FNIHB- OR Nursing Policy and Procedure

Section:	**Administration**	Policy Number:	**I - 13**
Subject:	**Pronouncement and Certification of Death**	Issued: Revised:	**2015-03-31**
Distribution:	**All Nursing Facilities**		

1. POLICY:

1.1 Pronouncing Death:

1.1.1 Registered Nurses (RN), Registered Practical Nurses (RPN) and Registered Nurses in the Extended Class (RN(EC)) have the authority to pronounce death only when death is expected and when the client's treatment plan does not include resuscitation.

1.2 Certifying Death:

1.2.1 RNs and RPNs are not authorized to complete the medical certificate of death.

1.2.2 The medical practitioner (physician) who was last in attendance during the last illness of the deceased shall sign the medical certificate in the prescribed form.

1.2.3 The RN(EC) is authorized to complete and sign a medical certificate of death only when all of the five (5) following conditions are met:

(i) The RN (EC) has had the primary responsibility for the care of the deceased during the last illness of the deceased;
(ii) The death was expected;
(iii) There was a documented medical diagnosis of a terminal disease for the deceased made by a legally qualified medical practitioner during the last illness;
(iv) There was a predictable pattern of decline for the deceased during the last illness of the deceased; and
(v) There were no unexpected events or unexpected complications during the last illness of the deceased.

2. PRINCIPLES:

2.1 The coroner is responsible for completing the medical certificate of death when he/she has conducted an investigation or held an inquest respecting the death.

2.2 When death is expected, there is no legal requirement for a direct physician's order authorizing the nurse to pronounce the death.

2.3 Death, as determined by physical assessment, is considered to have occurred when cardiac and respiratory vital signs have ceased (pulseless at the apex and absent respirations) and the pupils

are dilated and fixed.

2.4 Through the basic nursing programs, nurses (inclusive of RPN, RN and NP) have acquired the knowledge, skill and judgment necessary to assess the presence or absence of vital signs.

3. DEFINITIONS:

3.1 **Certification of Death:** Is the legally required signing of a death certificate stating the cause of death (CARNA, 2011).

3.2 **Pronouncement of Death:** Is the determination that, based on a physical assessment, life has ceased.

3.3 **Expected Death:** There is no legal definition of expected death. However, for the purpose of this document, the term "expected" death implies that the death of the client has been anticipated by the client, the family and the health team and anticipated events have been planned for in a written plan (CNO, 2009).

4. PROCEDURE:

4.1 In the case of an expected death,

4.1.1 The RN, RPN, or NP may pronounce the death when there are no resuscitation requirements. The nurse shall pronounce death by confirming:

(i) Absence of respirations;
(ii) Absence of a palpable pulse and heart sounds; and
(iii) Pupils are fixed and dilated.

4.1.2 The nurse shall inform the physician of the client's death, as he/she is responsible for completing the *Medical Certificate of Death*.
If there is an RN(EC) in the community, then he/she may be informed of the death as the RN(EC) may have the authority to complete the *Medical Certificate of Death*, as outlined in the Policy Statement 1.2.3.

4.1.3 Prior to signing a Medical Certificate of Death, the RN(EC) must read and follow the instructions in the Handbook on Medical Certification of Death published by the Office of the Registrar General. (It can be downloaded from:
http://www.publications.serviceontario.ca/ecomlinks/016600.pdf

4.1.4 The body is to be prepared and released in accordance with the *Post-Mortem Care in the Health Facility Policy* found in the *FNIHB Infection Prevention and Control Manual*.

4.1.5 When pronouncing death, the nurse shall document the following (at minimum) in the client's health record:

- The physical assessment findings used to confirm death had occurred and the time of death was pronounced;
- All relevant information regarding the events leading up to the time of death;
- Who was notified of the death (e.g. family, physician, etc.) and time of notification;
- The name of the attending physician who will be responsible for signing the death certificate;
- Cultural and religious beliefs and traditions of the client and family about death and treatment of the body after death;
- Whether the family visited the body after the death;
- All post-mortem care provided;
- If the client had any personal items with them at the time of death, include the name of the person to whom these items were released to; and
- The date and time the body was released from care and to whom it was released.

4.1.6 Promptly complete and submit an occurrence report to the zone office.

4.2 In the case of an unexpected death,

4.2.1 Resuscitation efforts must be initiated unless a do not resuscitate order is documented in the client's health record.

4.2.2 Whenever death is unexpected, the RN / RPN / NP must consult the physician, as he/she is responsible for pronouncing death and completing the medical certificate of death. When the RN(EC) is unsure if the circumstances surrounding the death of the client were unexpected, they must consult with a physician.

4.2.3 Under circumstances whereby the death is unexpected or falls under unusual circumstances, the body should not be moved before consulting the physician.

4.2.4 The physician will notify the Coroner as required. The Coroner is to be notified under the Coroner's Act when there is reason to believe that an individual has died:

- As a result of violence, misadventure, negligence, misconduct or malpractice;
- By unfair means;
- During pregnancy or following pregnancy in circumstances that might be reasonably attributed to the pregnancy;
- Suddenly and unexpectedly;
- From disease or sickness for which he or she was not treated by a legally qualified medical practitioner;
- From any cause other than disease; or
- Under circumstances that may require investigation.

4.2.5 If the nursing staff and/or physician are uncertain if the coroner is required, consult the local coroner.

4.2.6 The body is to be prepared and released in accordance with the *Post-Mortem Care in the Health Facility Policy* found in the *FNIHB Infection Prevention and Control Manual*.

4.2.7 If the death is associated with a Coroner's investigation, the body will be prepared and released as directed by the Coroner.
Do not remove any tubes, drains and catheters, etc. (Tie them off to avoid leakage). The endo-tracheal tube can be removed once placement of the tube is confirmed and documented. Do not send IV bags or drainage bags with the body.

4.2.8 Ensure all personal belongings not accompanying the body are returned to the family and documented in the client's health record.

4.2.9 In the case of an unexpected death, at minimum, the nurse shall document the following in the client's health record:

- All relevant information regarding the events leading up to the time of death;
- All nursing / medical care services rendered and assessment data collected;
- The name of the physician consulted, time of consult, all physician orders;
- The time of death;
- The name of other persons notified of the death (e.g. family, Coroner, etc.) and time of notification;
- Cultural and religious beliefs and traditions of the client and family about death and treatment of the body after death;
- Whether the family visited the body after the death;
- All post-mortem care provided (include description of the body and any related medical equipment left insitu when the death is associated with a Coroner's case);
- If the client had any personal items with them at the time of death, include the name of the person to whom these items were released to; and
- The date and time the body was released from care and to whom it was released.

4.2.10 Promptly complete and submit an occurrence report to the zone office.

4.2.11 The Zone Nursing Office will initiate a debriefing process for the staff involved and notify the Occupational and Critical Incident Stress Management team.

5. RELATED POLICIES:

Handbook on Medical Certification of Death (Office of the Registrar General, 2010)
Coroner's Act, R.S.O. 1990, c. C. 37
FNIHB-OR Policy: Documentation Standards

6. REFERENCES:

College of Nurses of Ontario (2009). Practice Guideline: Guiding Decisions About End-of-Life Care.
College of Nurses of Ontario (2009). Review Tool: Guiding Decisions About End-of-Life Care.
College & Association of Registered Nurses of Alberta (2011). Pronouncement of Death: Guidelines for Regulated Members
Coroner's Act, R.S.O. 1990, c. C. 37
Office of the Registrar General (2010). Handbook on Medical Certification of Death.

Approved by:		**Effective Date:**
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