POLICY AND PROCEDURE

Topic: Resident Expiration with DNR order in Place/Prouncement of Death

**Policy**: Residents that have a physician order not to have CPR initiated will be assessed by the RN Supervisor when they have no pulse or respirations.

**Purpose**: To ensure that clinical assessment is completed by a qualified staff member to evaluate the resident for the absence of human response, spontaneous breathing and heart beat so that a determination can be made that death has occurred in accordance with NYS and Federal regulations.

**Background:** There are situations in which the death of a patient is expected and can be anticipated, and the patient’s primary provider cannot be present within a reasonable time to determine death; it is in these situations that a registered professional nurse may pronounce death, if allowed by facility policy.

A registered professional nurse is both qualified, by education and experience, and authorized in New York State Education Law to diagnose the absence of human responses and therefore can diagnose the absence of responsiveness, spontaneous breathing and heart beat as identified in the Department of Health Guidelines cardiopulmonary criteria (NYCRR, Title 10, 400.16).

**Definitions:**

**Certification of death:** Defined in New York State Public Health Law, Article 41, Death Certificate. The death certificate identifying the patient and the cause of death must be dated and signed by the physician last in attendance on the deceased (Gould’s, 2004).

**Medical death:** “the end of life; the permanent cessation of vital bodily functions, as manifested in humans by the loss of heartbeat, the absence of spontaneous breathing, and brain death” (Stedman’s, 2002).

**Brain death:** “Irreversible brain damage and loss of brain function, as evidenced by cessation of breathing and other vital reflexes, unresponsiveness to stimuli, absence of muscle activity, and a flat electroencephalogram for a specific length of time. (Stedman’s, 2002) Guidelines for determination of brain death can be found in New York Title 10 section 400.16.

**Procedure:**

1. The Unit nurse will contact the RN Supervisor when a resident is noted with a change in condition.
2. If the resident is found unresponsive the Unit nurse will verify the resident’s DNR status to determine if a Code Blue should be called.
3. If the resident is a DNR, the RN Supervisor will complete an assessment of the resident for clinical signs of death when a physician is not available.
4. The **pronouncement of death by a registered professional nurse is** the determination made after an assessment that there is an absence of human responses, spontaneous breathing and heartbeat.
5. The Registered Nurse will conduct an assessment to include:
* Residents are unconscious and un-arousable.
* Heartbeat (absent – auscultate for 60 seconds)
* Blood pressure non perceptible
* Respirations absent. Listen, feel, and watch for chest movements for 60 seconds.
* Pupil reaction to light (fixed/nonreactive and /or dilated)
1. In addition to assessing the body, the registered nurse will observe the resident for any unusual circumstances, i.e., bruising on body, bleeding from body orifices, etc.
2. The registered nurse will note time of death; time is recorded as the time the assessment is completed.
3. The Registered Nurse will notify the physician.
4. The physician will notify the family.
5. The RNS and /or Social Worker will ascertain the burial/funeral plans from the family.
6. The Registered Nurse will document in the medical record a progress note to include the following information:
* Absence of vital signs (BP, carotid pulse, respirations)
* Resident pronounced dead at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_AM/PM
* Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ notified.
* Family notified by doctor.
* Family wishes regarding viewing of body
* Families wishes regarding burial arrangements
* Funeral Home contacted when applicable
1. If a physician is present, he/she will complete a clinical assessment and, based on physician knowledge of signs of irreversible death, will pronounce and certify and document the death and complete the death certificate.
2. If the resident is on hospice, the Hospice Service must be notified.
3. The RNS in conjunction with the PMD will determine if there is any reason for the resident’s death to be reported to the Medical Examiner for investigation and when indicated report the death to the ME office at 516 772-5166.
4. When there is no family involved and no burial plans, the Medical Examiner can be notified at\_\_\_\_\_\_\_\_\_.
5. The Social Worker and/or RNS will complete and submit all forms required by the Medical Examiner.
6. A copy of the death certificate will be placed in the medical record.
7. The nurse will document the disposition of the body to include the name of the person who picked the body up, the destination and the time.