VERIFICATION OF EXPECTED ADULT DEATH PROCEDURE

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VALIDITY – Procedures should be accessed via the Trust intranet to ensure the current version is used.

CHANGE RECORD

Version	Date	Change details
5.00	*15/2/11*	*CP25*
6.00	*3/12/12*	*ERYPCT policy CP25 reviewed and harmonised.*
		Procedure (Proc 470)
1.00	*23/05/18*	*Transfer from Policy (P137) to Procedure. Duplication in competencies – removed*
2.00	*December 2018*	*Amendments through clinical networks and GP forum*
2.01	*April 2020*	*Updated to current national guidance. Change to verification process. Addition of COVID-19 advice.*
2.02	*November 2023*	*Reviewed. Proc471 incorporated into Proc470 (this document). Complete redraft to align to national guidance (Hospice UK).* *Approved at Physical Health and Medical Devices Group (14 February 2024).*

Contents

1. INTRODUCTION

This Trust procedure is aligned to national guidance; “Hospice UK. Care After Death: Registered Nurse Verification of Expected Adult Death Guidance (5th Edition)” and with consideration to person and family centred care recommendations in national documents.

This procedure ensures that the death is dealt with:

- in line with the law and coroner requirements (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.
- ensuring the health and safety of others, e.g. from infectious illness including COVID-19, radioactive implants, and implantable devices

2. SCOPE

The scope of this procedure is to provide a safe framework for the timely Verification of Expected Adult Death (VOEAD) for deceased over the age of 18, in their own home, care home or hospital. This can only by undertaken by a competent Registered Nurse (RN), in the employment of Humber Teaching NHS Foundation Trust or agency RN following confirmation of their competency with Trust procedure by team leader or clinical lead.

Inclusion criteria:

- 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 and on DNACPR / ReSPECT form.
- Where the person is found deceased without a DNACPR conversation documented and there are signs of irreversible death (e.g. rigor mortis), VOEAD by the RN can be carried out.
- Death occurs in a private residence, care home, or hospital.
- It includes where the patient dies under the Mental Health Act including Deprivation of Liberty Safeguards (DoLS).
- Patient must be under the care of Humber Teaching NHS Foundation Trust as an inpatient or registered with Trust District Nursing Team.

Exclusion criteria

In these circumstances the VOEAD must not be undertaken by and the patient’s GP/Out of Hours GP or the Police must be informed.

- Any expected adult death believed to have occurred in suspicious circumstances:
    - In cases of expected death when death occurs in an unexpected manner or unexpected circumstances.
    - Death has occurred as a result of an untoward incident, fall or drug error.
    - Any unclear or suspicious deaths

Ongoing practice in response to sustained COVID-19:

- **Infection Control precautions:** Trust Infection Control Policy alongside the NHS National Infection, Prevention and Control Manual should always be followed. The principles of standard infection control precautions and transmission-based precautions continue to apply for the deceased. This is due to the ongoing risk of infectious transmission via contact although the risk is usually lower than for living patients. The table in this web link NHS England » National infection prevention and control manual for England – appendices details the additional precautions which may be required in the case of specific infectious organisms and activities carried out.
- **Medical Certificate of the Cause of Death (MCCD):** can be issued where the medical practitioner has seen the deceased up to 28 days prior to death 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 (Appendix 1).
- **Notifiable Diseases:** Diagnosis of suspected or confirmed COVID-19 is a notifiable infectious disease and must be reported by the deceased patient's medical registered practitioner to the Health Protection team at the time of the suspected diagnosis. (Appendix 1)

3. PROCEDURE STATEMENT

VOEAD is an important and compassionate aspect of care of the deceased and the bereaved. Timely and respectful VOEAD is supportive to bereaved families and is necessary prior to the deceased being moved to either the mortuary or funeral directors.

Humber Teaching NHS Foundation Trust has a legal responsibility to take all practical steps to ensure that the health and safety of staff, service users and visitors is maintained in all situations. This procedure details the process for providing equipment and trained personnel to provide a safe and timely VOEAD, in line with service requirements.

4. DUTIES AND RESPONSIBILITIES

Chief Executive
The chief executive is required to ensure the organisation has systems and processes in place to implement this procedure.

Director of Nursing
Director of nursing has devolved responsibility for the overall management of this procedure within the organisation.

Matrons and Clinical Leads
It is the responsibility of matrons and clinical leads to ensure VOEAD is required; the RNs have access to training required and competency is supported. This can be documented within clinical supervision and monitored within the appraisal process.

Registered Nurses (RN)

- All RNs undertaking VOEAD must have read and understood this procedure, 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, Medical Certification of Cause of Deaths (MCCDs) and the electronic transfer of these to the registrar and the need for families to register the death in person.
- The RN carrying out this procedure must inform the doctor of the patient's death (both in and out of hours) and document the date and time VOEAD was carried out in the clinical record.
- The RN must instigate the process for deactivation of the Implantable Cardiac Defibrillator (ICD), where applicable. Contact Cardiology team.
- The RN carrying out the VOEAD of death must notify the funeral director or 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, or police if there is any unusual situation.

5. PROCEDURE

Verification of Expected Adult Death Flowchart (Appendix 2)

5.1 Timing and temperature

Timely verification: **within one hour in a hospital setting and within four hours in a community setting.** This is supportive to bereaved families. There may be circumstances when this timeframe may not be achievable, in these cases offer support to families and if appropriate guidance regarding the positioning of the deceased person and the maintenance of a cool environment.

Families should be advised that there will be a difference between the time of the last observed breath and the official time of death; **time of death is the time the death was verified, this could even extend into the next day.**

Temperatures between 32-34°C are occasionally associated with an impaired level of consciousness. These deficits are potentially reversible. **If any concern of risk of hypothermia in lead up to death, core temperature should be confirmed as greater than 34°C before carrying out VOEAD**.

5.2 Equipment: For Observation and Personal Protective Equipment (PPE)

To maintain the safety of the RN carrying out the VOEAD, these guidelines should be used in conjunction with the National Infection Prevention and Control Manual (NIPCM)for England and Trust infection control policies and procedures Infection Prevention and Control Policies (humber.nhs.uk) and applied to all VOEAD irrespective of any COVID-19 status.

The RN completing VOEAD must undertake a risk assessment with regards to suspected or confirmed infection risks and adopt the precautions and PPE required in accordance with the NIPCM. Transmission Based Precautions (TBPs) are a set of infection prevention and control measures that should be implemented when patients are known or suspected to be infected with an infectious agent. These should be implemented, as required, in addition to Standard Infection Control Precautions (SICPs) due to the ongoing risk of infectious transmission.

Where COVID-19 is suspected or confirmed a face mask should be placed over the deceased's mouth when moving them as per Health and Safety Executive (HSE) guidance for handling the deceased with suspected or confirmed COVID-19.

NHSE National infection prevention and control manual and the associated appendices :

- Appendix 5a: Personal protective equipment (PPE) when applying standard infection control precautions (SICPs) Appendix 5a (england.nhs.uk)
- Appendix 5b: Personal protective equipment (PPE) when applying transmission based precautions (TBPs) Appendix 5b (england.nhs.uk)
- Appendix 6: Putting on and Removing Personal Protective Equipment (PPE) Putting on and Removing PPE v3 (england.nhs.uk)

Equipment:

- Pen torch
- Stethoscope
- Watch with second hand.
- Disposable plastic apron
- clean disposable gloves
- Single use, small clean disposable sheet
- Disposable plastic waste bags
- (Dressing pack can provide the above 4 items, supplemented with clean gloves as required)
- Alcohol hand gel

Reusable equipment can be a potential source of infection if not appropriately decontaminated. Any reusable equipment used should be cleaned and decontaminated between each use and when soiled (Please refer to Appendix 11 in the Medical and Non-medical Devices Policy N-042.pdf (humber.nhs.uk)

5.3 Verification of Expected Adult Death Examination

ACTION	RATIONALE
Advice family and loved ones that they may wish to leave the room during the verification	To reduce distress
Adopt standard infection control precautions/ transmission based precautions based on risk assessment: Where COVID-19 is suspected or confirmed, place a barrier, such as a cloth or face mask, over the mouth of the patient when moving them.	To ensure protection of the RN from cross-contamination To prevent the potential release of respiratory tract droplets on movement.
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 record. Where a DNACPR is not available, ensure clear clinical judgement and assessment of signs of irreversible death. Or do not proceed.	To ensure a decision has been made. To articulate and document decision not to commence CPR
Identify any suspected or confirmed infectious diseases*, radioactive implants, implantable medical devices. *Notification of Infectious Disease (Appendix 1)	To enable correct information to be passed on to ensure others involved in the care of the deceased are protected.
Where applicable, instigate the deactivation of Implantable Cardiac Defibrillator (ICD). Contact Cardiology team for support	To ensure the timely deactivation of ICD.
Open a 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). Lie the patient flat.	In readiness for VOEAD . To ensure the patient is flat ahead of rigor mortis
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 all treatments are stopped prior to the VOEAD of death examination. These may be removed after the VOEAD of death examination and only if the death is not being referred to the coroner.

VERIFICATION OF EXPECTED ADULT DEATH EXAMINATION The deceased patient should be observed by the RN verifying death for a minimum of five (5) minutes to establish that irreversible cardio-respiratory arrest has occurred.	
ACTION	RATIONALE
Heart Sounds For at least one minute, ensure absence of heart sounds on auscultation. Using the stethoscope, listen for heart sounds through clothing if appropriate.	To ensure there are no signs of cardiac output. To minimise movement of the person and reduce contamination
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 five minutes by observation and listening with stethoscope, through clothing if appropriate. **NB: Do not place your ear near to the person's nose or mouth to listen for breathing.** Place stethoscope on clean sheet	To ensure there are no signs of breathing. To minimise movement of the person and reduce contamination. Ready for cleaning
Central Pulse For at least one minute, ensure absence of a central pulse on palpation. Palpate for a central pulse e.g. carotid or femoral pulse, through clothing if appropriate.	To ensure there are no signs of cardiac output. To minimise movement of the person and reduce contamination.
Motor/ Cerebral 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 motor or cerebral activity. To minimise movement of the person and reduce contamination
In case of any signs of cardiac or respiratory activity during the procedure should be stopped for 10 minutes, after which the full procedure may be repeated.	
Remove gloves and dispose of in the small waste bag whilst leaving on the remaining PPE. Perform hand hygiene as per NICPM and don clean pair of disposable gloves.	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.

Clean the stethoscope and pen torch with disinfectant wipes and place in a clean bag.	
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 PPE in the correct order as per the NICPM and place in waste bag, include hand hygiene.	To eliminate cross-contamination from the PPE.
Dispose of waste in line with Trust policy for waste management (section 9).	To ensure correct management of infective clinical waste in patient's own homes.
Perform hand hygiene following removal and disposal of PPE as per the NICPM	To eliminate cross-contamination from the PPE.
The RN verifying the death needs to complete the Trust VOEAD form (Appendix 3). Time of death is recorded as when VOEAD is completed (i.e. not when last breath is witnessed).	For legible documentation and legal requirements.
The RN must notify the doctor of the death (including date / time) by secure email, clinical record task or phone.	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 should support with personal care of the deceased as appropriate for the patient, family and care setting. With regard to cultural and family wishes.	To provide ongoing compassionate and holistic care after death.
The RN verifying death should understand the 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.

5.4 Syringe Driver(s) and other attached devices

In the event of an unexpected death or unexpected circumstances the GP/ward doctor/ OOH doctor/999 should be contacted immediately and any attachments, including the syringe driver and contents, should be left in place untouched, visually inspected and documented on the MAR chart. In these circumstances the RN must not complete VOEAD and in cases of concern contact the police.

Following completion of VOEAD any syringe driver(s) may be removed, the medication(s) in the syringe and total volume remaining must be documented on Medication Administration Record (MAR) chart the medication(s), documented in the patient's clinical record and then disposed of appropriately. Unused controlled drugs should be disposed as per Trust procedure (see section 9).

Following completion of VOEAD, attached devices, such as urinary catheters, drips etc can be removed or capped off. Individualised clinical judgement should be made regarding removal of urinary catheter, or other collection devices, at this stage depending on risk of leakage of bodily fluids.

5.5 Reporting Deaths via Datix

All expected and unexpected deaths will be reported via Datix as soon as practicable or within 24 hours of becoming aware of the death.

6. IMPLEMENTAION: TRAINING AND COMPETENCY

The Nursing and Midwifery Code (2018) places specific responsibilities on RNs to maintain professional knowledge and competence. RNs must work within the limits of their competence and complete the necessary training before carrying out a new role.

A competency assessment framework (see Appendix 4) accompanies this procedure for RNs to demonstrate their practical skills, knowledge and understanding for VOEAD.

7. EQUALITY AND DIVERSITY

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust-approved EIA.

A positive impact is explicitly intended and very likely in that by ensuring a safe evidence-based framework is in place, patients will have competent safe care from healthcare professionals who are educated and competent in VOEAD. If, at any time this procedure is considered to be discriminatory in any way, the author of the procedure should be contacted immediately to discuss these concerns.

8. DEFINITIONS/ REFERENCES/EVIDENCE/GLOSSARY/

See Appendix 5

9. ASSOCIATED POLICIES

- DNA CPR - ReSPECT Policy N-012.pdf (humber.nhs.uk)
- Guidance for Staff Responsible for Care after Death (Last Offices) (humber.nhs.uk)
- Infection Prevention and Control Policies (humber.nhs.uk)
- NHS England » National infection prevention and control manual for England – appendices
- Infection Prevention and Control Arrangements Policy N-014.pdf (humber.nhs.uk)
- Safe and Secure Handling of Medicines Procedures Proc431.pdf (humber.nhs.uk)
- Waste Management Policy F-020.pdf (humber.nhs.uk)
- Handling the deceased with suspected or confirmed COVID-19 - HSE

Appendix 1: Deaths Requiring Coroner Investigation

Deaths requiring referral to the coroner's office by medical practitioner or police for investigation are when:

- 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

In the Out of Hours (OOH) setting the police act as a coroner's officer and can be contacted via tel. no. 101 for non-emergencies, staff will then be redirected to the appropriate area. In an emergency staff should still call 999/112.

Notification of infectious diseases
Notifiable diseases are nationally reported by medical practitioner in order to detect possible outbreaks of disease and epidemics as rapidly as possible Notifiable diseases and causative organisms: how to report - GOV.UK (www.gov.uk), it is important to note:

- 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 the UK Health Security Agency, previously 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: Verification of Expected Adult Death in the Community Flowchart

Patient is known palliative care/end of life care.
An ‘Expected Death’
↓
Has appropriate documentation (such as ReSPECT/DNACPR) in place.
↓
Is under Humber teaching NHS Foundation Trust Distirct Nursing services for this care
↓
Is in their own home, residential care home or hospital
↓
Registered Nurse (RN) has undertaken suitable training and is confident and competent to verify the expected death
↓
RN is satisfied there are no suspicious circumstances surrounding the expected death
↓
VOEAD can be undertaken by RN in accordance with Humber Teaching Foundation NHS Trust Procedure.

If the answer is NO at any stage of the flow chart the RN should not carry out VOEAD and should refer on to patient’s own GP/OOH GP/111/999 as deemed appropriate at the time.

Initiating resuscitation attempt.
In the absence of any advanced directive, DNACPR or ReSPECT documentation the RN should usually commence basic life support/immediate life support and arrange further ambulance assistance via a 999 call. However, where resuscitation attempt is inappropriate in the case of **“conditions unequivocally associated with death”** it is justifiable that CPR should not be commenced. The justification for this non-action needs to be clearly documented.

Conditions unequivocally associated with death include:
Hypostasis: the pooling of blood in congested vessels in the dependent part of the body in the position in which it lies after death. Initially hypostatic staining may appear as small round patches looking rather like bruises but later these coalesce to merge as the familiar pattern. Above the hypostatic engorgement there is obvious pallor of the skin. The presence of hypostasis is diagnosis of death - the appearance is not present in a living person.

Rigor mortis: the stiffness occurring after death from the postmortem breakdown of enzymes in muscle fibres. Rigor mortis occurs first in the small muscles of the face, next in the arms and then in the legs (30 minutes to 3 hours).

Massive cranial or cerebral destruction.

Appendix 3: Registered Nurse Record of Verification of Expected Adult Death Form

(Available from Forms on Trust intranet)

REGISTERED NURSE VERIFCATION OF EXPECTED ADULT DEATH (VEOAD) FORM	NHS Humber Teaching NHS Foundation Trust

Details of Deceased			
Last name		First name(s)	
NHS Number		Date of Birth	
Address			
Postcode			

General Practitioner Name:	
Surgery Name & Address:	

Details of any person present at time of last observed breath:		
Name (s)	Relationship to deceased	Contact number(s)

DNACPR in place, expected death, and no untoward or suspicious circumstances in lead up to death.	**Yes / No**
If '**No'**, you are advised **not to undertake VOEAD** and leave any attached devices in place (e.g.: syringe diver, catheter). Record in clinical record action you have taken (e.g. contacted GP, OOH, 101 or 999).	

Vital signs:	Tick to confirm	**Vital signs:**	Tick to confirm
Heart sounds absent for at least one minute		Central pulse absent for at least one minute	
Pupils unresponsive to light		Absence of motor response	
Respirations absent for at least five minutes			

Date of VOEAD:		**Time of VOEAD**	

Time of death is the <u>time the death was verified</u>. There will be a difference between time of last observed breath and recorded time of death, this could extend into the next day. Explain this to loved ones and support.

<u>If Known</u>; For Cremation ☐ or burial. ☐ Details of Funeral Director:
Information for funeral director (eg: implantable devices, infections):

RN confirming VOEAD			
Signature		**Print name**	
Date		Time	
Role & base		Contact no.	

Form to be left with patient for funeral director. Detail to be added to clinical record

Rest in Peace

Appendix 4: Competency Framework

RNs must have attended the appropriate theoretical training and be assessed and signed off as competent in practice, either by direct observation in real practice or with clinical simulation and with discussion in supervision. Assessors can be any RN competent in VOEAD.

Assessment of competence in practice is required, this can be completed in clinical practice or with clinical simulation. RNs already competent in VOEAD are not expected to repeat the competency assessment, rather to familiarise themselves with any changes within this procedure and adopt the changes into their practice. Need for additional and refresher training should be identified during supervision and the appraisal process.

Theory training is delivered by Saint Catherine's hospice or internally by Professional Lead for Palliative and End of Life Care. Information available from both organisations' education webpages.

RNs should discuss any concerns related to their competence or the procedure with their line manager or clinical lead for further supervision and support.

Appendix 5: Definitions and References

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. [14] 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[15]. Doctors call this process 'confirmation of death' and paramedics call this process 'recognition of life extinct'. Nurses will continue to use the term 'verification of death'.

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[16.] The Coronavirus Act 2020 [17] and information for Death certification processes: information for medical practitioners after the Coronavirus Act 2020 expires[18] - March 2022 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 a video link, 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.

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 was 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 [19] . Trust staff are required to be familiar with Trust policy regarding resuscitation and compliant with related mandatory training (Resuscitation Policy.pdf (humber.nhs.uk))

The Resuscitation Council UK gives guidance 20160123 Decisions Relating to CPR - 2016.pdf (resus.org.uk) for circumstances where a patient is discovered dead and there are signs of irreversible death[20]. *"There will be cases where healthcare professionals discover patients with features of irreversible death – for example, rigor mortis. In such circumstances, any healthcare professional who makes a carefully considered decision not to start CPR should be supported by their senior colleagues, employers and professional*

bodies." (p.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 clearly document their actions and reasoning.

Do not attempt cardio-pulmonary resuscitation (DNACPR)
Cardiopulmonary Resuscitation (CPR) is a medical treatment that endeavours to restart cardiorespiratory function. The advance decision not to attempt CPR and allow a natural death is underpinned by comprehensive national guidance[22] . 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, involving those important to the patient.

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    - Appendix 5a: Personal protective equipment (PPE) when applying standard infection control precautions (SICPs) Appendix 5a (england.nhs.uk)
    - Appendix 5b: Personal protective equipment (PPE) when applying transmission based precautions (TBPs) Appendix 5b (england.nhs.uk)
    - Appendix 6: Putting on and Removing Personal Protective Equipment (PPE) Putting on and Removing PPE v3 (england.nhs.uk)
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Appendix 6: Equality Impact Assessment (EIA) Toolkit

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: **Verification of Expected Adult Death Procedure**
2. EIA Reviewer (name, job title, base and contact details): **Debi Adams, Professional Lead for Palliative and End of Life Care**
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? **Procedure**

Main Aims of the Document, Process or Service
To set out the requirements that must be met for approval, ratification and dissemination of all Humber Teaching FT policies.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	**Equality Impact Score** Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	1. who have you consulted with 2. what have they said 3. what information or data have you used 4. where are the gaps in your analysis 5. how will your document/process or

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people, Young people, Children, Early years	Low	Procedure for care of adults over 18 years only – for reasons of legality and safety.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory, Physical, Learning, Mental Health (and including cancer, HIV, multiple sclerosis)	Low	See summary below.
Sex	Men/Male, Women/Female	Low	See summary below.
Married/Civil Partnership		Low	See summary below.
Pregnancy/ Maternity		Low	See summary below.
Race	Colour, Nationality, Ethnic/national origins	Low	See summary below.
Religion or Belief	All Religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	See summary below.
Sexual Orientation	Lesbian, Gay Men, Bisexual	Low	See summary below.
Gender Re-assignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	See summary below.

Summary

Please describe the main points/actions arising from your assessment that supports your decision above			
There is should be no differential impact on the care provided under this procedure for any of the equality target groups.			
EIA Reviewer	Debi Adams		
Date completed;	4th January 2024	Signature	D. Adams