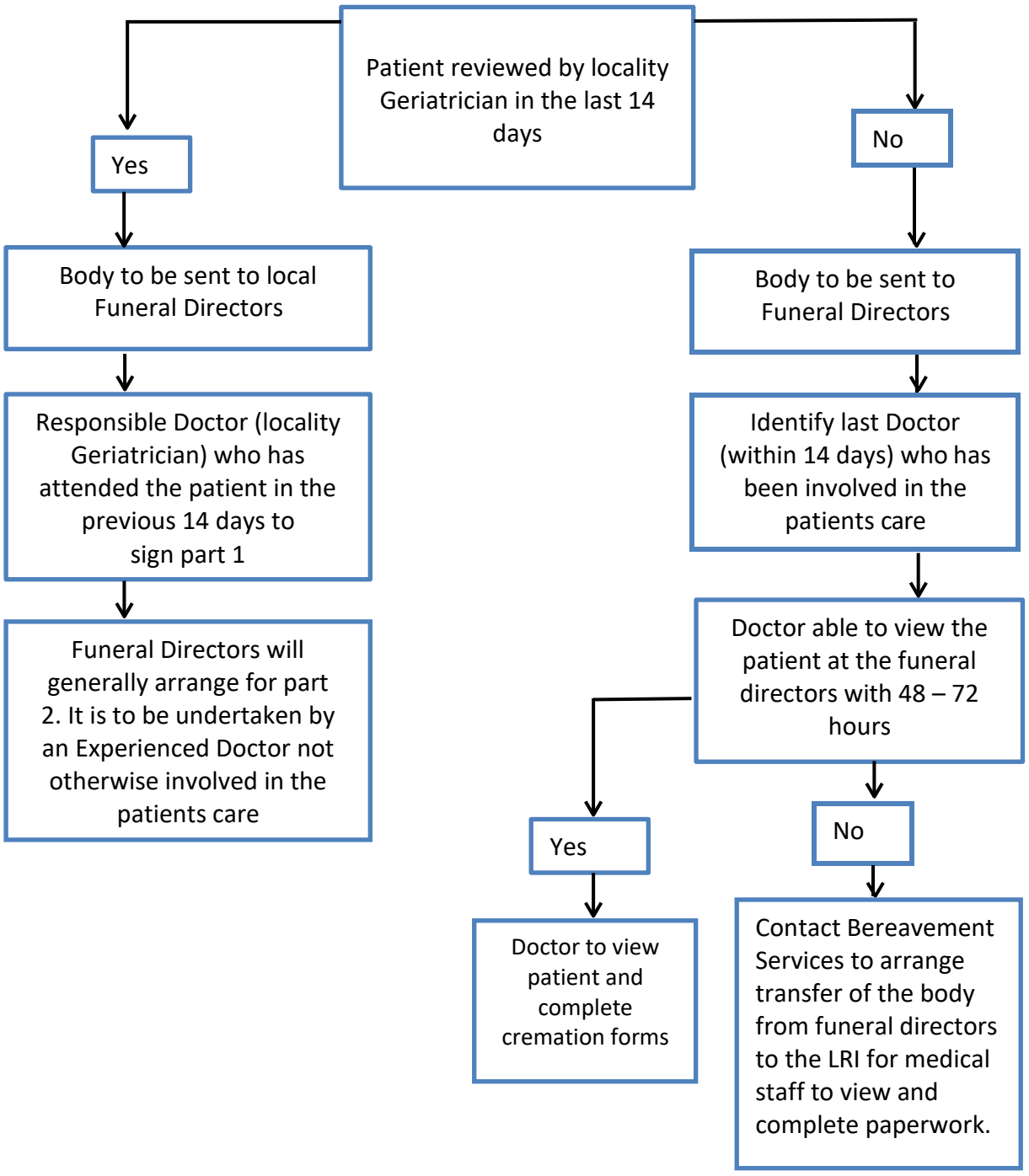
You must complete the form yourself. It must not be completed by another person on your behalf. The form Cremation 5 medical practitioner should not amend form Cremation 4, and should record any differences or discrepancies on his or her own form.

Medical referees will expect that the evidence offered on the certificates demonstrates sound clinical grounds for the cause of death given, and you should complete form Cremation 4 with this in mind.


Expected Death Certification Flow Chart
Expected death
Yes
Verify death and Complete verification of Death Form
Yes
Has the Responsible Doctor seen the patient within the preceding 14 days?
No
Inform the relevant clinician that death certification is required
Reportable Death??
No
Yes
ANP to review medical notes
Doctor not on site
Discuss with HM Coroner
ANP to identify appropriate clinician within UHL to complete form
Contact the Doctor and inform them that medical notes will be delivered to Bereavement services
Inform Bereavement Services 0116 258 5196
HM Coroner will review death certification and manage accordingly
Locality Geriatrician or ANP to discuss with the identified UHL Clinician
No identified person
Send documentation to UHL Bereavement Services
Send medical notes including Verification of Expected Death form to Bereavement Services LRI
Doctor to complete death certification and send back to LPT Patients ward
Locality Geriatrician to discuss with HM Coroner
UHL Bereavement Services 0116 258 5196

Expected Death, Cremation Form requested

Although there is no legal obligation for the doctor certifying death to complete a cremation form, it is good clinical practice.
The doctor completing a cremation form MUST have been involved in the patients care for at least 24 hours and MUST view he body after death



LRI Bereavement Services 0116 258 5196

Appendix 3

Training Requirements

Training Needs Analysis

Training Required	YES	
Training topic:	Verification of Death	
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) ☐ **Role specific** ☐ Personal development	
Division(s) to which the training is applicable:	□ **Adult Mental Health & Learning Disability Services** □ **Community Health Services** ☐ Enabling Services ☐ **Families Young People Children** ☐ Hosted Services	
Staff groups who require the training:	*Please specify…* Registered nurses undertaking verification of death.	
Regularity of Update requirement:	One off.	
Who is responsible for delivery of this training?	Clinical Education Team	
Have resources been identified?	Yes	
Has a training plan been agreed?	Yes	
Where will completion of this training be recorded?	☐ **ULearn** ☐ Other (please specify)	
How is this training going to be monitored?	Via ulearn / feedback from attendees.	

Appendix 4

The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	Yes
Respond to different needs of different sectors of the population	Yes
Work continuously to improve quality services and to minimise errors	Yes
Support and value its staff	Yes
Work together with others to ensure a seamless service for patients	Yes
Help keep people healthy and work to reduce health inequalities	Yes
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	Yes

Appendix 5

Stakeholders and Consultation

Key individuals involved in developing the original document

Name	Designation
Sue Swanson	Clinical Trainer Practice Development Nurse
Caroline Barclay	Nurse Consultant - Advanced Practice
David Leeson	Clinical Education Lead
Victoria Peach	Head of Professional Practice and Education

Circulated to the following individuals for comment

Name	Designation
Emma Wallis	Associate Director of Nursing and Professional Practice
Laura Belshaw	Lead Nurse (MHSOP)
Martine Pritchard	Advanced Nurse Practitioner
Ruth Tandy	Advanced Nurse Practitioner
Jude Smith	Head of Nursing/Deputy Clinical Director
Claire Armitage	Lead Nurse (Adult Mental Health)
Noel O'Kelly	Clinical Director (CHS)
Michelle Churchard-Smith	Head of Nursing (Adult Mental Health & L&D)
Katie Willetts	Senior Nurse (Children's & Families Services)
Jonathan Dexter	Nurse Consultant (Advanced Practice)
Sarah Latham	Lead Nurse (CHS – Community Hospitals)
Sue Swanson	Clinical Trainer / Practice Development Nurse
Michelle Law	Specialist Palliative Care/Hospice at Home Service Lead

Appendix 6

Due Regard Screening Template

Section 1	
Name of activity/proposal	Verification of Death
Date Screening commenced	June 2019
Directorate / Service carrying out the assessment	Clinical Effectiveness Group
Name and role of person undertaking this Due Regard (Equality Analysis)	Jonathan Dexter
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: The purpose of this policy is to state the standards and procedures to enable registered nurses to verify the death of a patient.	
OBJECTIVES: The objective of this policy is to ensure that patients whose death can be verified by a registered nurse is done so to enhance the continuity if end of life care for patients, their families and significant others.	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	No impact expected for any protected characteristics.
Disability	
Gender reassignment	
Marriage & Civil Partnership	
Pregnancy & Maternity	
Race	
Religion and Belief	
Sex	
Sexual Orientation	
Other equality groups?	

Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please <u>tick</u> appropriate box below.			
		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
Discussion at CEG and through consultation process.			
Signed by reviewer/assessor	Jonathan Dexter	**Date**	June 2019
Sign off that this proposal is low risk and does not require a full Equality Analysis			

Appendix 7

DATA PRIVACY IMPACT ASSESSMENT SCREENING

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy. **The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.**			
Name of Document:	**VERIFICATION AND CERTIFICATION OF DEATH POLICY**		
Completed by:	**JONATHAN DEXTER**		
Job title	**CONSULTANT NURSE (ADVANCED PRACTICE)**	**Date**	**28th JUNE 2019**
Screening Questions		**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.		No	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.		No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?		No	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?		No	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.		No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?		No	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.		No	
8. Will the process require you to contact individuals in ways which they may find intrusive?		No	
If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk **In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.**			
Data Privacy approval name:	**JONATHAN DEXTER**		
Date of approval	**28th June 2019**		