HSE National Policy on the Pronouncement of Death by Registered Nurses

National Policy ☒ National Procedure ☐ National Protocol ☐ National Guideline ☐
National Clinical Guideline ☐

HSE National Policy on the Pronouncement of Death by Registered Nurses

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1	02/09/2024	Title Change to HSE National Policy on the Pronouncement of Death by Registered Nurses
		Algorithms to incorporate change in scope of policy
		Scope of Policy to include pronouncement of unexpected death
		Inclusion of nurse led intellectual disability services providers under the remit of the policy
		Updated Literature Review
		Updated HSeLanD eLearning Programme, *The Pronouncement of Death by Registered Nurses* to reflect the revisions in the policy
0	2017	Original *(Archived with ONMSD) - National Policy of Expected Death by Registered nurses 2017*
Note: **This revised Policy supersedes** the *Interim Clinical Guidance for the Pronouncement of Death by Registered Nurses in identified services in the context of the Global COVID-19 Pandemic, 2020 and* the *National Policy of Expected Death by Registered nurses 2017*.		

PUBLICATION INFORMATION
Topic:
'Pronouncement of Death'
National Group:
National Policy for Pronouncement of Expected Death by Registered Nurses 2017 – National Review Group 2022/2023
Short summary:
'It is the policy of the HSE to provide a framework for the timely and safe pronouncement of death by registered nurses in the HSE and Section 38 services: designated centres for older persons, nurse led intellectual disability services registered by HIQA and specialist palliative care services. The policy outlines the role of the nurse in the safe pronouncement of death in adults (over 18 years of age), the necessary governance procedures to facilitate, enable and ensure safe pronouncement of death by nurses, to include: education, competence assessment and application of local policy. The policy promotes a quality, safe environment for the dying person and provides support to those important to the dying person'.
Description:
The overall purpose of this policy is to enable registered nurses to pronounce (as distinct from certifying) death in certain defined circumstances. The ability to pronounce a death facilitates timely communication with families and those important to the deceased, provides continuity of care, and will support those important to them during the bereavement period. Nurses in identified services provide end-of-life care as an integral part of the complete spectrum of nursing care. The ability for nurses to confirm the death of a person provides continuity of care at the final stage of a person's life. Certification (as distinct from pronouncement) of death is and remains the legal responsibility of the dying persons treating doctor. The policy provides best practice evidence to directors of nursing and line managers and other key stakeholders in the development and implementation locally.

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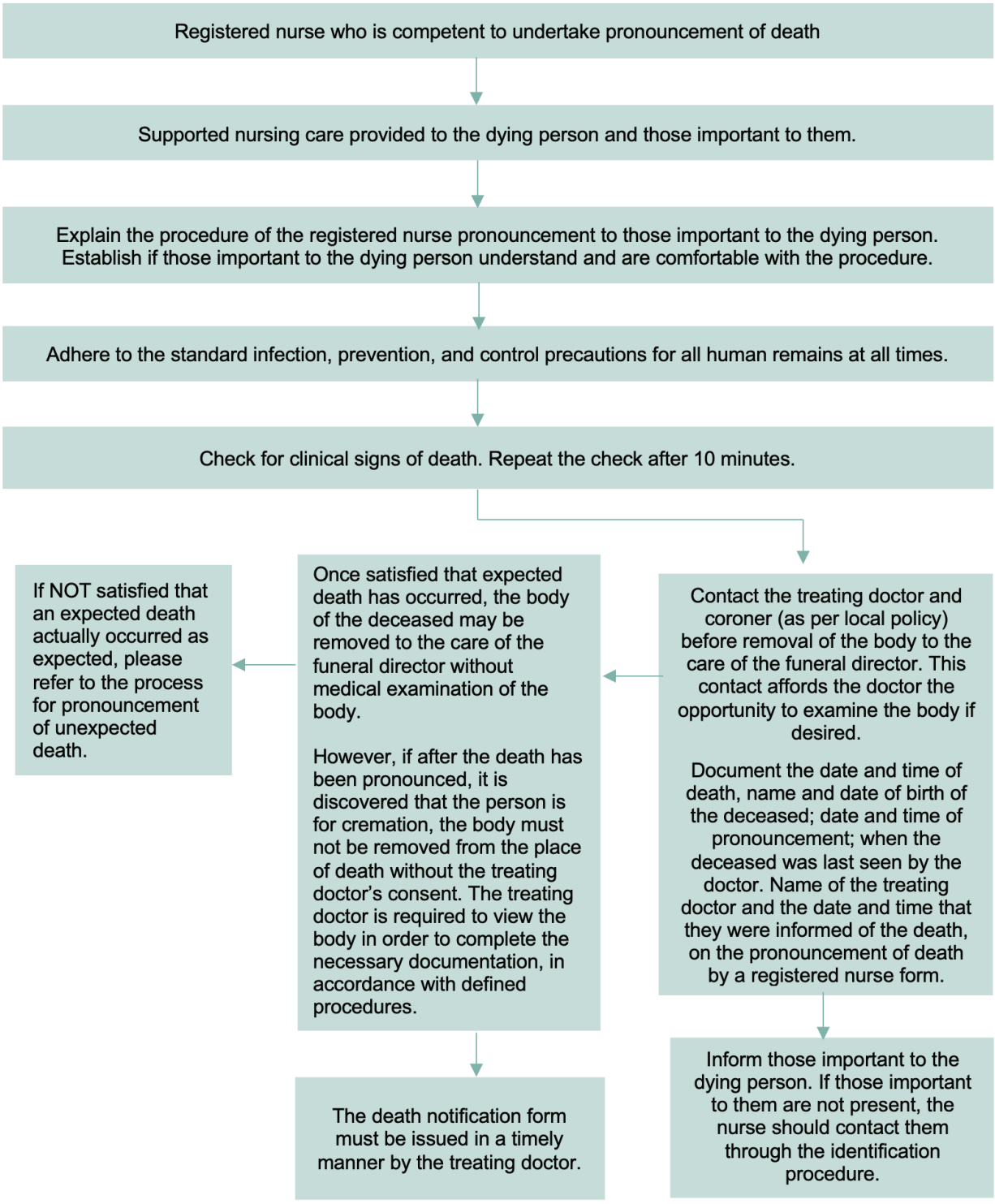
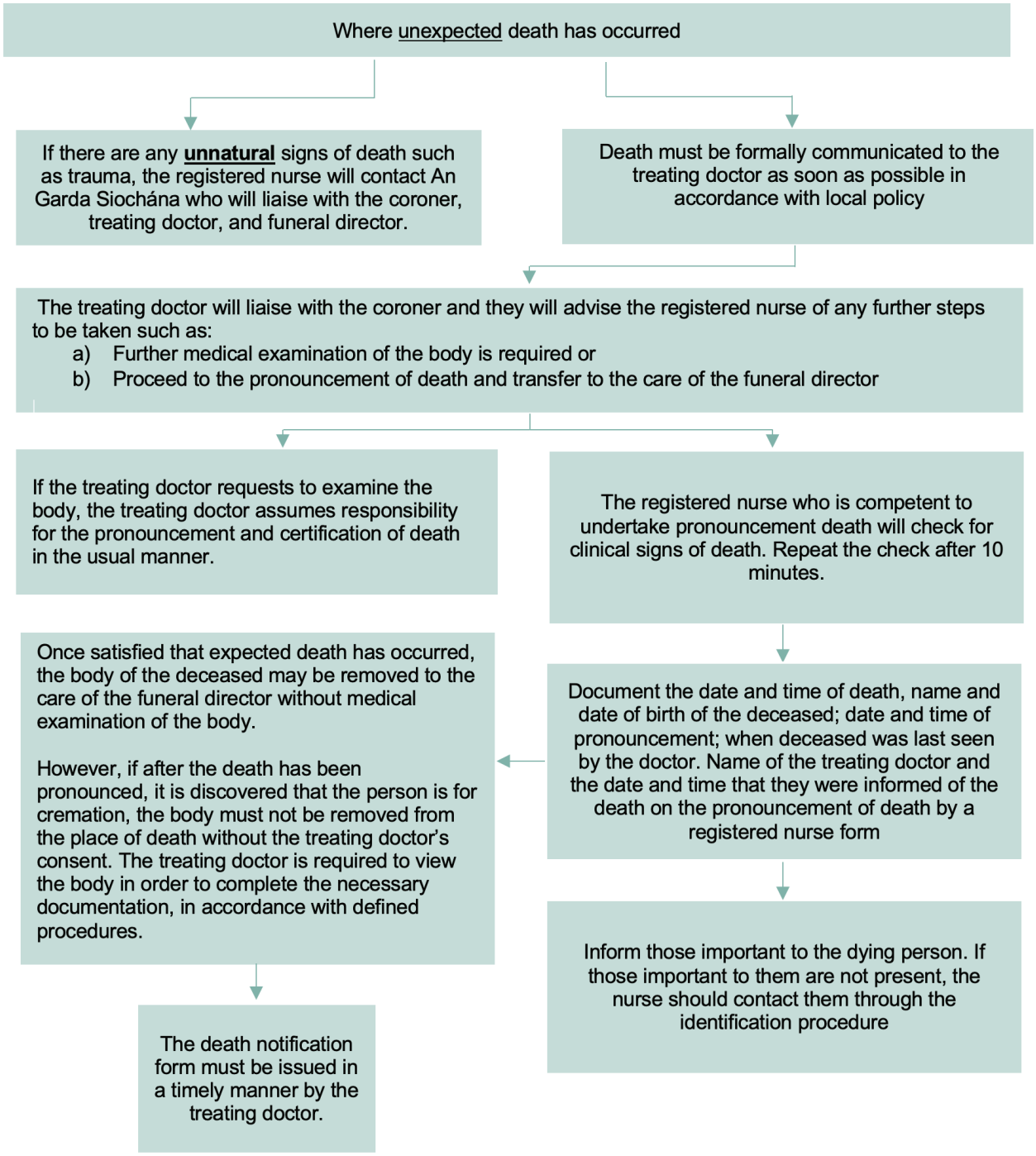


1.2 Procedure for the Pronouncement of Unexpected Death by Registered Nurses



1.3 Glossary of Terms and Definitions

Certification of death

Certification of death is the process of completing the death notification form, and must be completed by a registered medical practitioner.

Clinical nurse manager (CNM)

A clinical nurse manager is a nurse who has responsibility for clinical and professional leadership in a nursing team, and is accountable for the delivery of safe, effective nursing care by their nursing team, in accordance with practice standards and through effective monitoring of clinical practice.

Competence

Competence is understood as: the attainment of knowledge, intellectual capacities, practice skills, integrity and professional and ethical values required for safe, accountable and effective practice as a registered nurse or registered midwife. The Nursing and Midwifery Board of Ireland (NMBI) define competence as "the ability of the nurse to practise safely and effectively, fulfilling their professional responsibility within their scope of practice". (NMBI, 2015, p.15)

Consent

Consent is the giving of permission or agreement for a treatment, investigation, receipt or use of a service or participation in research or teaching (intervention). Consent involves a process of communication about the proposed intervention in which the person has received sufficient information to enable them to understand the nature, potential risks and benefits of the proposed intervention. HSE National Consent Policy (National Consent Policy, 2022).

Continuing professional development (CPD)

"Continuing professional development (CPD) is a lifelong learning process which takes place after the completion of pre-registration education and training. It consists of planned learning experiences which are designed to augment the knowledge, skills and attitudes of registered nurses for the enhancement of nursing practice, education, leadership and research." (NMBI, 2015, p.19)

Coroner

An independent office holder charged with the legal responsibility (Coroners Acts 1962, Coroners (Amendment) Acts 2005 and 2019) for the investigation of sudden, unexplained, violent and unnatural deaths in their district. They must be either a medical practitioner or a lawyer of at least five year's experience. It is a legal requirement that all deaths that occur in a HSE designated centre for older persons registered by HIQA are reported to the coroner (refer to your site local policy for contact details). Expected deaths of people under the care of the specialist palliative care services will be communicated to the coroner as per local policy. Please refer to the Statutory Instrument (SI) for deaths reportable to the Coroner: Coroners (Amendment) Act 2019, Schedule (irishstatutebook.ie)

Coroner's district

The coroner's district refers to the geographical area covered by a coroner. Please see www.coroners.ie for further information.

Death Notification Form

Following a death, a registered medical practitioner who attended the deceased must complete and sign part 1 of the Death Notification Form (DNF). Part 1 includes the Medical Certificate of the Cause of Death (MCCD). This form is given to a relative or civil partner of the deceased. This form is then used to register the death. A relative or civil partner must register the death within 3 months of the death occurring.

Department of Health (DoH)

The Department of Health (DoH) is an Irish Government department which supports the Minister for Health in the formulation and evaluation of policies for the Irish health services. It also has a role in the strategic planning of health services.

Director of nursing (DoN)/Person in charge (PiC)

The DoN/PiC is the most senior nurse within a service or organisation with responsibility for strategic and clinical leadership for nursing and related services, which results in the delivery of effective, safe, quality nursing care.

Doctor

Doctor refers to a medical practitioner who is registered with, and regulated by, the Irish Medical Council in accordance with the provisions of the Medical Practitioners Act 2007. For the purposes of this policy the term doctor (hereafter referred to as a 'treating doctor') includes the person's general practitioner (GP), locum GP, medical officer or medical physician who is involved in the treatment and care of the person or who is called upon to certify the death.

Do Not Attempt Cardiopulmonary Resuscitation Order (DNACPR)

A DNACPR order is a written order stating that cardiopulmonary resuscitation should not be attempted if a person suffers a cardiac or respiratory arrest. (National Consent Policy, 2022).

Dying person

The term 'dying person' is used throughout this policy. A person is terminally ill when they are in the last hours or days of life. This is when the person is "actively dying". Reference may also be made to the deceased within the policy.

End-of-life care

End of life care is a continuum of palliative care and is usually used to describe the care that is offered during the period when death is imminent, and life expectancy is limited to a short number of days, hours or less. (HSE and Palliative Care, 2012) Glossary of Terms, Palliative Care Programme

Expected death

Expected death occurs when an underlying pathology is expected to lead to death in the foreseeable future. A medical note must be documented in the patients' healthcare record to state that the patient's condition is terminal. There is no question about the doctor completing the medical certificate of death.

Healthcare record

Healthcare record refers to all information collected, processed and held in both manual and electronic formats pertaining to the service user and their care. It includes: demographics, unique health identifier, clinical data, images, investigations, samples, correspondence and communications relating to the service user and their care (HSE, 2011).

Health Service Executive (HSE)

The HSE or Health Service Executive is the public health service in Ireland that is responsible for providing health and personal social services to the population.

Local policy for pronouncement of death by registered nurses

A policy developed between the treating doctor(s) (general practitioner/physician), local coroner(s), HSE service manager and DoN/PiC in a specific HSE service site which plans to implement the national policy for PDRN. The aim of the local policy is to articulate the local arrangements in relation to communication between the treating doctors, coroners and local HSE service site. The local policy is developed in advance of implementation of the national policy. The local policy will not conflict with the guidance and procedures within the national policy and is a supporting policy for site specific communication arrangements.

Medical certification of the cause of death

Medical certification of the cause of death is the process of completing the death notification form, and must be completed by a registered medical practitioner (i.e. a treating doctor). This form is then presented to the registrar of deaths at the civil registration office by appropriate person (usually a relative of the deceased). Subsequently, the death certificate is issued. The certification of death declares the date, location and cause of a person's death as later recorded in the official register of deaths. The legal position regarding medical certification of the cause of death and the public registration of deaths is governed by the Civil Registration Act, 2004. The investigation of specified deaths by coroners (chiefly unexpected or untoward deaths) is governed by the Coroners Act, 1962. The legislation does not specifically require a treating doctor to pronounce the fact of death. The medical certification duty is limited to certification of the cause of death "to the best of [the doctor's] knowledge and belief". The aim of this policy is to enable nurses to pronounce (as distinct from certifying) death in certain defined circumstances. This pronouncement would mainly be for the purposes of notifying family members of the death.

National Review Group for Pronouncement of Death by Registered Nurses (hereafter referred to as National Review Group)

The National Review Group provided governance for the project and policy review.

Palliative care

Palliative care is an approach that improves the quality of life of persons and their families facing problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems – physical, psychosocial and spiritual (WHO, retrieved on the 17th April 2015).

- ### General palliative care

  Care provided by health and social care professionals who, although not engaged full time in palliative care, apply the principles of palliative care in the course of their work. Some health and social care professionals providing general palliative care will have additional training/education and experience in palliative care.

Specialist palliative care services

Specialist palliative care services are services with palliative care as their core speciality, and which are provided by an inter-disciplinary team under the direction of a consultant physician in palliative medicine (Department of Health and Children, 2001).

PDRN

PDRN is the acronym for the term pronouncement of death by registered nurses.

Pronouncement of death

Pronouncement of death is the determination, based on physical assessment, that life has ceased, and the subsequent documentation of this determination. Pronouncement of death is defined as deciding whether a person is actually deceased.

Registered nurse (hereafter referred to as a 'nurse')

Is a person registered in any division of the register held by the Nursing and Midwifery Board of Ireland (NMBI). A person cannot call themselves nurse or use the title of nurse without being registered with the NMBI. The individual must be registered with the NMBI in order to commence employment or to practise as a nurse in Ireland. Registration assures the public, employers and colleagues of the registrant's accountability to the NMBI in meeting and maintaining the competencies and standards of the profession. Hereafter, a nurse registered with the NMBI will be referred to in this policy as a 'nurse'.

Resident

Resident is the term used to describe a person residing in long-term and residential care facilities.

Residential care setting

Residential care setting is defined as public, private or voluntary services providing some or all of the following for older people: long-term care, respite, rehabilitation and convalescence (HIQA, 2009).

Service user

A service user is a person who receives health or social care services from a provider, such as the HSE or a voluntary organisation.

Trauma

Trauma is a term which refers to physical injuries of sudden onset and severity which may lead to death.

Unexpected death

The following types of deaths are considered unexpected:

- sudden, unnatural, violent, or unexplained deaths (where a doctor cannot sign a Death Notification Form),
- deaths where the doctor has not attended to the deceased in the last month,
- deaths in other categories which must be reported to the coroner. Refer to the Coroners (Amendment) Act 2019, Coroners (Amendment) Act, 2019

Verification of death

Verification of death as distinct from pronouncement of death refers to the process of establishing the truth, accuracy, or validity of the death.

2.0 Pronouncement of death

Pronouncement of death is the determination, based on physical assessment, that life has ceased, and the subsequent documentation of this determination. Pronouncement of death is defined as deciding whether a person is actually deceased, and it may allow for the removal of the deceased's remains. Pronouncement of death (as distinct from certification of cause of death) need not be undertaken by a registered doctor (HSE, 2017). The pronouncement of death is an integral part of the coroner's death inquiry and a safeguard in that process.

2.1 Expected death

Expected death is where there is an agreement between the dying person, those important to the dying person, and medical and nursing teams that no further active intervention to prolong life is ongoing and this is reflected in the dying person's healthcare record. Wherever possible, the dying person and those important to them should be made aware of the dying person's deteriorating condition, and of the anticipatory care plan/end-of-life care plan.

It should be clearly understood that further intervention would be inappropriate, that attempts at cardiopulmonary resuscitation would be considered futile, and that death is expected to be imminent. A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision should be signed and recorded by the treating doctor and held in the healthcare record and should be communicated to the entire team (HSE, 2022) Refer to the Assisted Decision-Making (Capacity) Act (2015) Assisted Decision-Making (Capacity) Act (2015).

The nurse should assess the communication needs of those important to the dying person, and should identify any communication support required, for example; interpreters or sign language interpreters. The nurse should, where possible, access or signpost those important to the dying person to the appropriate communication support. The nurse must be respectful of the person's autonomy and preferences including religious/spiritual/cultural needs in accordance with any advanced care plan/end-of-life care plan and where required, liaise with a funeral director in advance of the expected death. The nurse will inform the resident's treating doctor, the coroner's office and the funeral director (as required) as per local policy. The treating doctor remains responsible for the certification of death.

2.2 Unexpected death

Where a death does not meet the criteria falling within the definition of expected death, or where the death is unexpected the nurse is obliged to adhere to their professional responsibilities and follow all procedures in relation to responding to an unexpected death (NMBI, 2015, 2021). The nurse will adhere to the residents advanced healthcare directive, if such a directive is in place.

- The nurse will make all reasonable efforts to attempt to revive the person unless a valid DNACPR decision is in place.
- The emergency ambulance service or 'crash call' must be called. Cardiopulmonary resuscitation should be commenced by the nurse within their scope of practice. Refer to the National Consent Policy (2022) National Consent Policy (2022).
- In cases of unexpected death, in line with local policy, the nurse must contact the person's treating doctor and coroner who will advise accordingly. The nurse may be required to contact An Garda Síochána.
- All designated centres for older persons and disability services registered by HIQA must complete a notification-of-the-death-of-any-resident (NFO 1) form in the case of an unexpected death of a resident. Refer to Form NFO1 - HIQA Unexpected Death of a resident Form NF01-HIQA Unexpected Death of a resident

2.3 Reporting to the coroner

It is a legal requirement that all deaths that occur in a HSE designated centre for older persons and for persons with a disability registered by HIQA are reported to the coroner (see local policy for contact details). Expected deaths of people under the care of the specialist palliative care services will be communicated to the coroner as per local policy. Please refer to the statutory instrument (SI) for deaths reportable to the Coroner: Coroners (Amendment) Act 2019, Schedule (irishstatutebook.ie) (see Appendix one).

3.0 Procedure for pronouncement of death by registered nurses

Note: Standard infection, prevention and control precautions apply when attending to the deceased person. For further information please refer to the national clinical effectiveness committee (NCEC) Infection Prevention and Control National Clinical Guideline document is available at the following Infection Prevention and Control National Guideline

3.1 Procedure for carrying out and recording a clinical assessment to correctly pronounce a death

In order to carry out and record a clinical assessment to correctly pronounce a death the nurse must:

- Check all clinical signs of death using a stethoscope and penlight or ophthalmoscope (Table 1.1),
- Repeat the check for all clinical signs of death after 10 minutes
- The assessment and declaration that 'death has occurred' should be undertaken in a calm and unhurried manner.

Table 1.1: Clinical signs used when pronouncing death

Clinical signs to determine death
All of the following clinical signs must be present before death is pronounced: • Absence of a carotid or femoral pulse for over one minute • Absence of heart sounds for over one minute • Absence of respiratory movements and breath sounds for over one minute • Fixed pupils (unresponsive to light) • No response to painful stimuli (e.g. sternal rub)

The nurse should note and document the date and time of death. In the case of a nurse not being present at the death, the time of death should be established, as close as possible, from persons who were present or last with the person (Table 1.2).

Table 1.2: Recording pronouncement of death

Recording pronouncement of death
When pronouncing death, the nurse must record the following details on the pronouncement of death by a registered nurse form (see Appendix two) and complete the notification check list • Name of the deceased • Address • Treating doctor (name) • Date person last seen by treating doctor • Date of birth of the deceased • MRN or ID Number • Date of death • Approximate time of death (24 hour Clock) • Place of death • Death occurred as expected Yes/No • Date death pronounced • Time death pronounced (24 hour Clock) • Name of nurse pronouncing death • Grade/position of nurse pronouncing death • Signature of nurse pronouncing death • NMBI pin number of nurse pronouncing death

3.2 Process flow for the pronouncement of *expected* death

- The nurse must be competent to undertake the pronouncement of death.
- The nurse must adhere to standard infection, prevention, and control precautions at all times.
- The occurrence and circumstances of death must be formally communicated (by direct telephone contact) to the treating doctor as soon as possible, in accordance with the local policy. If the death occurs out of hours, this communication may take place the following morning as per local policy.
- If the treating doctor is satisfied that death occurred as expected, they will indicate their intent to issue the death notification form. The body of the deceased may be removed to the care of the funeral director without medical examination of the body.
- If the treating doctor is not satisfied that death actually occurred as expected, they may ask to examine the body.
- In a residential care setting, once the death has been pronounced, the nurse formally communicates with the coroner in accordance with local policy.

- The nurse informs those important to the deceased. If those important to the deceased are not present, the nurse should contact them using the local policy, unless it is specified that those important to the deceased do not wish to be contacted at a particular time. It may be necessary to explain to those important to the deceased the administrative aspect of recording date and time of death and date and time of pronouncement if there is a significant variance.
- If, after the death has been pronounced, a change in circumstances arises which affects the operation or applicability of this guidance (for example a decision is taken that the body of the deceased is for cremation or for donation to medical science) the body must not be removed from the place of death without a treating doctor's consent. The treating doctor is required to view the body in order to complete the necessary documentation.
- The relevant service must contact all professionals involved in the care of the dying person, so that they are aware of the death, as per local policy.

3.3 Process flow in the event of an *unexpected* death

The occurrence and circumstances of death must be formally communicated to the treating doctor as soon as possible, in accordance with local policy.

- The treating doctor will liaise with the coroner, and they will advise the nurse on any further steps to be taken such as:
  - Proceed to pronouncement of death and transfer to the care of the funeral director.
  - A further medical examination of the body is required.
- In cases of unexpected death, in line with local policy, the nurse must contact the person's treating doctor and coroner who will advise accordingly. The nurse may be required to contact An Garda Síochána. An Garda Síochána will liaise with the coroner and the treating doctor. The nurse will not proceed with the pronouncement of death.
- If family members/significant others were not present at the time of death the nurse informs them of the death in line with the local policy, unless it is specified that those important to the deceased do not wish to be contacted at a particular time. It may be necessary to explain to those important to the deceased the administrative aspect of recording date and time of death and date and time of pronouncement if there is a significant variance, for example a person might die at 23:55 on 1st January 2024 and may not be pronounced dead until 00:15 on 2nd January 2024. In this situation the date of death will be 2nd January 2024.
- If, after the death has been pronounced, a change in circumstances arises which affects the operation or applicability of this policy (for example a decision is taken that the body of the deceased is for cremation or for donation to medical science) the body must not be removed from the place of death without a treating doctor's consent. The treating doctor is required to view the body in order to complete the necessary documentation. The nurse will abandon the pronouncement of death procedure and complete Section 4 on the pronouncement of death by a registered nurse form (see Appendix two).
- The service must contact all relevant professionals involved in the care of the dying person, so that they are aware of the death, as per local policy.

PART B: National Policy for Pronouncement of Death by Registered Nurses

4.0 Purpose, Scope and Objectives of the Policy

4.1 Purpose

The purpose of this policy is to:

- Provide a framework for the timely and safe pronouncement of a death by a nurse in the HSE and Section 38 services: designated centres for older persons, nurse led intellectual disability services registered by HIQA, and specialist palliative care services.
- Outline the role of the nurse in the safe pronouncement of a death in adults (over 18 years of age).
- Outline the necessary governance procedures to facilitate, enable and ensure safe pronouncement of a death by a nurse, to include: education, competence assessment and application of local policy.

4.2 Scope

The policy will apply to nurses working in services across HSE and Section 38 designated centres for older persons registered by HIQA, nurse led intellectual disability services and specialist palliative care services (refer to Table 3). The adoption of the policy is voluntary.

- A nurse cannot legally certify death. The nurse may, however, pronounce that death has occurred when this policy is applied. A nurse can only pronounce a death as outlined in this policy, and with the application of a local supporting policy.
- This policy will apply to all nurses working in identified services outlined above, who have undertaken specified education and are deemed competent in recognising the clinical signs to pronounce a death as outlined in Table 1.1.
- Application of the policy in individual HSE facilities is also subject to local agreement and the development and application of a local policy. The aim of the local policy is to articulate the local arrangements in relation to communication between the treating doctor(s), coroners and local HSE service sites.
- HSE services are any services which the HSE provides directly. This policy does not apply to private service providers, even if those services are funded wholly or in part by the HSE. For example, in the nursing home context, this policy does not apply to nursing homes funded by the HSE pursuant to the "fair deal" scheme (i.e., under the Nursing Home Support Scheme Act, 2009).
- Specialist palliative care is delivered in many settings, including specialist inpatient palliative care units and the person's home. Where HSE specialist palliative care community teams are involved, this policy will apply to a death that takes place in inpatient units and the dying person's home.

- Exclusion criteria: The policy does not provide for pronouncement of a death by a nurse in the following circumstances:
  - Any death that is reportable to the coroner, except where death is expected, and the sole reason for reporting to the coroner is that the person is a resident in a nursing home/residential setting. Please refer to the statutory instrument for deaths reportable to the coroner: Coroners (Amendment) Act 2019
  - Any death where cremation is planned.
  - Any death where the person's remains are being donated to medical science/organ donation.
  - Unexpected deaths, as defined under section 3.0 pronouncement of death.
  - Any death of persons under 18 years of age.
  - The nurse has not successfully completed the pronouncement of death CPD education programme.

Table 1.3: Scope of Policy

Services in Scope	Services out of Scope
• All nurses working in services across HSE and Section 38 designated centres for older persons registered by HIQA • Nurse led intellectual disability services • Specialist palliative care services	• Services regulated by the Mental Health Commission • Children's residential centres • Public health nursing (unless a member of the specialist palliative care community teams) • Designated centres for adults and children with a disability (except nurse led adult disability service as described in the scope)

4.3 Objective of policy

- The objective of this policy is to enable nurses to pronounce (as distinct from certifying) a death in certain defined circumstances.
- The ability to pronounce a death facilitates timely communication with families and those important to the deceased. There are circumstances where a person's death is imminent, and it is therefore appropriate to pronounce that death has occurred for the purpose of advising those important to the person who has died, and also for the purpose of tending to and moving the body.
- Nurses in identified services provide end-of-life care as an integral part of the complete spectrum of nursing care. The ability for nurses to pronounce the death of a person provides continuity of care at the final stage of a person's life.
- Certification (as distinct from pronouncement) of death is and remains the legal responsibility of the dying persons treating doctor.
- National Review Group: the National Review Group 2022/2023 was established to revise and update the 2017 National Policy for Pronouncement of Expected Death by Registered Nurses. It commenced its work in September 2022 with an agreed project plan and under the guidance of a project lead. Refer to Appendix three for membership of the National Review Group.

4.4 PDRN Expert Reference Network

The Expert Reference Network for PDRN provided expert opinion and advice to the Policy National Review Group. Refer to Appendix four for membership of the Expert Reference Network for PDRN.

4.5 Supporting evidence

Legislation and regulation publications, which are relevant to the pronouncement of death by registered nurses, were referred to in the development of the policy. In addition, existing policy and standards were referred to and aligned to the development of the policy.

These were identified as:

- The Health Act, 2007 (Care and Support of Residents in Designated Centers for Persons (Children and Adults) with Disabilities) Regulations 2013 (Health Act, 2007)
- Health Act, 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (Health Act, 2007)
- Coroners Act, 1962
- Nursing Home Support Scheme Act, 2009
- Nurses and Midwives Act, 2011
- Assisted Decision Making (Capacity) Act, 2015
- Recording Clinical Practice to Nurses and Midwives (NMBI, 2015)
- Scope of Nursing and Midwifery Practice Framework (Nursing and Midwifery Board of Ireland, 2015)
- National Quality Standards for Residential Care Settings for Older People in Ireland (Health Information and Quality Authority, 2009)
- National standards for older people (HIQA 2016)
- National Standards for Safer Better Healthcare (Health Information and Quality Authority, 2012b)
- Health Service Executive Standards and Recommended Practices for Healthcare Records Management (HSE, 2011
- Health Service Executive Incident Management Framework (HSE, 2020)
- Health Service Executive Serious Reportable Events Guidance Document (HSE, 2015)
- Health Service Executive National Framework for developing Policies, Procedures, Protocols and Guidelines (PPPGs) (HSE, 2016)
- National Consent Policy (HSE, 2022)
- Palliative Care Competence Framework (Palliative Care Competence Framework Steering Group, HSE, 2014).

5.0 Development of PDRN policy

5.1 Literature review

In order to conduct an extensive literature search, the research question and the aims and objectives were considered. The aim of this research was to inform the national policy on the nurse's role and responsibility in the pronouncement of death. The objectives were to:

- Explore the evidence in relation to the pronouncement of death by nurses.
- Define the relevant terms for this policy.
- Improve the quality of care provided to bereaved relatives.
- Inform nursing practice.

According to Booth (2006) one of the key steps to searching the evidence is to have a well-articulated question to focus the search for information. Furthermore, the use of the search concept tool SPICE ensures the evidence is further directed. The SPICE framework thus comprises:

- **S**etting; the proposed setting is the acute, the community, palliative care and hospice
- **P**erspective; the proposed research aims to explore the perspectives of nurses of pronouncement of death
- **P**henomenon of **I**nterest: the phenomenon of interest is the nurses' role and responsibility in the pronouncement of death.
- **C**omparison; it is anticipated that meaningful comparisons can be drawn from the experiences of nurses in the pronouncement of death.
- **E**valuation; the aim of the research is to identify the key definitions that constitute death and the nurse's role and responsibility in pronouncing death and to identify the impact this has on nurse(s), patients and bereaved. These in-depth insights will provide recommendations for nurses and will inform policy.

Table 1.4: Literature review search criteria

Key concepts	Inclusion criteria	Exclusion criteria
Population nurses	General nurses Intellectual disability nurses Palliative care nurses Advanced nurse practitioners	Paediatric nurses Psychiatric nurses Registered midwives
Patients	Adult patients	Children Paediatrics
Setting	Acute hospital Hospice Community Palliative Care	Mental Health Services Maternity services

5.2 Literature search strategy

A literature search was undertaken by the lead investigator in collaboration with the literature review subgroup consisting of members of the National Review Group. Review terms were 'pronouncement of death by nurses', 'criteria for pronouncing death', 'definition of death' and 'unexpected death'. The terms were used interchangeably within the search strategy. Resources searched were PubMed, CINAHL, MEDLINE, PSYCINFO and EMBASE. Truncation and MeSH terms (medical subject headings) were applied where applicable to include associated words and connotations.

Thirty-six studies were included in the literature review. See Appendix five for complete literature review.

Key words used is search strategy included:

- Death or dying or expired
- Pronouncement or announcement or declare
- Nurses or palliative care nurses or community
- COVID-19
- Unexpected

5.3 Method of appraising evidence

- The literature review subgroup worked with the principal investigator to appraise the quality, validity and relevance of the literature gathered as part of the search. A scoping exercise was utilised to categorise the 'hierarchy of evidence' and critically appraise the evidence gathered.
- The group considered the following: clarification from the evidence in the literature on definitions that would support the final definitions used in the policy document, scope of the policy in respect of expected and unexpected deaths and implications for the pronouncement of a death by a nurse.
- The results of the literature review were considered in terms of their applicability to the population of this PPPG.

5.4 Recommendations

The National Review Group considered the results from the literature review in relation to pronouncement of death by nurses in the Irish context;

- The literature review is consistent with the proposed definitions for expected and unexpected deaths as outlined in the draft policy.
- Pronouncement of death by nurses is a practice used in several jurisdictions, this is determined by each country's nursing regulatory body, and supported by successful completion of an appropriate education programme.
- The national policy to be implemented and applied with a local supporting policy which articulates local arrangements between the treating doctor, director of nursing/ person in charge and the coroner.

5.5 Summary of the evidence from the literature

Death definition has evolved over the years. This is as a result of medical technology and medical advances for example mechanical ventilation and organ transplantation. Unexpected death is also clearly defined. Pronouncement of death by nurses is allowed in some countries. However, this is determined by each country's nursing regulatory body. In Ireland, registered nurses are permitted to pronounce a death. However, before they can undertake this expanded role they must successfully complete an on-line programme and have the recommended supports in place. The evidence suggests that nurses pronouncing death leads to better care for the deceased and the bereaved. The implications for practice will be an enhanced personal experience for 'the person', their family/ significant others and the nursing team. The membership of the literature review sub group is outlined in Appendix six.

5.6 Resources necessary to implement the PPPG recommendations

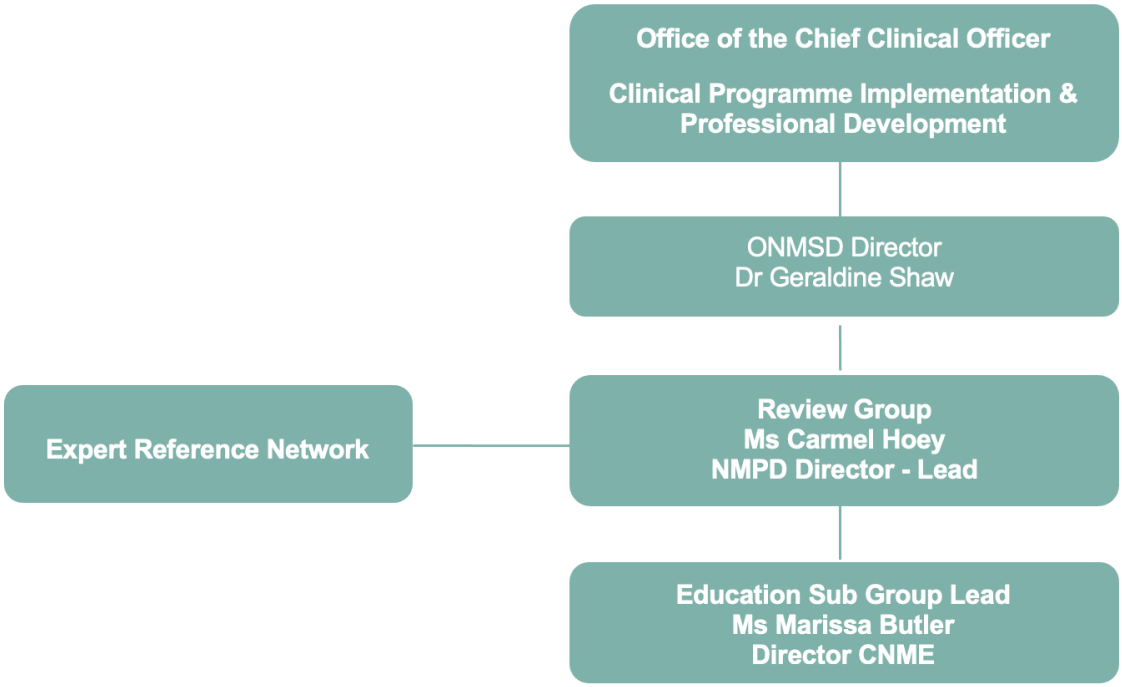
The ONMSD is committed to the maintenance and update of the Pronouncement of Death by Registered Nurses HSeLanD e-learning Programme. A member of the National Review Group will lead on this element of the work.

6.0 Governance and approval

6.1 Formal governance arrangements

- The National Review Group provided formal governance for the policy review. Ms Carmel Hoey, Director Nursing & Midwifery Planning & Development Unit (NMPDU), HSE West Mid West is the designated chairperson for the group.
- The National Review Group worked to an agreed scope and terms of reference. Roles and responsibilities of the National Review Group members and the process of meetings were clearly outlined and agreed. The project lead reported to the director of the ONMSD, Dr Geraldine Shaw.
- The policy was developed within the template of the HSE National Framework for developing PPPGs (2016) and adhered to the standards as set out therein.
- The approved PPPG checklist was adhered to throughout the policy review.

Figure 1.1: Organisation chart/overarching governance



7.0 Communication and dissemination plan

A communication and dissemination plan was agreed by the National Review Group.

Staff will be made aware of this policy through HSE directorate communication mechanism, nursing forums and the ONMSD communication process. The policy will be available on: HSE National Central Repository (NCR).

8.0 Implementation

The National Policy for Pronouncement of Death by Registered Nurses will apply to all nurses working in services across HSE and Section 38 designated centres for older persons registered by HIQA, nurse led intellectual disability services and specialist palliative care services. The adoption of the policy is voluntary, with decisions to implement the policy based on service need and agreement by the treating doctor(s), director of nursing and coroner(s).

Application of the policy in individual HSE facilities is also subject to local agreement and the development and application of a supporting local policy. The aim of the local policy is to articulate the local arrangements in relation to communication between the treating doctor(s), coroner(s) and local HSE service site.

8.1 Education requirements to implement the PDRN policy

- A standardised CPD blended learning (e-learning) education programme has been developed for nurses who will be undertaking the expanded role of pronouncement of death in specific circumstances. Nurses are responsible for undergoing a CPD process in order to achieve competence to deliver safe, effective care in the pronouncement of death.
- The blended learning CPD education programme for PDRN is designed to respond to the CPD requirements. Before a nurse carries out this clinical procedure the nurse must undertake an approved e-learning programme, supervised practice and competency assessment session(s) and be deemed ompetent by an approved assessor.
- Before a nurse carries out a pronouncement of death it is imperative that there is a local policy in place.

The nurse must:

- Be supported by the DON/ADON/CNM, in relation to training, competency achievement and supervision as necessary.
- As a prerequisite to the e-learning programme “Pronouncement of Death by Registered Nurses”, the nurse must complete the HSeLanD AMRIC Introduction to Infection Prevention and Control and Antimicrobial Resistance programme.
- Complete the e-learning programme “Pronouncement of Death by Registered Nurses” and successfully pass the associated on-line assessment.
- Complete the self-assessment of competency for a registered nurse in the pronouncement of death (see Appendix seven). A copy of this completed self-assessment must be discussed with their line manager and a copy logged in their human resources file.

8.2 Specific roles and responsibilities

Sites implementing the policy are responsible for adhering to the National Policy for Pronouncement of Death by Registered Nurses.

HSE senior management are responsible for:

- Ensuring that employees are aware of the National Policy for Pronouncement of Death by Registered Nurses.
- Ensuring that the necessary resources and opportunities are available in order to facilitate nurses to participate in CPD assessment and thus enable them to pronounce a death safely.

Director of nursing/person in charge is responsible for;

- Developing a supporting local policy for pronouncement of death by registered nurses, in order to support the policy.
- Ensuring that all relevant staff are aware of their responsibilities.
- Ensuring that management and compliance with this policy is effective in each area within their remit of responsibility.
- Ensuring that education is carried out in accordance with the Blended Learning CPD Programme for PDRN.
- Ensuring that any statutory requirements for reporting have been implemented.
- Assisting with risk assessment where complex decisions are required.
- Monitoring and evaluating the application of, and adherence to, the policy within the work area overseen by the director of nursing/person in charge.
- Ensuring that the necessary governance procedures are in place to enable, support, and monitor, safe pronouncement of death by nurses.

The clinical nurse manager (CNM) is responsible for:

- Ensuring that the policy is read, discussed and signed as read and understood by all existing and new nurses taking up their appointment to the service, for example; during their induction or probation period.
- Ensuring that the relevant CPD assessment completed by each nurse is recorded.
- Satisfying themselves that each nurse has the theoretical knowledge and practical skills necessary to recognise the clinical signs of death.
- Implementing the policy and monitoring compliance in accordance with the procedures outlined in the policy.
- Communicating with and supporting nurses with the implementation of the policy.
- Monitoring the standard of relevant nursing documentation, in order to ensure that it provides an accurate account of the dying person's current diagnosis and the nurse's account of their actions in the pronouncement of death procedure, in accordance with this policy.
- Informing, liaising with and supporting those important to the dying person in understanding the pronouncement of a death by a nurse.
- Ensuring that the necessary equipment is in place, and that equipment monitoring systems are in operation, so as to ensure equipment reliability and safety.
- Facilitating attendance of the nurse in periodically organised refresher education sessions, in order to ensure adherence to the policy and its procedures.
- Alerting the director of nursing to any potential hazards and associated risks in the nursing unit.

The nurse has responsibility to;

- Read and understand the policy as it pertains to their workplace.
- Ensure that they have the appropriate knowledge and skills to practise effectively and safely.
- Participate in a verified CPD education programme and competence assessment, and be deemed competent in recognising the clinical signs of death and the process outlined in the policy.
- Continuously develop and update their knowledge and skills to remain competent to undertake the pronouncement of death as per policy.
- Ensure that they are aware of the content and ramifications of the policy during their induction, if they have been recently appointed.
- Accept accountability for their practice, and acknowledge any limitations in their practice, and consequently seek the necessary support to develop their practice in consultation with their manager.

- Develop safe nursing practice and therefore support the implementation of, and adherence to, this policy within their clinical practice environment.
- Raise any concerns regarding the implementation of the policy with their clinical nurse manager in a timely manner.
- Follow the procedure for pronouncement of death on a case-by-case basis. Each case is considered in consultation with the nurse manager and treating doctor and those important to the dying person.

Administrative officers (or designated responsible persons) are responsible for;
- Ensuring that each nurse supplies a certificate of competence following successful completion of the HSeLanD e-learning module.
- Recording this information in the relevant HSE IT system.
- Monitoring and ensuring that all education/competency certificates are in date and alert the relevant nurse when their refresher session is due.

The treating doctor is responsible for:
- Contributing to the development of a local policy to support nurses in the pronouncement of death.
- Agreeing communication process for timely verification of death when a person dies.

9.0 Monitoring, audit, and evaluation

9.1 Audit

Each service area/organisation implementing PDRN must ensure robust governance and accountability processes for monitoring and evaluation are in place (See sample Clinical Audit Tool Appendix eight).

- According to the Nursing and Midwifery Board of Ireland's (NMBI) Code of Professional Conduct and Ethics "Individuals have a right to receive quality care by competent nurses and midwives who practise in a safe environment" NMBI Code-of-Professional-Conduct-and-Ethics (NMBI, 2021, p.16).

The aim of the audit is to;

- Measure nurses' compliance with agreed practice standards for 'Pronouncement of Death by registered Nurses'.
- Measure and evaluate activity of nurses in pronouncing death.
- Ensure that nurses pronouncing death are practicing within their scope of practice.

- All nurses who pronounce a death must have the required competence, skill and knowledge to do so competently and safely. The Scope of Nursing and Midwifery Practice Framework states that expansion of practice "must only be made with due consideration to legislation, international, national or local evidence-based clinical practice guidelines and available resources" (NMBI, 2015, p.30). The nurse "should collaborate, consult and communicate with other health care professionals, health providers and other individuals and agencies regarding the appropriate nursing assessment, diagnosis, planning and intervention, and evaluation of patient care" (NMBI, 2015, p.31). NMBI Publications Scope-of-Nursing-Midwifery-Practice-Framework
- Each service area/organisation which implements the policy must ensure robust governance and accountability processes for monitoring and evaluation are established.

Responsibility

The director of nursing/person in charge is responsible for the development of local policy for the pronouncement of death by registered nurses. Local policy will define the governance structures and procedures to enable, support and monitor safe practice within their area of remit are identified.

Frequency

Audits must be completed on deaths pronounced by nurses and be undertaken within the organisation in line with local policy.

Data Sources

- National policy for pronouncement of death by registered nurses
- Person's records
- Local policy for 'Pronouncement of death by registered nurses'
- Record of supervised practice competence assessment record
- Complaint reports
- Adverse incident reports
- Evidence that the algorithm: Procedure for Pronouncement of Expected Death by Registered Nurse/ Procedure for Pronouncement of Unexpected Death by Registered Nurse is located in key clinical areas.

9.2 Monitoring of Policy

The director of nursing or person in charge is responsible for monitoring the policy using the clinical audit tool under the following indicators (see Appendix eight):

- **Indicator 1:** All documentation related to pronouncement of death by registered nurse is completed in full.
- **Indicator 2:** There are no complaints related to the pronouncement of death by a registered nurse.
- **Indicator 3:** The nurse who has undertaken pronouncement of death is educated and competent to the required level, as outlined in the policy.
- **Indicator 4:** An up-to-date register of nurses who have successfully completed the required CPD education programme to undertake pronouncement of death is maintained in the workplace and is available for audit.
- **Indicator 5:** The algorithm relating to pronouncement of death by registered nurses is available in all clinical areas (where applicable).
- **Indicator 6:** Existing structures for reporting adverse incidents are used for pronouncement of death by registered nurses when appropriate. Evidence of any adverse incidents are recorded on the clinical audit protocol.
- **Indicator 7:** The algorithm as part of this policy for pronouncement of death by registered nurse is reviewed every three years.

9.3 Evaluation

Each service area/organisation which implements the policy must ensure robust governance and accountability processes for monitoring and evaluation are established. It is recommended that formal evaluation of the PDRN policy is undertaken every three years.

10.0 Revision and update

10.1 Procedure for the update of the PDRN policy

The national PDRN policy will be due for revision three years from publication. The procedure for update will be aligned to HSE PPPG policy.

10.2 Method for amending PDRN policy if new evidence emerges

In the event of new evidence emerging which relates directly to the policy, a working group will be convened to revise and amend the policy if warranted.

11.0 References

Assisted Decision Making (Capacity) Act 2015

Coroners Society of Ireland (2020) Guidance in relation to the Coroners Service and Deaths due to COVID-19 Infection

Coroners Society of Ireland (2020) Modified Requirements for Death Pronouncement In Coroners' Cases during COVID-19 Pandemic

Coroners (Amendment) Act 2019, Schedule (irishstatutebook.ie)

Form NF01-HIQA Unexpected Death of a Resident

Health Service Executive (2020) Guidance regarding Cardiopulmonary Resuscitation and DNAR Decision Making during the COVID-19 Pandemic

HSE National Consent Policy (2022)

Health Service Executive (2021) Public Health and Infection Prevention Control Guidelines on the Prevention and Management of Cases and Outbreaks COVID-19, Influenza and other Respiratory Infections in Residential Care Facilities

Health Service Executive (2017) National Policy for Pronouncement of Expected Death by Registered Nurses [For use in HSE residential, HSE long-stay and HSE specialist palliative care services only

Health Service Executive (2021) Use of PPE to support Infection Prevention and Control Practice when performing aerosol generating procedures on Confirmed or Clinically Suspected Cases of COVID-19 [V2.3 Guidance on Covid].

Hospice Friendly Hospitals (ND) Ethical Framework for End of Life care

Nursing and Midwifery Board of Ireland (2021) Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives. Nursing and Midwifery Board of Ireland

Nursing and Midwifery Board of Ireland (2015) Scope of Nursing and Midwifery Practice Framework 2015

The Irish Hospice Foundation (2021) Advance Care Planning for Health and Social Care Professionals

Palliative Care, WHO, retrieved on the 17th April 2015/palliative-care

Report of the National Advisory Committee on Palliative Care 2001

12.0 List of Appendices

Appendix one: Reporting to the Coroner
Appendix two: Pronouncement of Death by a Registered Nurse Form
Appendix three: Membership of the National Review Group
Appendix four: Membership of the Expert Reference Network
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Appendix one: Reporting to the Coroner

Second Schedule, Coroners (Amendment) Act 2019

(a) Any death that may be murder, manslaughter or infanticide.

(b) Any death that appears to be connected with a crime or suspected crime.

(c) Any death, whether or not accidental, caused wholly or partly by stabbing, drowning, poisoning, hanging, electrocution, asphyxia or a gunshot wound.

(d) Any death where the deceased person is dead on arrival at a hospital.

(e) Any death which may be by suicide.

(f) Any death where the body of the deceased person is unidentified.

(g) Any death where no key contact member of the deceased person can be traced within a reasonable time of the death.

(h) Any death where the body of the deceased person is found or recovered in circumstances that indicate that the death may have occurred a considerable period of time previously.

(i) Any death (other than in circumstances to which paragraph 8 applies) in respect of which the date of death may not be ascertainable.

(j) Any death caused wholly or partly by any of the following:

- (a) an incident, whether or not accidental, resulting in any physical injury, including a cut, fracture or contusion;
- (b) a fall;
- (c) self-neglect;
- (d) an eating disorder;
- (e) exposure or hypothermia;
- (f) burns.

(k) Any death which may be by assisted suicide.

(l) Any death caused wholly or partly by any of the following:

- (a) an accident arising out of the use of a vehicle in a public place;
- (b) an incident occurring on a railway;
- (c) an incident arising on a train, aircraft, ship or other vessel.

(m) Any death caused wholly or partly by any of the following:

- (a) a notifiable disease or condition that is, under provisions in that behalf in any other enactment, required to be notified to a Minister of the Government, a Department of State or a statutory body or to an inspector or other officer of a Minister of the Government, a Department of State or a statutory body;
- (b) an adverse reaction to any drug;
- (c) a drugs overdose or the presence of toxic substances;
- (d) in the case of an infant death, maternal drug addiction;
- (e) an infection contracted as a result of previously contaminated blood product administration;
- (f) a lack of care or neglect;
- (g) starvation or malnutrition.

(n) Any death which may be due to a prion disease.

(o) Any death caused wholly or partly by an accident at work or due to industrial or occupational injury or disease.

(p) Any death occurring in a hospital or other health institution—

- (a) that is unexpected,
- (b) within 24 hours of presentation or admission, whichever is the later, or
- (c) of a person transferred from a nursing home.

(q) Any maternal death or late maternal death.

(r) Any death of a stillborn child, death intrapartum or infant death.

(s) Any death occurring in a hospital or other health institution that is directly or indirectly related to a surgical operation or anaesthesia (including recovery from the effects of anaesthesia) or to any other medical, surgical or dental procedure, regardless of the length of time between the procedure and death.

(t) Any death which may be due to any healthcare acquired infection.

(u) Any death where an allegation is made or a concern has been expressed regarding the medical treatment provided to the deceased person or the management of his or her healthcare.

(v) Any death which may be as a result of an unconventional medical procedure or treatment.

(w) Any death occurring in

- an institution for the care and treatment of persons with a physical or mental disability, or
- any public or private institution for the care of elderly or infirm persons, including a nursing home.

(x) Any death where the deceased person was at the time of his or her death, or immediately before his or her death, in State custody or detention.

(y)

(z) Any death of a child in care.

Appendix two:

Pronouncement of Death by Registered Nurse Form

(To be completed by a registered nurse following death in accordance with local policy)

Section 1 Persons Details and Time of Death		Address:
Persons Name:		*Affix Addressograph here*
D.O.B	MRN/I.D. No.	
Date of death:	Time of death: *(approximately)*	
Place of death:		Treating Doctor (name):
Death occurred as expected: Yes [ ] No* [ ]		Date Person last seen by treating Doctor:
If No the treating doctor will liaise with the coroner and they will advise the registered nurse on any further steps to be taken.* *Further medical examination of the body is required and the treating doctor assumes responsibility for pronouncement and certification of death* *Proceed to pronouncement of death and transfer to the care of the funeral director*		
Are there any contraindications for pronouncement of death by a registered nurse? Yes* [ ] No [ ]		
If yes proceed to Section 4: Decision made to abandon pronouncement of death*		

Section 2 Clinical observation of absence of life *(to be repeated after 10 min)*							
Respiration	**Assessment First**	**Second**	**Cardiac**	**Assessment First**	**Second**	**Cerebral**	**Assessment First**	**Second**
There are no signs of spontaneous respiration *(one minute) (Do not check for flow of air against your cheek)*	*RN Initials*	*RN Initials*	There is no carotid or femoral pulse palpable *(one minute)*	*RN Initials*	*RN Initials*	There is no response to painful stimuli	*RN Initials*	*RN Initials*
There are no breath sounds *(one minute using a stethoscope) (Do not listen for air escaping during exhalation)*	*RN Initials*	*RN Initials*	There are no heart sounds *(one minute using a stethoscope)*	*RN Initials*	*RN Initials*	Pupils are unresponsive to light	*RN Initials*	*RN Initials*
						Pupils are fixed	*RN Initials*	*RN Initials*
Date			Date			Date		
Time			Time			Time		
Date Death Pronounced:			**Time Death Pronounced:**					

Section 3 Absence of life pronounced by Registered Nurse		
Registered Nurse's Name: *(Print name)*	Grade/ Position:	
Registered Nurse's Signature:	Date:	NMBI PIN:
Treating Doctor notified by registered nurse as per local policy: *(specify below)*		
Name of treating Doctor: *(Print name)*	Date notified:	Time notified:
Treating Doctor satisfied that death occurred as expected and indicated intent to complete the Death Notification Form in a timely manner	Yes	No*
If No treating doctor will liaise with the coroner and they will advise the registered nurse on any further steps to be taken*		
Treating Doctor stated intention to view the body	Yes*	No
If Yes the treating doctor assumes responsibility for pronouncement and certification of death. RN completes Section 4*		

Coroner notified as per local policy and coronial procedure therein: *(specify below)*		
Name of Coroner: *(Print name)*	Date notified:	Time notified:
Once satisfied that death occurred, the body of the deceased may be removed to the care of the funeral director without medical examination of the body		
After death has been pronounced a change of decision (meaning the person is for cremation or for donation to medical science) is identified	Yes*	No
If Yes the body must not be removed from place of death without the treating doctor's consent. The treating doctor is required to view the body and assumes responsibility for pronouncement and certification of death. RN completes Section 4*		

Section 4 Decision made to abandon pronouncement after death *(complete if applicable)*			
Decision to abandon pronouncement made by: *(Print name)*	Grade/Position:		
Identified reason(s) to abandon pronouncement: *(specify)*			
Do/Does the identified reason/s to abandon pronouncement warrant further action	Yes*	No	
If Yes ensure reporting in line with the HSE's Incident Management Framework (IMF) 2020 and National Incident Report Form (NIRF 01).*			
Treating Doctor informed: *(Print name)*	Date:	Time	
Registered Nurses Name: *(Print name)*	Signature:		

Section 5 Notification Checklist	
Next of kin/significant others were present at time of death	Yes [ ] No* [ ]
If No communicate with the next of kin/significant others and record all communication(s) made in the deceased person's healthcare record*	
Pastoral Support facilitated (as applicable)	Yes [ ] No [ ] not applicable [ ]
Record relevant details in the deceased person's healthcare record.	
Ensure any expressed religious/ spiritual/ cultural needs are completed	Yes [ ] No [ ]
Record specific details in the deceased person's healthcare record	
Funeral Director notified (as applicable)	Yes [ ] No [ ] Not applicable [ ]
Record specific details in the deceased person's healthcare record stating as applicable Funeral Directors Name	
Procedures for last offices followed in accordance with relevant policy or individual care plan	Yes [ ] No [ ]
Record specific details in the deceased person's healthcare record	
Those important to the person given information if required on the collection of the Death Notification Form	Yes [ ] No [ ] Not required [ ]
Record specific details in the deceased person's healthcare record	

Section 6 Removal of a deceased person's body		
Date body removed:	Time body removed:	
Removal undertaken by:		
Registered Nurse's Name: *(Print name)*	Date:	Time:
Record specific details in the deceased person's healthcare record		

Appendix three:

Membership of the National Review Group

Name	Title	Organisation	Representing
Ms. Carmel Hoey	Director Nursing and Midwifery Planning and Development (NMPD)	HSE Nursing and Midwifery Planning and Development	HSE Nursing and Midwifery Planning and Development & Project Lead (ONMSD)
Dr Patrick Glackin	Area Director NMPD	HSE Nursing and Midwifery Planning and Development	Office of the Nursing and Midwifery Services Director (ONMSD)
Ms. Marissa Butler	Director Centre of Nursing and Midwifery Education	Centre of Nursing and Midwifery Education	Association of Directors of Centre's of Nursing and Midwifery Education (ADCNME)
Dr David Hanlon	National Clinical Advisor & Group Lead – Primary Care	NCAGL- Primary Care, HSE	Primary Care
Ms. Grainne Bourke	Director of Nursing St Michael's House Ballymun, Dublin 9	Intellectual Disability Services	Directors of Nursing Intellectual Disability Services/Irish Nurse Managers in Intellectual Disability
Ms. Deirdre Lang	Director of Nursing/National lead, Older Persons Services	Office of the Nursing & Midwifery Services Director	National Older Persons Services, ONMSD
Ms. Ann Lister	Nursing and Midwifery Planning and Development (NMPD) Officer	HSE Nursing and Midwifery Planning and Development	Nursing and Midwifery Planning and Development
Ms. Susan Daly	Clinical Development Co-ordinator, Cork/Kerry Community Hospitals/Nursing Units	HSE Cork/Kerry Community Hospitals/Nursing Units	Clinical Development Co-ordinator
Ms. Máire McGetrick	Director of Public Health Nursing	HSE North West	Public Health Nursing
Ms. Essene Cassidy	Head of Services Older Persons Representative	Head of Service Older Persons CHO 9	Older Persons Services
Dr. Mary Butler	Directors of Nursing/Person in Charge, Residential Services	Ballinasloe CNU, Formally HSE Plunkett Home Boyle	Residential Services & National Forum Older Persons Services
Ms Beryl McKee (until February 2023)	Director of Nursing	St John's Hospital, Enniscorthy	Residential Services & National Forum Older Persons Services
Ms. Aishling Kearney	Director of Nursing	St. Francis Hospice Dublin	Palliative Care Services
Ms. Aisling Culhane	Psychiatric Nurses Association (PNA)	Psychiatric Nurses Association	Psychiatric Nurses Association
Mr. Steve Pitman	Irish Nurses and Midwives Association (INMO)	Irish Nurses and Midwives Association	Irish Nurses and Midwives Association
Mr. Ciaran Murphy	SIPTU Trade Union	SIPTU Trade Union	SIPTU Staff Organisations

Appendix four:

Membership of the Expert Reference Network

Members represent other key internal and external subject matter expert stakeholder's that will provide expert opinion and advice to the National Review Group.

Name	Title	Organisation
Mr. Sean Egan	Head of Regulation	Health Information & Quality Authority (HIQA)
Ms. Lorraine Clarke Bishop	Professional Officer Education, Policy and Standards	Nursing & Midwifery Board of Ireland (NMBI)
Dr. Diarmuid Quinlan	Medical Director Irish College of General Practitioners	Irish College of General Practitioners (ICGP)
Ms. Cliodhna Grady	Senior Clinical Risk Manager	States Claims Agency
Dr. Eleanor Fitzgerald	President Coroners Society of Ireland	Coroners Society of Ireland
Ms. Maureen Gilbert	Patient Involvement Partner	Patient Involvement Partner
Mr. Tom Lawless	President Irish Association of Funeral Directors	Irish Association of Funeral Directors
Dr Fergal Twomey	Consultant in Palliative Medicine	Milford Hospice & UL Hospitals Group
Mr Maurice Dillon	National Lead for Palliative Care, Operations Planning	Health Service Executive (HSE)

Appendix five:

Literature Review

What is the role of the nurse in the pronouncement of death in adults?

Abstract

Background:

Defining death is not as straightforward as it may seem. It is suggested that the death definition should consider, not just the biological definition but also other perspectives. Classifying death has evolved over the decades to include, cardiopulmonary and neurological criteria. The pronouncement of death is the clinical judgment that life has ceased. When death has occurred, it is essential that this pronouncement is done in a timely manner, as any delays can lead to additional trauma for the bereaved. In the past, it was only a medically trained doctor who could pronounce a death. However, with the expansion of the nurse's role, nurses who have carried out specific training, and who are deemed competent can pronounce a death. Therefore, it was decided to conduct a literature review to examine the evidence around death and the role of the nurse in the pronouncement of death in adults.

Aims and Objectives:

The aim of this literature review was:

To inform the national policy on the nurse's role and responsibility in the pronouncement of death

The objectives were:

- To explore the evidence in relation to the pronouncement of death for nurses
- To define the relevant terms of this policy
- To improve the quality of care provided to bereaved relatives
- To inform nursing practice.

Data Sources:

Electronic databases (CINAHL, MEDLINE, PsycINFO, EMBASE & PUBMED).

Study Selection:

A scoping exercise was conducted prior to carrying out the literature review (Appendix 1). This informed the search strategy and supported the development of key concepts. The review included studies published from 2003-2023 and other relevant literature.

Results:

Thirty-six studies were included in the review. This review provided information on the key concepts namely, the definition of death, criteria for classifying death, pronouncing death for nurses, and unexpected death.

Conclusion:

This literature review provided information on the definition of death and examined evidence on the criteria for pronouncing death, and how this has been influenced over the decades. The role of the nurse in pronouncing death was explored making reference to expected and unexpected death.

Research Question

What is the role of the nurse in the pronouncement of death in adults?

Aims and Objectives:

Aims: To inform the national policy on the nurse's role and responsibility in the pronouncement of death

Objectives are:

- To explore the evidence in relation to the pronouncement of death for nurses
- To define the relevant terms for this policy
- To improve the quality of care provided to bereaved relatives
- To inform nursing practice.

Search Strategy

According to Booth (2006), one of the key steps to searching for evidence is to have a well-articulated question to focus the search for information. Furthermore, using the search concept tool SPICE ensured the evidence was further directed. The SPICE framework thus comprised:

S = Setting – The proposed setting was the acute hospital, community and primary care setting, palliative care, and hospice

P = Perspective – The proposed literature review aimed to explore death definition, death classification, and the nurse's role in the pronouncement of death

I = Phenomenon of Interest – The phenomenon of interest was the pronouncement of death.

C = Comparison – It was anticipated that meaningful comparisons could be drawn from the experiences of nurses in the pronouncement of death.

E = Evaluation – The aim of the literature review was to identify the key definitions that constitute death and the nurse's role and responsibility in pronouncing death. To identify the impact this has on nurses, patients, and the bereaved. These in-depth insights will provide recommendations for nurses and will inform policy.

Based on the above, inclusion and exclusion criteria were devised.

Table 1: Inclusion and exclusion criteria

Key concepts	Inclusion criteria	Exclusion criteria
Population nurses	General nurses Intellectual disability nurses Palliative care nurses Advanced nurse practitioners	Paediatric nurses Psychiatric nurses Registered midwives
Patients	Adult patients	Children Paediatrics
Setting	Acute hospital Hospice Community Palliative Care	Mental Health Services Maternity services

Therefore, four key concepts were included in the search strategy

- Definition of death
- Classification of death
- Pronouncing death for nurses and midwives
- Unexpected death

Databases searched included CINAHL, MEDLINE, PsycINFO, EMBASE & PUBMED. Truncation and MeSH terms where applicable are applied to include associated words and connotations.
Thirty-six studies were identified for inclusion in this literature review.

Keywords used in the search strategy:

- Death* or Dying* or Expired*
- Pronouncement* or Announcement* or Declare*
- Nurses* or Midwives* or Palliative care nurses* or Community*
- COVID-19*
- Unexpected*

Summary of Evidence

Definition of Death

Death is an everyday medical occurrence that has social, legal, religious, and cultural consequences. Therefore, this requires clinical standards for its diagnosis and legal regulation (WHO, 2017). Death is a process that involves the cessation of physiological functions, and the determination of death is the final event in that process (Huang and Bernat, 2019). Death is described as the irreversible loss of those essential characteristics that are necessary to the existence of a living human person (Academy of Medical Royal Colleges (AOMRC), 2008). Hershenov (2019) states that the term death refers to our ceasing to exist. A further definition of death is either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem (Guidelines for the Determination of Death, 1981). Most people consider death to have occurred with the confirmation of irreversible cessation of cardiorespiratory function (Liao, 2022). However, according to White (2019), definitions of death have evolved from the intuitive to the pathophysiologic and the medicolegal.

It is suggested that the death definition should not be based on biology but should also incorporate the multifaceted nature of human life (Specker Sullivan, 2018). According to Molina et al. (2015) defining death is not merely a medical question but also a matter of philosophical and cultural beliefs with Jacobe (2015) proposing that death has religious, philosophical, metaphysical, and scientific aspects, and some of the controversies around death definition can be explained by these different perspectives on death. Religious authorities traditionally viewed death as occurring when the soul departs the body. Philosophers might argue death occurs when personhood is lost. Biologists might define death as loss of integration of the organism or even loss of integrity of all cells. Although 'dying' is clearly a process that precedes death, whether 'death' itself is a process or a distinct event marking a change from one binary state to another remains controversial.

Others have suggested the need for a metaphysical definition of death. One such definition is "the body must no longer be capable of the most basic function of material living being, which is to maintain its own energy supply; and the body must no longer be able to serve the spirit in its moral choices—that is, a permanent, irrecoverable state of unconsciousness is present. If these two conditions are found, then the form of the body is no longer sufficient for Ensoulment to persist and the body is dead" (Sealey, 2016).

However, a legal definition of death is necessary for a multitude of legal reasons—including criminal law, family law, and testamentary succession. It is also clearly needed for medical practice where legal requirements for treatment and organ donation depend upon whether a patient is alive or dead. The legal definition of death is of fundamental importance since the status of being alive sets the boundaries of legal and moral concepts such as personhood. In Canada, the legal definition of death is, "irreversible cessation of the functioning of the organism as a whole, as determined by the irreversible loss of the brain's ability to control and coordinate the organism's critical functions [which means] (i) respiration, (ii) circulation, and (iii) consciousness." The common law definition is that a person is considered dead when there is either "the irreversible cessation of cardiorespiratory function or the irreversible cessation of all brain function" (Chandler and Pope, 2023).

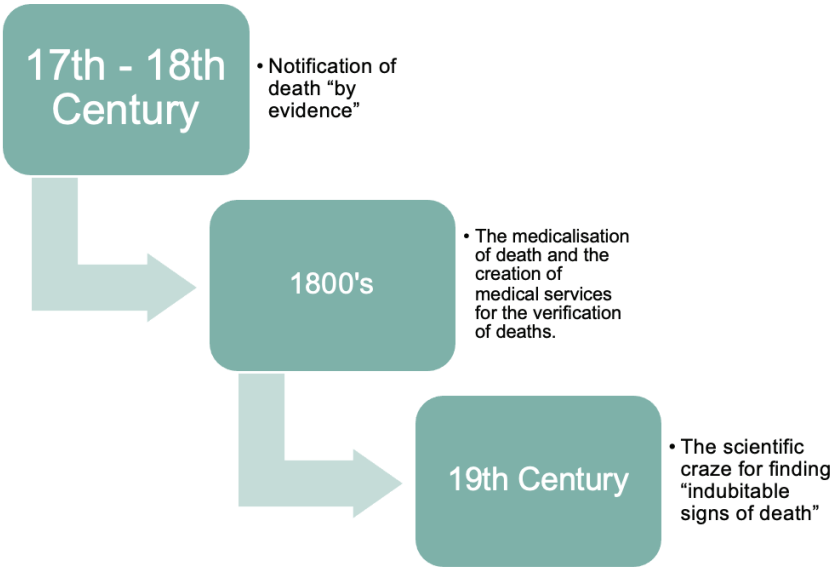
Moreover, Ross (2018), suggested that the definition of death was clearer one hundred years ago than it is today. People were declared dead if diagnosed with permanent cessation of both cardio-circulatory function and respiratory function. However, the definition has been muddled by the development of new technologies and interventions. Regardless of the debate around the definition of death, it is essential if we are to care well for both the irretrievably dying and the newly dead, we have an ontologically sound and clinically practical definition of death (Rubenstein et al. 2006). Death can be expected or unexpected. 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. Unexpected death is not anticipated or related to a period of illness that has been identified as terminal (Laverty et al. 2018). Over the years the classification of death has evolved and this is presented next.

Classification of Death

Death classification can vary quite widely among countries. Verifying or confirming death involves undertaking certain checks to ensure the person has died and the documentation of death, in accordance with national policy (Pearce, 2022). Traditionally, death has been determined by the medical profession using basic assumed cardiopulmonary standards. These standards took the form of using either heart or lung functioning criteria for death (Sareby, 2016). The report on "Guidelines for the Determination of Death" is a landmark document with far-reaching medical, ethical, and legal implications. It is a summary of currently accepted medical practices for the determination of death, both cardiorespiratory and neurological (Barclay, 1981). In 1968, the definition of death in the United States was expanded to include not just death by cardiopulmonary criteria, but also death by neurologic criteria (Lewis et al. 2017). According to Hershenov (2019), we die or cease to exist when we irreversibly lose the capacity for consciousness. The best criterion for when this happens is a higher-brain criterion. However, Carrasco and Valera (2021) argue that neurological and circulatory-respiratory criteria are not good instruments for diagnosing death, since they can offer only probabilistic prognoses of death. Of the two, brain death is further away from the moment of death as it merely predicts cardiac arrest that will likely result in death.

Historically death has been understood and defined in terms of thermodynamic concepts; death is an event that separates two processes. It separates the process of dying (progressive loss of capacity to maintain homeostasis) from the process of bodily disintegration caused by entropic forces. Death is most often defined as an irreversible cessation of the functioning of the organism as a whole (Rusinova and Simek, 2014). See below figure 1 for the timelines for influences on the classification of death.

Figure 2: Timelines for influencing factors on the classification of death



17th – 18th c: In the 17th -18th century notification of death "by evidence", was diagnosed by a pastor except in forensic cases in which a doctor or surgeon made the diagnosis. Signs of death were: the sensation of the last breath, the end of agony, immobility, the absence of reaction to stimuli, apnoea (tested by the absence of condensation on a mirror placed close to the mouth), pallor, and lower body temperature. Practitioners, in case of doubtful death (drowning, plague, childbirth) two other techniques were used: a feather on a nostril, and a glass filled with water on the stomach.

1742: The publication of the dissertation on the uncertainty of the signs of death and the abuse of burials and precipitated embalming by Bruhier d'Ablaincourt, Paris, France led to the questioning of the processes for diagnosing death.

1745: This was further questioned in 1745 with the publication of the memoir on the need for a general regulation on burials and embalming by Bruhier d'Ablaincourt, Paris, France who proposed the notion of apparent death opposing the "real and constant death". Bruhier proposed the creation of death verification officers chosen from doctors/surgeons and put forward signs of death.

1755: In 1755 the publication of the letters on the certainty of the signs of death by Antoine Louis, Royal Academy of Surgery, Paris, France suggested that the unmistakable signs of death were cadaverous rigidity and the flaccidity of the eye.

1800: The 1800s saw the medicalisation of death and the creation of medical services for the verification of deaths.

19th c.: The scientific craze for finding "indubitable signs of death". Most of the time, it was recommended to wait until the signs of putrefaction occurred (abdominal green spot), leaving the body to be stored in mortuary deposits. Others proposed the identification of Hippocratic facies, absence of pulse, rigidity, drop in temperature, lack of response to stimulation (loud cry in the ear, a bottle of ammonia placed on a nostril, sting, burn, pinching on the soles of the feet, at the end of the fingers or the nipples, etc.).

1848: Death was determined by the absence of perception of the cardiac pulsations to the auscultation of the heart by the stethoscope.

2nd half of 19th c.: This saw the use of objective tools for the signs of death, (thermometer, reagents confirming the acidity of the body, lancet showing the absence of bleeding at the cut of the superficial veins/arteries, lighter to create non-bleeding blisters, etc.).

1941: In France, it was decided to ensure death was determined the corpse could not be buried or autopsied until 24 hours have elapsed, (to watch for the appearance … or not, of signs of decomposition/putrefaction).

1948: There was one French circular that outlined the criterion of death as being the cessation of any cardiac activity.

1950: Professor Mollaret (France) created the notion of "out-of-date coma" (the state where the relationship life is abolished and the vegetative life condemned if it is not supplemented); this was further developed by Professor Vigouroux (France) who proposed the notion of "prolonged coma" (a state in which the vegetative life is maintained spontaneously but the subject, unconscious, is totally dependent on the care given to him).

1968: Further developments in the classification of death were put forward by the Harvard Committee who proposed the concept of a "brain-dead state" (absence of cerebral vasculature objectified by 2 flat and 30-minute EEGs at least 4 hours apart in the absence of sedation and sedation, hypothermia, or absence of intra-cranial enhancement in arteriography).

Developments in medicine have seen a further evolution in the classification of death. In the second half of the twentieth century, the use of mechanical ventilation and cardiovascular support, carried out in intensive care units began to allow maintenance of the cardiac activity of patients with serious brain injuries who had cerebral circulatory arrest, no encephalic functions, and an absence of spontaneous breathing. It has become scientifically evident that death is a result of the irreversible loss of the functions in the brain, either from an intra-cranial cause (devastating brain injury) or an extra-cranial cause (absence of circulation). Defining the precise moment when death occurs can be difficult and should be based on the best available scientific evidence. This has led to the development of tests to determine a certain and immediate diagnosis of death. Therefore, the minimum determination of death criteria should be rigorous, and globally acceptable for medical practice, while remaining respectful of diversities. There needs to be worldwide consensus on the clinical criteria for the determination of death to maintain public trust and promote ethical practices that respect the fundamental rights of people and promote quality health services (Ross, 2018).

Prior to the development of the mechanical ventilator, the determination of human death was based solely on cardiopulmonary criteria namely the irreversible cessation of heart and lung function. Yet, with the aid of mechanical ventilation, loss of brain function is no longer necessarily accompanied by nearly immediate and irreversible loss of heart and lung function (Moschella and Condic, 2016).

According to the National Institute for Clinical Excellence (NICE) (2018), The diagnosis and confirmation of death are required in a number of different situations, both as a result of a natural process and also in situations where artificial interventions are sustaining cardiorespiratory function in the absence of a patient's ability to breathe independently. NICE developed a Code of Practice to address the diagnosis and confirmation of death in all situations and made practical recommendations, which are acceptable both to the relatives of the deceased, to society in general, and also to the medical, nursing, and other professional staff involved.

When examining death, it is important to consider organ transplantation. The procurement of vital organs for transplantation has been based, since the early 1960s, on the dead donor rule (DDR). This rule, which is not a law, provides a general ethical framework and stipulates that vital organs can only be procured after death, in other words, physicians may not cause death by procuring vital organs for transplantation (Miller et al. 2010).

However, Machado (2003) argues that human death should not be related to organ transplantation.

The definition of death and the criteria for determining it are deeply contested issues, despite being of central significance in the practice and ethics of organ donation. The established position on the transplantation of vital organs affirms the following three propositions: (1) donors must be dead before vital organs are procured (the 'dead donor rule'); (2) death is defined as the cessation of the functioning of the organism as a whole; and (3) individuals who satisfy the clinical criteria for 'brain death' are dead on the basis of this biological definition of death (Miller and Truog, 2010). In India, the definition of brain death is contained only in the Transplantation of Human Organs Act (THOA) of 1994. Doctors of ICU patients who are brain-dead are unsure of what to do when their relatives refuse organ donation (Shroff and Navin, 2018).

The Western world now recognises two types of biological death: "real and constant" death (i.e., prolonged and definitive arrest of cardiac, respiratory, and cerebral functions), and encephalic death (i.e. beating heart, breathing maintained by an artificial process, complete cessation of all cerebral vasculature, and absence of any encephalic electrical activity) these are recognised by law for the certification of death and for the authorisation of organ transplantation (Charlier and Annane, 2018).

In December 2008, the President's Council on Bioethics released a report entitled 'Controversies in the Determination of Death'. The report discusses whether the neurological standard of death, that is, a diagnosis of 'brain death', is, in fact, equivalent to 'death' (Thomas, 2012).

Overall, the circulatory criteria remain the most appropriate for diagnosing death outside an ICU setting, but considerable variation is seen in their application. A minimum observation period of apnoea and asystole is required to confirm death following cardiorespiratory arrest. Death can be diagnosed using three different sets of criteria: somatic, circulatory, and neurological. Somatic criteria are the features visible on external inspection of a corpse, such as rigor mortis or decomposition. Determining death by neurological criteria was endorsed by at least 70 countries by 2015, yet there is continued debate regarding the concept of brain death, the criteria used, and their application (Ranawaka, 2021). An intense debate has been rekindled in orthodox Jewish circles on whether brain-stem death is compatible with the definition of death by the Halacha—the collective body of Jewish law (The Lancet, 2011). Japan, which allows people to decide whether brain death can be used to determine their death in agreement with their family. Arguably, Japan could become a unique example of individual choice in the definition of death if the law is revised to allow individuals to choose the definition of death independently of their family (Bagheri,2007).

Pronouncement of Death by Nurses

Pronouncement of death is the process of gathering information about a client's health status, analysing that data, and making a clinical judgment that life has ceased by observing and noting the absence of cardiac and respiratory function (Guitard, 2017). The certification of death of an individual, namely the medical act which provides a written record of the person's diagnosis of death has been clinical practice for centuries. This diagnosis generally leaves few or no doubts (World Health Organisation (WHO), 2017). Pronouncing or verifying a death means carrying out certain checks to ensure the person has died, and documenting the death formally in line with national guidance. The verification process includes checking that the patient's cardiac and respiratory functions are non-existent for five minutes and that there is no cerebral activity (Pearce, 2022). When a patient dies, it is important that nurses understand their role in the pronouncement of death. Pronouncement of death is not a mechanistic task, but one that requires sensitivity and compassion (Churcher and Dowie, 2020). Despite UK national guidance on care after death, it is clear that the bereaved family can experience distress while waiting for the patient's death to be verified. It has been suggested that delays in pronouncing death can escalate the bereaved distress.

In the UK nurses can pronounce a death for expected death in accordance with the 5th Edition of Care After Death: Registered Nurse Verification of Expected Adult Death (RNVoEAD) Guidance. This guidance supports timely verification of death– within one hour in a hospital setting and within four hours in a community setting. It is supportive of bereaved families and is necessary prior to the deceased being moved to either the mortuary or funeral director. It was initially developed in 2017 to address delays in the verification of death, primarily out of hours and in community settings. It is based on UK law and associated clinical practice in the UK, but it can be adapted to suit other countries (Laverty et al. 2018). This is supported by findings from a study in the USA which reported, that when Advanced Practice Registered Nurses (APRN) and Registered Nurses (RNs) pronounced death without delay this supported the bereaved (Jackson, 2019).

Certain states in the USA for example Texas allow APRN to pronounce a death in accordance with written policy, jointly developed and approved by the medical staff, medical consultant, and nursing staff, of the appropriate licensed health care facility, institution, or entity providing services to the patient. If an APRN does not have the authority to pronounce a death, the APRN must notify a person legally authorized to pronounce the death (APRN, 2021).

In October 2006, the New Jersey State Nurses Association (NJSNA) initiated a change to the New Jersey statute allowing RNs to determine and pronounce a death in all settings. Before this statute change, New Jersey RNs could pronounce a death only in the deceased's home or place of residence, hospice, long-term-care facility, or nursing home. The NJSNA Congress on Practice and Policy believes this change is a significant service to families. "Allowing the personal touch of nurses in the continuum of care is an essential and long-overdue piece of the New Jersey healthcare puzzle that will increase the comfort and peace of mind of patients and families," (Weaver, 2011). Furthermore, in the USA an RN, and charge nurses in the CCU can pronounce a death for patients in hospice or with a do-not-resuscitate order. Allowing nurses to make the final determination of death for their patients shows compassion and respect for patients and their families (Kennings, 2011).

In Vermont an RN or LPN may pronounce a death if all of the following are present: 1. The patient's death is expected 2. The patient has a valid Do Not Resuscitate/Clinician Orders for Life Sustaining Treatment (DNR/COLST) order 3. All five signs of death are present 4. The pronouncement of death is in accordance with written facility/agency policy and procedure. Registered Nurse Verification of Expected Adult Death (RNVoEAD) guidance and associated competencies have recently been developed to ensure that the registered nurses involved in the patient's care can feel confident about their responsibilities and competent in the process of verifying death (Vermont Board of Nursing, 2015).

Irish Nurses can engage in the pronouncement of death in certain circumstances. The National Policy for Pronouncement of Expected Death by Registered Nurses (2017) allows for a nurse's pronouncement of death. Prior to implementing this policy all RGNs must have undertaken the relevant training and have participated in a competence assessment (Fitzpatrick, 2020). Furthermore, in Ireland before a registered nurse can undertake this expanded role s/he must successfully complete this online program with the following supports in place: National HSE Interim Clinical Guidance for the Pronouncement of Death by Registered Nurses in identified services in the Context of the Global COVID-19 Pandemic (2020). Local policy in place to support the Interim Clinical Guidance for the Pronouncement of Death by Registered Nurses in identified services in the Context of the Global COVID-19 Pandemic (2020). Scope of Nursing and Midwifery Practice Framework (2015). The Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives (2014). Local line management support. Following on from completing the online programme, registered nurses must: Complete the Self-Assessment of Competency for a Registered Nurse in the Pronouncement of Death in the Context of the Global COVID-19 Pandemic. A copy of this completed self-assessment must be discussed with her/his line manager and a copy logged in her/his human resources file.

In Ireland nurses may not certify the cause of death or issue a death certificate but may pronounce a deaths in HSE residential, long stay, or specialist palliative care services that were expected, thereby negating the need for a post-mortem (Mudiwa, 2016).

Nurses trained and competent in pronouncing death can lead to verification of death being carried out in a timely manner which supports the bereaved. Nurses who engage in the pronouncing of death have undertaken additional training and have achieved competence in carrying it out. Kaloti et al. (2022) reported that only 30% of clinicians received training in the pronouncement of death. This suggests that nurses are well placed in the pronouncement of death.

Unexpected Death

When examining death, it is also important to consider unexpected death. While death is a certainty in life the timing of death is often uncertain. When death occurs suddenly and earlier than anticipated, it is considered an unexpected death (Nanavati et al. 2014). It is reported that the overall estimated incidence of sudden unexpected death may account for approximately 10% of all deaths classified as 'natural' (Lewis et al. 2016).

According to the WHO (2023), sudden death is non-violent, unexpected death occurring less than 24 hours from the onset of symptoms. A sudden unexpected death has significant negative impacts on patients, family caregivers, and medical staff (Satoko et al. 2021). Even in the palliative care setting in which death is relatively common, up to 5% of deaths in hospice and 10% of deaths in palliative care units were considered to be unexpected. Unexpected death has a significant impact on care, including unrealized dreams and unfinished business among patients, a sense of uneasiness and complicated bereavement among caregivers, and uncertainty in decision-making among healthcare providers. Clinicians may minimize the impact of unexpected events by improving their accuracy of prognostication, communicating the uncertainty with patients and families, and helping them to expect the unexpected by actively planning ahead. Furthermore, because of the emotional impact of unexpected death on bereaved caregivers, clinicians should provide close monitoring and offer prompt treatment for complicated grief. Prompt pronouncement of unexpected death reduces the trauma for the bereaved (Hui, 2015).

Conclusion

Death definition has attracted much debate over the decades. Revolutions in medicine to include mechanical ventilation have led to debate as to when death actually occurs. However, the Western world recognises two types of biological death: "real and constant" death and encephalic death. These are recognised by law for the certification of death and for the authorisation of organ transplantation.

Death can be described as expected or unexpected. Once death has been determined it is important to pronounce it in a timely manner. This has been found to help the bereaved with their grief.

Nurses who are specifically trained and who have achieved competence may pronounce a death in different countries. In Ireland, nurses who have undertaken the appropriate training and who have been deemed competent may pronounce unexpected death as per their local agreed policy.

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Appendix six:

Membership of the Literature Review Sub Group

Name	Title	Organisation	Representing
Ms. Aishling Kearney	Director of Nursing	St. Francis Hospice Dublin	Palliative Care Services
Dr. David Hanlon	National Clinical Advisor & Group Lead – Primary Care	NCAGL- Primary Care, HSE	Primary Care
Ms. Grainne Bourke	Director of Nursing St Michael's House Ballymun Dublin 9	Intellectual Disability Services	Directors of Nursing Intellectual Disability Services/Irish Nurse Managers in Intellectual Disability
Ms. Ann Lister	NMPD Officer	HSE Nursing and Midwifery Planning and Development	Nursing and Midwifery Planning and Development (NMPD)
Ms. Essene Cassidy	Head of Services Older Persons Representative	Head of Service Older Persons CHO 9	Older Persons Services
Ms. Teresa Donnelly	Principal Investigator	Director, Centre for Nursing and Midwifery Education, Sligo	Nursing and Midwifery Planning and Development (NMPD)

Appendix seven:

Self-Assessment of Competency for a Registered Nurse in the Pronouncement of Death

"Competence is understood as the attainment of knowledge, intellectual capacities, practice skills, integrity and professional and ethical values required for safe, accountable and effective practice as a registered nurse" (NMBI 2015). On certified completion of the e-learning programme on Pronouncement of Death by Registered Nurses, the registered nurse:

- Deems them self competent using this Self-Assessment of Competency for a Registered Nurse in the Pronouncement of Death form.

NAME:_____
(Print in capitals)

NMBI PIN number:_____

NMBI – Domain *Adapted from Registration Programmes Standards and Requirements (NMBI 2016)*	Criteria	Competent Date/ initials	Needs Practice Date/ initials	Needs Theory Date/ Initials
Domain 1 **The registered nurse is aware of guidance and policy underpinning their Practice**	I operate within the Nursing and Midwifery Board of Ireland legislative frameworks and guidance www.nmbi.ie o Code of Professional Conduct & Ethics for Registered Nurses and Registered Midwives (2021); o Scope of Nursing and Midwifery Practice Framework (2015); o Recording Clinical Practice Professional Guidance (2015);			
	I understand my responsibility to liaise with my line manager to seek additional education, competency support if required.			
	I practice in accordance with Nursing & Midwifery values of Care, Compassion and Commitment (DoH, NMBI, ONMSD 2016)			
	I understand the role of the Health Information and Quality Authority (HIQA) in regulation as it applies to this guidance. www.higa.ie o National Standards for Residential Care Settings for Older People in Ireland (Health Information and Quality Authority, 2016) o General Guidance on the National Standards for Safer Better Healthcare (Health Information and Quality Authority, 2012a) o National Standards for Safer Better Healthcare (Health Information and Quality Authority, 2012b) o National Standards for Residential Services for Children and Adults with Disabilities (Health Information and Quality Authority, 2013) o National clinical effectiveness committee (NCEC) Infection Prevention and Control National Clinical Guideline document available at the following link https://www.gov.ie/IPCclinicalguideline			
	I understand the General Data Protection Legislation (GDPR) as it applies to this guidance.			
	I understand HSE National Consent Policy (2022) as it applies to this guidance.			
	I understand the Assisted Decision Making (Capacity) Act (2015) as it applies to this guidance.			
	I understand the Health Service Executive Standards and			

NMBI – Domain *Adapted from Registration Programmes Standards and Requirements (NMBI 2016)*	Criteria	Competent Date/ initials	Needs Practice Date/ initials	Needs Theory Date/ Initials
	Recommended Practices for Healthcare Records Management (HSE 2011) as it applies to this guidance.			
	I understand the HSE Incident Management Framework Policy, 2020 and the HSE Serious Reportable Events Guidance Document, 2015 as it applies to this policy.			
	I understand the Coroners Act, 1962 - 2019 as it applies to this policy.			
	I operate within the HSE National Policy on the Pronouncement of Death by Registered Nurses			
Domain 2, 3 & 5 **The registered nurse is aware of their responsibility in completing the required education and training**	I have undertaken the pre-requisite HSE AMRIC e-learning programme www.hseland.ie			
	I have undertaken the e-learning programme on Pronouncement of Death by Registered Nurses online via www.hseland.ie			
	I have certification of completion of the e-learning programme on Pronouncement of Death by Registered Nurses.			
Domain 1, 2 & 3 **The registered nurse is aware of terminology and legislative requirements pertaining to death**	I understand the implications of the following as it applies to this guidance: o Pronouncement of death o Certification of Death o Expected death o Unexpected death o Reporting to the Coroner			
Domain 2, 3 & 4 **The registered nurse understands the procedure for the pronouncement of death**	I have the ability to explain the process of pronouncement of death to those important to the deceased person, who may be present.			
	I understand the rationale of a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decision as it applies to this policy.			
	I understand the rationale for confirming the person's identity and associated clinical records.			
	I understand the rationale for confirming the infection prevention and control status and requirement for universal infection control precautions as per https://www.gov.ie/IPCclinicalguideline			
Domain 1, 2, 3, & 4 **The registered nurse is able to carry out an examination to pronounce a death**	I am competent in checking for all clinical signs of death:			
	I understand the equipment required o Pen torch or ophthalmoscope o Stethoscope o Watch with second hand o PPE as appropriate			
	I understand the requirement to perform hand hygiene / infection control measures as per https://www.gov.ie/IPCclinicalguideline			
	I understand the requirement to check the person's identity as per local policy.			
	I understand the requirement to position the person for examination and pronouncement of death.			
	I understand that the person must be observed for a minimum of 10 minutes to establish that irreversible cardio-respiratory arrest has occurred.			
	I understand the rationale for repeating all clinical checks after 10 minutes *and within 30 minutes if required.*			
	I am proficient in undertaking carotid and femoral arteries pulse palpation: o Palpate one side at a time. o Gently tilt the head to relax the sternomastoid muscle.			

NMBI – Domain *Adapted from Registration Programmes Standards and Requirements (NMBI 2016)*	Criteria	Competent Date/ initials	Needs Practice Date/ initials	Needs Theory Date/ Initials
	○ Place your first, second, and third fingers over the artery near the upper neck between the sternomastoid and trachea roughly at the level of cricoid cartilage. ○ Using a watch with a second hand, feel for presence of pulsations for 1 minute. ○ Repeat the procedure on the opposite side to confirm findings.			
	I am proficient in assessing respirations: ○ Observe persons chest for a minimum of one minute for signs of respiration i.e. rise and fall of chest wall. ○ Listen for breath sounds verified by observation and listening with a stethoscope for a minimum of one minute. ○ Understand the rationale for not checking for air against your cheek or listening for air escaping during exhalation.			
	I am proficient in assessing heart sounds: ○ Check for heart sounds using a stethoscope. ○ Auscultate for more than one minute to determine absence of heart sounds.			
	I am proficient in assessing cerebral function: ○ Test for the absence of pupillary responses to light using pen torch or ophthalmoscope after 10 minutes of continued cardio-respiratory arrest.			
	I am proficient in assessing motor response: ○ Test the absence of motor response to trapezius squeeze after 10 minutes of continued cardio-respiratory arrest.			
	I am proficient in discontinuation / removal of tubes, lines, drains, patches and pumps.			
Domain 1, 2, 3 & 4 **The registered nurse completes appropriate documentation in a timely way**	I maintain records in accordance with legislation and organisational policies and procedures in respect of pronouncement of death.			
	I understand the rationale for accurately documenting the date and time of death.			
	I have the knowledge to signpost nursing staff /relatives to where to collect paperwork / what the next steps are.			

Appendix eight:

Sample Clinical Audit Tool – Pronouncement of Death by Registered Nurse in Identified Services

Name of Organisation/ Service:		Ward/ location	
Persons Unique ID No:	Date of Audit:	Audit completed by:	Auditor Role/ Grade:

Standard: HSE National Policy on the Pronouncement of Death by Registered Nurses						
No.	**Protocol**	**Compliance Expected**	**Supporting documentation/ evidence**	**Answer options with weighted scoring** *All non-compliance* must be actioned for resolution*		**Action plan for non-compliance identified**
1.	Discussion regarding burial/ cremation or donation to medical science had taken place between the person/ their designated healthcare representative and/ or significant other, and the persons preference regarding burial or cremation or donation to medical science was documented in the persons care plan/ nursing record prior to death.	100%	*Deceased person's healthcare Record / care plan.*	Yes	No*	
2.	Was the registered nurse who pronounced the persons death registered with NMBI.	100%	*NMBI register*	Yes	No*	
3.	Had the registered nurse who pronounced the persons death successfully completed the e-learning programme, the self-assessment competency document and/or the pre-requisite document?	100%	*Certification of completion of e-learning programme. Completed Self-Assessment document and if required Perquisite to PDRN*	Yes	No*	
4.	Was the person's death expected?	100%	*Section 1 and Section 3 of PDRN*	Yes	No *(if no proceed to Q4a)*	
4a.	If no, is there documented evidence that the treating doctor liaised with the coroner and advised the registered nurse on any further steps to be taken	100%	*Section 1 and Section 3 of PDRN form and persons healthcare record*	Yes	No*	
5.	Were any contraindications for pronouncement of death by a registered nurses identified	100%	*Section 1 and Section 3 of PDRN form*	Yes *(if Yes proceed to Q5a & Q5b)*	No	
5a.	If yes, did the registered nurse proceed to and complete Section 4 of the PDRN form: Decision made to abandon pronouncement of death.	100%	*Section 1, Section 3 and Section 4 of PDRN form*	Yes	No*	
5b.	If yes, is there documented evidence that the treating doctor assumed responsibility for pronouncement and certification of death	100%	*Section 1 and Section 3 of PDRN form and persons healthcare record*	Yes	No*	
6.	The Pronouncement of death by registered nurse procedure was completed as per national policy and available within the persons care plan/ nursing record.	100%	*Section 2 of PDRN form*	Yes	No*	
7.	Was the treating doctor satisfied that the persons death occurred as expected and indicated intent to complete the Death Notification Form in a timely manner	100%	*Section 3 of PDRN form*	Yes	No *(if no proceed to Q7a)*	
7a.	If no, is there documented evidence that the treating doctor would liaise with the coroner and advise the registered nurse on any further steps to be taken	100%	*Section 3 of PDRN form and persons healthcare record*	Yes	No*	

8.	Did the treating doctor state the intention to view the body	100%	*Section 3 of PDRN form*	Yes *(if Yes proceed to Q8a and Q8b)*	No	
8a.	If yes, did the treating doctor assume responsibility for pronouncement and certification of death	100%	*Section 3 of PDRN form*	Yes	No*	
8b.	If yes, did the registered nurse proceed to and complete Section 4: Decision made to abandon pronouncement of death	100%	*Section 3 of PDRN form*	Yes	No*	
9.	Is there documented evidence that the coroner was notified as per local policy and the coronial procedure therein by the registered nurse who pronounced death	100%	*Section 3 of PDRN form and persons healthcare record/ care plan*	Yes	No*	
10.	After the persons death was pronounced was a change of decision identified	100%	*Section 3 of PDRN form*	Yes *(if Yes proceed to Q10a and Q10b and*	No	
10a	If yes, is there documented evidence that the body of the deceased person was not removed from the place of death without the treating doctors consent	100%	*Section 3 of PDRN form and persons healthcare record*	Yes	No*	
10b.	If yes, is there documented evidence that the treating doctor viewed the body of the deceased and assumed responsibility for the pronouncement and certification of the persons death	100%	*Section 3 of PDRN form and persons healthcare record*	Yes	No*	
10c.	If yes, did the registered nurse proceed to and completed Section 4: Decision made to abandon pronouncement of death	100%	*Section 3 of PDRN form and persons healthcare record*	Yes	No*	
11	Did an adverse incident occur during or was an adverse incident identified any stage of the pronouncement of death process	100%	*Indicator 6*	Yes *(if Yes proceed to Q11a)*	No	
11a.	Where existing structures for reporting adverse incidents used when appropriate.	100%	*Indicator 6*	Yes	No*	

No.	**Action Plan:** *Outline non-compliance and the associated action plan designed to resolve / ensure ongoing compliance* with the standard	**Date action plan achieved**	**Approved by Director of Nursing signature**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Appendix nine:

Signature Sheet

I have read, understand and agree to adhere to this Policy, Procedure, Protocol or Guideline:

Print Name		Signature	Area of Work	Date