Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Pronouncing Death		Nursing Practice	07-013-00
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APPLIES TO:			
Licensed Practical Nurses, Registered Nurses, Nurse Practitioners, Acute Care and Primary Care Paramedics			

1. BACKGROUND:

1.1 The Department of Health (Health) recognizes that, in the remote and isolated communities of Nunavut, health care is primarily delivered by nurses in a variety of roles. In the event that a health centre is closed, Acute Care Paramedics (ACP) or Primary Care Paramedics (PCP) may be the only health care professionals in a community.

2. POLICY:

2.1 In the event of an **expected death**, the Licensed Practical Nurse (LPN), Registered Nurse (RN), and Nurse Practitioner (NP) is authorized to pronounce the death of a client. The nurse will record the time and date of death on the client record.

2.2 In the event of an **unexpected** death, an on-site physician or NP will pronounce the death. If neither a physician nor NP is available in the community, the RN may pronounce death, however, the on-call physician must be promptly notified.

2.3 During periods of Health Centre closure when an RN, NP or physician is unavailable, the Advanced Care Paramedic (ACP) or Primary Care Paramedic (PCP) on site is authorized to pronounce death and must comply with the policy statements 2.1 and 2.2.

3. PRINCIPLES:

3.1 The pronouncement of death is not a reserved medical act or a delegated medical function. There are no laws governing the event when death is expected nor are there laws defining who is qualified to pronounce death in such circumstances. An unexpected death must be reported to the coroner in accordance with the *Coroners Act* and Policy 07-014-00 *Reporting a Death to the Coroner*.

3.2 In the case of a sudden and/or unexpected death, the RCMP along with the coroner conducts an investigation, as defined in the *Coroners Act.* The coroner authorizes an autopsy if necessary. The coroner is the only person who is authorized to order an autopsy without consent.

3.3 Where the death is considered a reportable death under the *Coroners Act*, the coroner and RCMP are responsible for the body. The responsibility of the health professionals listed in 2.2 ends after a pronouncement of death has been made and the details of the case discussed with the coroner or RCMP.

4. DEFINITIONS:

Pronouncement of death: the act of determining the cessation of bodily function through assessment e.g., with a stethoscope or electrocardiogram, a patient's condition and determining

the time of death.

5. GUIDELINE

5.1 Death may be pronounced when all of the following criteria are met:

- 5.1.1 Client is in cardiac arrest (absence of apical pulse, absence of respirations, fixed and dilated pupils, and no response to painful stimuli).
- 5.1.2 The cardiac arrest is not complicated by hypothermia.
- 5.1.3 Asystole has been documented in two monitoring leads for at least one (1) minute.
- 5.1.4 If only an Automated External Defibrillator (AED) is available with single lead capabilities, personnel should note it on client's health record.
- 5.1.5 Verification of asystole is **not** necessary if one of the following are present
  - i. Death is being pronounced pursuant to a properly executed Do Not Resuscitate advance directive
  - ii. Decomposition of body tissues
  - iii. Decapitation
  - iv. Incineration
  - v. Separation of or massive destruction to heart or brain
  - vi. Rigor is present

5.2 When the client **MEETS** the criteria for the pronouncement of death:

- 5.2.1 Do not initiate cardiopulmonary resuscitation (CPR) unless requested by a physician or family.
- 5.2.2 Notify the Supervisor of Community Health Programs (SCHP) and the on-call physician if not present.
- 5.2.3 Notify a member of the RCMP of all deaths in the community, expected or unexpected.
- 5.2.4 Notify the Coroner in accordance with the *Coroners Act.*
- 5.2.5 If the death occurred in the health centre, the SCHP, RN or attending physician will notify the family. If the death occurred in the community (outside of the health centre), the RCMP will notify the family of the client's death.

5.3 When the client **does NOT** meet the criteria for the pronouncement of death (e.g., family requests etc.):

- 5.3.1 5.3 Begin CPR.Contact the on-call physician immediately to determine the appropriate actions. The physician may elect to pronounce death or to administer additional interventions.
- 5.3.2 Contact SCHP, if available, to provide further clinical and procedural support.

6. DOCUMENTATION

6.1 Complete the Vital Statistics Form 3 *Registration of Death* as per Policy 07-012-00. A photocopy of the completed form is placed in the client's health record. The original form is forwarded to Vital Statistics as outlined on the *Registration of Death* form.

6.2 Document the pronouncement of death in the client's health record. Documentation must include:

- i. No apical pulse
- ii. No respiration
- iii. Pupils fixed/dilated
- iv. No response to painful stimuli

v. Time of the pronouncement of death
vi. Name of the physician and supervisor notified and the time of notification
vii. Name of the coroner notified and time of notification
viii. Time the body was transferred to the morgue
ix. Name and time next of kin was notified

6.3 Submit an incident report regarding the unexpected death utilizing the MEDITECH QRM Module as soon as possible and no later than the end of the working shift.

7. **GUIDELINE: HEALTH CENTRE POSTMORTEM RESPONSIBILITIES**

7.1 Notify a member of the RCMP, the Coroner and the Director of Health Programs of all deaths in the community, expected or unexpected. The Coroner must be promptly notified in accordance with the *Coroners Act* and Policy 07-014-00 *Reporting Death to a Coroner*.

7.2 Process necessary lab tests as ordered by the physician.

7.3 If applicable, collect postmortem samples as directed by the Coroner and in accordance with Policy 08-004-00 *Post Mortem Samples.* The Coroner must complete and sign a Form 11 of the schedule in order to authorize a nurse to obtain post mortem samples.

7.4 Provide holistic, supportive care to the family based on a comprehensive assessment of wishes and needs, contacting other team members as needed to assist with support.

7.5 Prepare for viewing by family members:

7.5.1 If the death is a coroner's case with autopsy, do not proceed with postmortem care until permission is received from the coroner.

7.5.2 Do not remove any tubes, drains and catheters etc. (Tie them off to prevent leakage.)

7.5.3 The endotracheal tube can be removed once placement of the tube is confirmed and documented.

7.5.4 Do not send bags containing intravenous fluids or drainage bags to the morgue.

7.6 If the family has not yet viewed the body of an infant/child, consider wrapping the deceased in warm blankets before giving to the parents. If this is a Coroner's case, the Coroner should be consulted first to avoid any compromise of evidence.

7.7 The family is responsible for preparing the body for the funeral. Support their participation in such activities (e.g., dressing the body in client's own clothing).

7.8 A plastic shroud is necessary if there is any potential for fluid leakage. The families may request blankets be used as a shroud. The plastic shroud may be applied over the blankets if fluid leakage is anticipated.

7.9 Ensure all personal belongings not accompanying the body are returned to the family and documented in the client's health record. Once the family is agreeable to transfer, contact the Hamlet to notify them that the body is ready to transport to the community morgue if there is no morgue in the health centre.

7.10 Restock the clinic room as required.

7.11 Clean the clinic room where the death occurred as per infection control guidelines found in the Government of Nunavut Infection Control Manual.

8. **RELATED POLICIES, PROTOCOLS AND LEGISLATION:**
   Policy 07-012-00 Certification of Death
   Policy 07-014-00 Reporting a Death to the Coroner
   Policy 08-004-00 Postmortem Samples
   Government of Nunavut Infection and Prevention Control Manual
   Vital Statistic Act R.S.N.W.T. 1998
   Coroners Act R.S.N.W.T. 1988

9. **REFERENCES**:

   Canadian Council for Practical Nurse Regulators, 2013 *Standards of Practice for Licensed Practical Nurses in Canada*
   *Vital Statistics Act (*R.S.N.W.t. 1998, c.17, s.29 as amended by Nunavut Statutes: S.NU. 2012, c.17, s.29
   Coroners Act R.S.N.W.T. 1988, c.C-20, as amended by Nunavut Statutes S. Nu2007, c.15, s.177

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