Keywords Verification/Registered nurses/Expected death

This article has been double-blind peer reviewed

In this article...

- A summary of guidance for verification of expected death and care after death
- Issues emerging in the process of aligning and updating national policy
- Educational and ethical perspectives on care around the time of death

Care at and after death: an update on policy and guidance

Key points

The circumstances in which people die affects the process of verifying the death

Offering care at and after the time of death is a vital nursing skill

Providers of nurse education have a key role in ensuring nurses feel confident to provide this care

An understanding of the legal, ethical and policy context is also fundamental

Hospice UK's updated guidance reflects the latest changes in care for verification of expected death and care after death

Authors Dr Diane Laverty is Macmillan nurse consultant, palliative care, London Ambulance Service NHS Trust; Theresa Mann is nurse consultant, Barts Health NHS Trust; Dr Jo Wilson is team lead, family and bereavement support, Helen and Douglas House Hospice.

Abstract This article, the eighth and final one in a series on palliative and end-of-life care, discusses the main updates on policy and guidance related to care at and after death, and the support that is offered to the family and key contacts. It also includes an account of alignment work while Hospice UK and the National Nurse Consultant Group (Palliative Care) have been working with the Academy of Medical Royal Colleges to ensure consistency of practice recommendations. The article reviews current issues that have arisen, which affect the procedure for verification of death, alongside the significant changes happening to death certification and how this may influence clinical practice. Hospice UK's updated national guidance on care after death and registered nurse verification of expected adult death are our main points of reference.

Citation Laverty D et al (2025) Care at and after death: an update on policy and guidance. *Nursing Times* [online]; 121: 1.

Over the past century, the number of deaths in England and Wales has decreased and the number of people living into old age has increased (Office for National Statistics (ONS), 2017). Alongside this, causes of death have changed over time. At the start of the 20th century, most people were dying of infections. Now young people are most likely to die of causes such as drug misuse, suicide and self-harm (men more than women), and older people are more likely to die of long-term conditions including cancer (ONS, 2017).

Covid-19, an infectious illness, temporarily changed the mortality profile of England's population when it became the leading cause of death in 2020 and 2021 (Raleigh, 2022). However, the situation is returning to its previous trends.

In 2022, hospital was the most common place of death (43.4%), although more than half of deaths (56.6%) occurred either at home (28.7%), in a care home (20.5%), a hospice (4.7%) or in other places (2.6%) (Office for Health Improvement and Disparities, 2024). It is vital, therefore, that nurses have a thorough knowledge of how to care for a dying and deceased person and support their family and carers in all care settings. This includes an awareness of the cultural and religious practices of the person and family. Bereaved families need to be able to tell a story of care about the person who has died and how they themselves were supported, as the "continuity of care up to and including bereavement is rooted in an ethic of non-abandonment" (Lichtenthal et al, 2024).

Historically, there have been few changes in the legal system around the issuing of the medical certificate of the cause of death or the registration of death – until the Covid-19 pandemic. In 2021, the

SHUTTERSTOCK AI GENERATOR

role of the medical examiner (ME) was introduced to the UK. It was established to ensure a robust and safe system for the oversight of deaths, alongside providing an efficient and improved service to the bereaved. Each ME office links with the local health and care providers and the regional ME offices to establish seamless processes for the certification of deaths (NHS England, no date).

It is against this backdrop of changing causes and places of death, recognition of the importance of the role of the nurse in end-of-life care and providing support for bereaved families that Hospice UK has published guidance on adult care after death and verifying adult expected deaths. Both documents have been updated several times since their first publications in 2010 and 2017, respectively, to reflect current best practice. We have also written papers on this subject (Laverty et al, 2019; Henry and Wilson, 2012).

This article summarises the latest key points in clinical practice in this area. Hospice UK and the National Nurse Consultant Group (Palliative Care) worked with the Academy of Medical Royal Colleges (AoMRC) as they updated the 2008 guidance on confirmation of death, *A Code of Practice for the Diagnosis and Confirmation of Death* (AoMRC, 2008), so in this article we describe the alignments and challenges we have faced in this process. One of the current clinical dilemmas is verifying an expected death with non-invasive ventilation in place so we explore this. We also look at the role of the ME; deaths in the community involving the police and the coroner; and current education and training provision, and include a case study which illuminates why care after death is a key nursing and clinical skill.

Our aim is to provide an update for current practice so that nurses feel empowered to engage with their education providers and employers regarding this core aspect of care, and feel equipped to deliver verification of expected death in a timely manner.

What is good practice?

Verification or confirmation of death is the process of identifying that a person has died. It does not refer to or involve providing a death certificate or identifying the cause of the death. Timely verification/confirmation of an expected death – within one hour in a hospital setting and within four hours in a community setting – is an extension of excellent clinical and palliative care being provided to the patient. It is supportive to bereaved families and is necessary prior to the deceased being moved to either the mortuary or the funeral directors (Hospice UK, 2024a).

> *"Verifying expected death and caring for bereaved families is an essential skill, especially for nurses working in a community setting"*

In circumstances when a patient has died at home but there is no community or palliative care nurse available to verify the death in a timely manner, relatives have to wait for the GP to perform this function. This can delay the process by several hours (especially in rural communities where travel can take a long time), which can understandably cause distress, especially if there are specific spiritual or religious rituals to undertake or that require burial or cremation within a short time frame (Public Health England, 2016).

The case study in Box 1 highlights the importance of timely verification if it is an

expected death and demonstrates how this incorporates the bereavement care and support provided to the patient and their loved ones. This is an extension of person-centred care, pre and post death.

Hospice UK's guidance documents

Both the *Care After Death: Registered Nurse Verification of Expected Adult Death (RNVoEAD) Guidance* (Hospice UK, 2024a) and the *Care after Death: Guidance for Staff Responsible for Care After Death* (Hospice UK, 2024b) documents have undergone many reiterations in response to changes in care and because of the Covid-19 pandemic. It has been important to keep them current and of use to relevant health professionals, with the emphasis being on encouraging each organisation to adapt and adopt the guidance to suit their particular needs.

The key points from the RNVoEAD guidance include:

- A great emphasis on the care of the family and significant others and how caring for the deceased dovetails with the care of the people left behind. This may not only be the family or friends but could also include close associates, for example, in a care home where people live closely together with a common bond;
- Recognition by the Care Quality Commission (CQC) that this is the guidance to follow for the verification of expected adult death (CQC, 2023). There is nothing in law that specifies who must verify a death, but the guidance aims to ensure a well-rounded, timely and compassionate approach to care (Hospice UK, 2024a);
- It aligns with the newly updated AoMRC's *A Code of Practice for the Diagnosis and Confirmation of Death: 2025 Update* (2025) (discussed below).

The key points from the *Care after Death* guidance documents include:

- The importance of joint working with faith, religious and spiritual leaders. Mutual respect and appreciation of each other's contribution at this difficult time can ensure the family are well supported and all rituals, customs and practices are followed;
- The dignified and sensitive handling of the deceased;
- The expanded role of the ME and how this aligns with the coroner;
- The disposal of the deceased and funeral processes;
- The provision of bereavement services for the family and significant others (Hospice UK, 2024b).

"Determining whether a death is expected or unexpected can be challenging in the community"

Box 1. Case study: verification of death and good practice

Peter Smith, aged 78, had been admitted to hospital for an acute chest infection. He had a last medical history of bronchiectasis, heart failure and a recent diagnosis of progressive supranuclear palsy.

Upon admission, he started treatment for the acute infection and fluid overload, but it became apparent after 48 hours in hospital that he was not responding well to treatment and was approaching end of life.

Mr Smith, although very drowsy at this point, had a period of lucidity and asked for a cup of tea. He also asked his daughter if he was at the end of his life. She confirmed that the medical team had informed the family that this was correct. He then asked if he could go home, as he did not wish to die in hospital.

The hospital palliative care team was called and were able to organise everything to expedite a rapid discharge home the next morning. Upon arrival home, he was visited by a community palliative care nurse and a district nurse, both of whom cared for Mr Smith and offered support to Mr Smith's family. After they had administered various injections for control of respiratory secretions and pain, they discussed with him and agreed to commence a continuous subcutaneous infusion syringe pump to manage his symptoms. The palliative care nurse visited again the next day to review the situation and offer further guidance and support to Mr Smith's family. She advised them to call the team if they had any further queries and/or when Mr Smith died.

Mr Smith died the same afternoon. His wife rang the palliative care nurse as instructed. She returned to the family home immediately and sat with Mr Smith's wife and explained the process of verification (confirmation) of his death. She then undertook the verification, meaning the family did not have to wait several hours for the GP to come and complete the process. The nurse then explained what would happen and what they needed to do, so the family were aware of the next steps.

The nurse reflected afterwards how this vitally important aspect of Mr Smith's care following his death also helped as a key part of the family's bereavement support. Offering verification of his death in such a timely manner was acknowledged as completing his episode of care with great dignity and respect, and served as an immense comfort to his family, who felt very supported and cared for.

The AoMRC and the updated guidance

The AoMRC leads on the confirmation of all deaths in all areas, including deaths in intensive care and confirmation of death ahead of organ donation. Its Code of Practice (AoMRC, 2025; AoMRC, 2008) builds upon an earlier code, which was originally published in 1998, and updated a number of important aspects of it, namely the format changing to separate out the confirmation of death from organ donation and transplantation. Former chief medical officer Sir Liam Donaldson stated in the 2008 foreword that "it provides clear, scientifically rigorous criteria for confirming death, both in clinical settings where confirmation of death by brain-stem testing is appropriate, and where confirmation of death following cardiac arrest is required" (AoMRC, 2008).

The AoMRC Code of Practice has now undergone a further review to update to reflect advances in medical practice and the evolving role of the health professional. This document was published on 4 November 2024 and came into force on 1 January 2025. This updated code will remain an authoritative source of guidance on the clinical aspects of the diagnosis of death. While most deaths are predictable and confirmation is straightforward, recent advances in medicine, together with new legislation, means that a new code is necessary to cover all situations now met in clinical practice (for example, different forms of ventilation to support patients dying in their preferred place of care).

The Communication section in the AoMRC Code of Practice (Chapter 7) refers to the process of 'confirmation' rather than 'verification' of death, but acknowledges that both terms are referring to the same process. There are ongoing discussions between the AoMRC and the National Nurse Consultant Group (Palliative Care) around aligning language to minimise

confusion and for professional clarity. Scotland already uses the term 'confirmation of death', whereas ambulance clinicians tend to use the term 'recognition of life extinct' (ROLE).

An amendment has been added to the most recent (sixth) edition of the RNVoEAD guidance (Hospice UK, 2024a) as it was highlighted during an academic writing group meeting for the updated Code of Practice (AoMRC, 2025) that to be completely accurate from an anatomical perspective, supraorbital pressure is the correct procedure for verifying the absence of a motor/cerebral response. This was in the original versions of the guidance, but was removed as it could mark the skin of the deceased, which was unnecessary in expected deaths and when time could be allowed to ensure many signs of death were present. The sixth edition, therefore, recommends either supraorbital pressure to align with the academic group, or a trapezius squeeze for expected deaths.

QUICK FACT **>50%** More than half of all deaths occur outside of hospital, and mostly at home or in a care home

Non-invasive ventilation

Since the publication of the fifth edition of the RNVoEAD guidance in 2022, there have been enquiries related to a registered nurse being able to verify an expected death of a patient who has non-invasive ventilation (NIV). If withdrawal of the NIV has not been managed in a planned and proactive manner, the rise and fall of the chest through the NIV can mimic respiratory effort from the patient. This can cause concern in relation to turning off the ventilator and verifying the death.

If the patient has died, with a do not attempt cardiopulmonary resuscitation (DNACPR) decision in place and in an expected manner, then all other signs of life will be absent. It is recommended that the ventilator be switched off and there is continued checking for a pulse, alongside auscultating for the presence of a heartbeat. Following this, the verification process should be followed, ensuring all checks are conducted over the specified five-minute period.

The RNVoEAD guidance also stipulates that if there are any doubts or concerns over verifying the death and/or whether it is 'expected', it is advisable to liaise with the GP or another medical practitioner. It is not expected that a registered nurse should ever undertake verification of death if they are unhappy or uncertain about the circumstances.

Deaths in the community

Determining whether a death is expected or unexpected can be challenging in the community, especially if the attending clinicians are emergency services, who may have minimal information available to them related to the patient and their family. This is why it is imperative that early advance care planning conversations are undertaken and documented to provide adequate and timely information to all health professionals delivering care to the individual.

Changes to the police death investigation policy following the Stephen Port murders and his trial in 2016 (Metropolitan Police, no date) have resulted in a higher level of scrutiny of all deaths, which can be distressing to families who have been prepared for the death by their health professional. They may have received detailed information about what will happen as the patient begins to die, alongside what they should do after the death. At this highly emotive time, people may still panic when death occurs, despite extensive preparations, and call the emergency services for support. Detailed documentation in the form of an electronic care plan that includes a DNACPR decision and is easily accessible can result in a death correctly being identified as 'expected' and the appropriate process and guidance for the family being followed, without the need for police presence.

Changes to the death certification process in 2024

The role of the ME is to provide independent scrutiny of deaths by a senior medical practitioner. From 9 September 2024, this has been extended in England and Wales to ensure that they have oversight of all proposed causes of death in any health setting (Department of Health and Social Care, 2024; NHS England, no date). For nurses undertaking verification of death, it is important that they understand the changes and how these – and any future changes – may impact on the bereaved family, so that they can explain this clearly.

There is also a new medical certificate of cause of death (MCCD), which has been expanded to include:

- Details of the ME who had responsibility for scrutinising the cause of death;
- The deceased's ethnicity;
- A cause of death for maternal deaths;
- Details of any medical devices or implants.

There is a new paper version of the MCCD and work is under way to develop an electronic version, which will facilitate easier sharing of the certificate between the attending practitioner, the coroner (if required), the ME and the registrar.

The registrar will need to receive notice of the cause of death from either the coroner or the ME. The registrar will no longer need to refer deaths to the coroner, as the ME or attending practitioner will undertake this role.

Finally, due to the additional scrutiny of each death provided by the ME, there is no longer a regulatory requirement for scrutiny prior to a cremation. Therefore, there will be a move to remove Cremation form 4 and the medical referee role.

The national medical examiner, who will ensure adequate training and preparation of each ME, alongside robust governance arrangements, is overseeing all of these changes.

Care at and after death in nurse training

In the Nursing and Midwifery Council's (NMC) *Future Nurse: Standards of Proficiency for Registered Nurses*, on which all nursing programmes are based, Annexe B states that a newly registered nurse must be able to demonstrate the following:

> *"10.5 understand and apply DNACPR decisions and verification of expected death*
> *10.6 provide care for the deceased person and the bereaved respecting cultural requirements and protocols" (NMC, 2018a)*

There is a requirement for all registered nurse training programmes to be teaching this, although it is anticipated that it will be addressed in a variety of different ways. Universities do not share one programme or curriculum, so it is impossible to say if this is being taught by everyone, although we actively encourage doing so. It would also help to standardise this training.

We would strongly recommend that verifying expected death and caring for bereaved families be made a standard mandatory module taught in all universities, so that all nursing staff are equipped with this crucial skill upon completion of their training.

The NMC also regulates nursing associates. There are NMC guidelines for educators (NMC, 2020) and *Standards of Proficiency for Nursing Associates* (NMC, 2018b),

but disappointingly, these do not mention verification of death as a skill expected of a nursing associate. However, there is reference made to care of the deceased:

> *"3.13 demonstrate an understanding of how to deliver sensitive and compassionate end of life care to support people to plan for their end of life, giving information and support to people who are dying, their families and the bereaved. Provide care to the deceased*
> *3.14 provide care for the deceased person and the bereaved respecting cultural requirements and protocols"*
> *(NMC, 2018b)*

The competencies listed for registered nurses are brief and, although there are no actual competencies listed for nursing associates, their standards have more detail, and more emphasis on sensitive and compassionate care. We advocate for competencies to be written for both professional groups of nurses and include comprehensive direction to equip the nurse/nursing associate with the skills to demonstrate this essential aspect of patient care.

The Scottish Government made a move to permit confirmation/verification of all deaths by appropriately trained nurses (Scottish Government, 2017), but in England, the confirmation of all deaths remains the domain of a medical practitioner or an ambulance clinician only. Registered nurses can verify expected deaths.

Box 2 features practice points to consider in the clinical setting.

Box 2. **Practice points**

- Consider the verification process in your area. Whose responsibility is it to verify an expected death in the community? Are there barriers to implementing this practice in your area?
- Are student nurses taught verification of death as part of their training, regarding caring for patients at end of life? If not why is this, given that it is an essential part of end-of-life care? What might help take this forward? How might you begin a conversation about this with your education link nurses and/or heads of professional development?
- Do you know where you can access verification of death training and competency sign off in your local area? How might you progress access to this training, either for yourself or others?
- Do you know where the resources are in your organisational setting to supplement the post-care after death processes and the support of the bereaved? How do you remain up to date?

> ***"It is not just the process of verification, but also the wraparound care that is crucial for the bereaved"***

Further training and resources

Both Hospice UK's guidance documents, with further reading about both verification of death and care after death, are available from the Hospice UK website or via the Royal College of Nursing's website. They provide the most up-to-date guidance for this important clinical skill and contain relevant and current references and resources.

Local education and training is encouraged, as each trust or organisation will have their own specific needs. It is, however, also encouraged that national resources, such as the e-ELCA Registered Nurse Verification of Expected Adult Death e-learning module (e-lfh.org.uk/programmes/end-of-life-care), alongside other e-ELCA modules pertaining to care after death, are used.

Conclusion

Care at and after death is an important nursing skill. It is not just the process of verification, but also the wraparound care that is crucial for the bereaved. This care is delivered at a most emotive time in the bereaved person's life and the manner in which it is delivered can have a significant impact on them and their bereavement journey. This care is a fundamental and unique skill of the registered nurse.

This article, which concludes our series on palliative and end-of-life care, has looked at some changes that are happening legally, ethically and professionally in this area of care. With the move to provide more end-of-life care in the community, alongside increases in technology such as NIV, nurses need to be better equipped to care for these patients. We welcome continued alignment with professional colleagues, such as the AoMRC, to ensure the consistency and clarity of all national guidance related to care after death. We actively encourage higher education and local education providers to mandate consistent education and training in this area to ensure that all registered nurses provide this aspect of care and are supported in clinical practice.

Hospice UK is committed to ensuring that both our guidance documents are current and the writing of the guidance is undertaken in line with our colleagues in the emergency services, the coronial and ME services, and other professional bodies. We hope to instil confidence in education providers and nurses to fulfil this core act of care after death for the patient and their family/carers. **NT**

References

Academy of Medical Royal Colleges (2025) *A Code of Practice for the Diagnosis and Confirmation of Death: 2025 Update*. AoMRC.

Academy of Medical Royal Colleges (2008) *A Code of Practice for the Diagnosis and Confirmation of Death*. AoMRC.

Care Quality Commission (2023) GP mythbuster 13: Verification and certification of death. *cqc.org.uk*, 27 November (accessed 4 November 2024).

Department of Health and Social Care (2024) An overview of the death certification reforms. *gov.uk*, 14 August (accessed 4 November 2024).

Henry C, Wilson J (2012) Personal care at the end of life and after death. *Nursing Times*; 108.

Hospice UK (2024a) *Care After Death: Registered Nurse Verification of Expected Adult Death (RNVoEAD) Guidance. Sixth Edition*. HUK.

Hospice UK (2024b) *Care after Death. Guidance for Staff Responsible for Care After Death. Fifth Edition*. HUK.

Laverty D et al (2019) Registered Nurse Verification of Expected Adult Death: A response to situational challenges. *International Journal of Palliative Nursing*; 25: 7: 354-355.

Lichtenthal WG et al (2024) Investing in bereavement care as a public health priority. *The Lancet Public Health*; 9: 4, e270-e274.

Metropolitan Police (no date) Police reforming the national approach to investigating unexplained deaths. *met.police.uk* (accessed 4 November 2024).

NHS England (no date) The national medical examiner system. *england.nhs.uk* (accessed 4 November 2024).

Nursing and Midwifery Council (2020) Educating nursing associates. *nmc.org.uk*, 14 July (accessed 4 November 2024).

Nursing and Midwifery Council (2018a) *Future Nurse: Standards of Proficiency for Registered Nurses*. NMC.

Nursing and Midwifery Council (2018b) *Standards of Proficiency for Nursing Associates*. NMC.

Office for Health Improvement and Disparities (2024) Palliative and end of life care profile December 2023 update: Statistical commentary. *gov.uk*, 17 September (accessed 4 November 2024).

Office for National Statistics (2017) Causes of death over 100 years. *ons.gov.uk*, 18 September (accessed 4 November 2024).

Public Health England (2016) *Faith at the End of Life: A Resource for Professionals, Providers and Commissioners Working in Communities*. PHE.

Raleigh V (2022) Deaths from Covid-19 (coronavirus): How are they counted and what do they show? *kingsfund.org.uk*, 23 August (accessed 4 November 2024).

Scottish Government (2017) Verification of death by a registered healthcare professional: Chief Nursing Officer guidance. *gov.scot*, 2 May (accessed 4 November 2024).