Office of the Nursing Services Director

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

**National Policy for Pronouncement of Expected Death by Registered Nurses (2017)**

**Is this document a:**

**Policy** ☒ **Procedure** ☐ **Protocol** ☐ **Guideline** ☐

*Office of Nursing and Midwifery Services Director, Clinical Strategy Programme Division*

| | |
|---|---|
| Title of PPPG Development Group: | **National Policy for Pronouncement of Expected Death by Registered Nurses Working Group [For use in HSE residential, HSE long-stay and HSE specialist palliative care services only]** |
| Approved by: | Clinical Strategy & Programmes Division Senior Management Team |
| Reference Number: | CSPD014/2017 |
| Version Number: | 1 |
| Publication Date: | 2017 |
| Date for revision: | 2020 |
| Electronic Location: | http://www.hse.ie/eng/about/Who/ONMSD/Practicedevelopment/PEDRN/PEDRN.pdf |

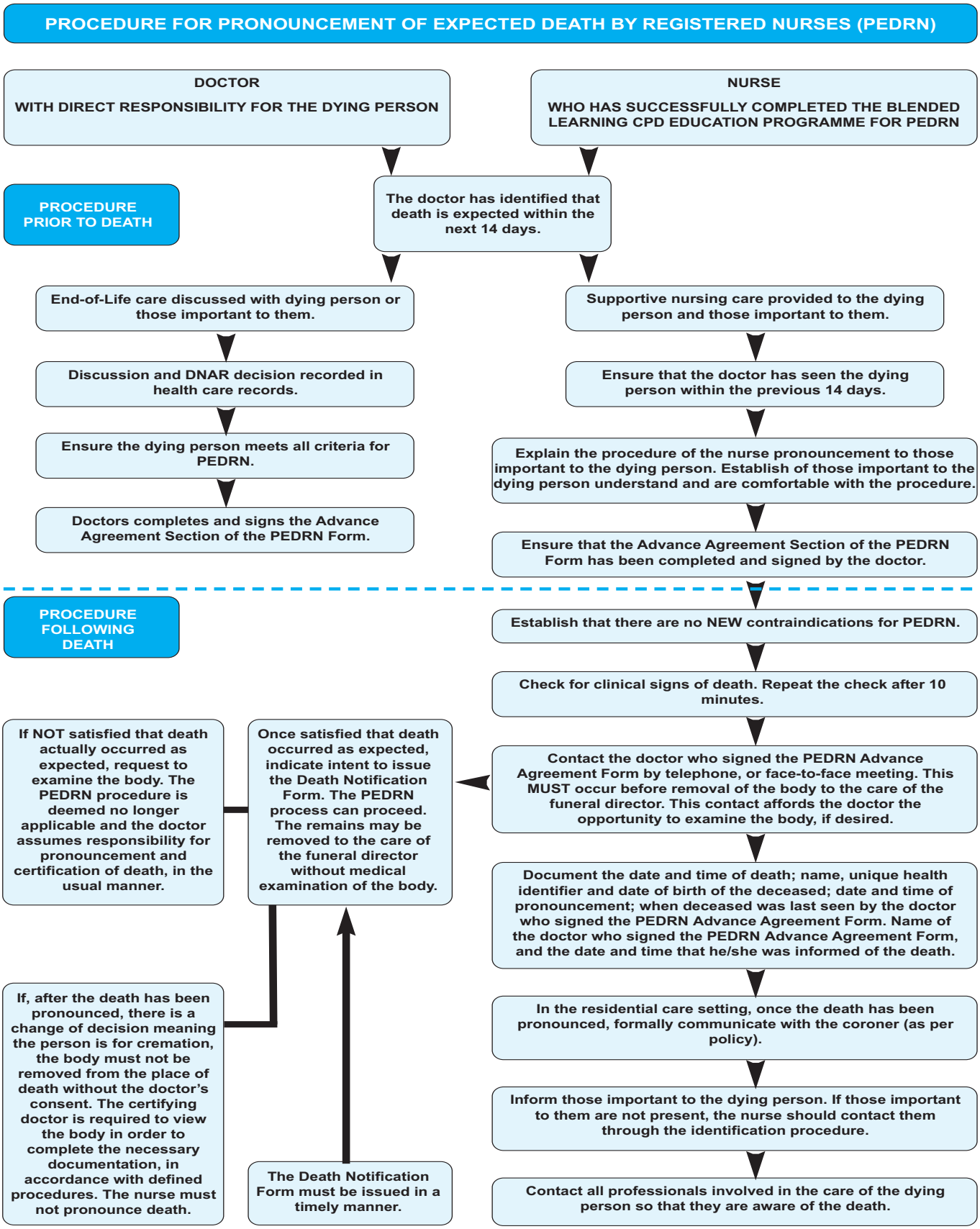
| Version | Date Approved | List section numbers changed | Author |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## PART A: Outline of PPPG Steps

## Title: National Policy for Pronouncement of Expected Death by Registered Nurses Working Group

## 1.1 1.0 ALGORITHM: PROCEDURE FOR PRONOUNCEMENT OF DEATH BY REGISTERED NURSES

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



## 2.0 Glossary of Terms and Definitions for the Purpose of this Policy

### Administrative Officer

The Administrative Officer facilitates and coordinates operations, processes and human resources to meet certain defined organisational goals.

### 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 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 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 registered 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.

### Certifying Doctor

In relation to each dying person, a doctor who has signed Section 1, 'Advance Agreement' of the PEDRN Form (at Appendix VII) in respect of that person.

### Competency

The ability of the nurse or midwife to practise safely and effectively, fulfilling their professional responsibility within their scope of practice. (NMBI, 2014)

### CNM (clinical nurse manager)

A clinical nurse manager is a registered 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 his/her nursing team in accordance with practice standards and through effective monitoring of clinical practice.

### Consent

Consent is the giving of permission or agreement for an intervention, receipt or use of a service or participation in research following a process of communication in which the service user has received sufficient information to enable him/her to understand the nature, potential risks and benefits of the proposed intervention or service. (National Consent Policy, 2014)

**CPD (continuing professional development)**

"Continuing professional development (CPD) encompasses experiences, activities and processes that contribute towards the development of a nurse or midwife as a healthcare professional. This means it is a lifelong process of both structured and informal learning. Continuing education is a lifelong learning process which takes place after the completion of pre-registration education and training, and is a vital component of CPD. It consists of planned learning experiences which are designed to augment the knowledge, skills and attitudes of registered nurses and registered midwives for the enhancement of nursing and midwifery practice, education, leadership and research." (NMBI, 2015, p.19)

**Doctor**

Doctor refers to a general practitioner or medical physician who is registered with, and regulated by, the Irish Medical Council in accordance with the provisions of the Medical Practitioners Act 2007.

**DoH or Department of Health**

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.

**DoN (Director of Nursing)**

The Director of Nursing 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.

**Do not attempt resuscitation (DNAR)**

A do not attempt resuscitation (DNAR) order is a written instruction stating that resuscitation should not be attempted if an individual suffers a cardiac or respiratory arrest (National Consent Policy, 2014). "Some individuals may be so unwell that death is considered imminent and unavoidable. In many cases, a sensitive but open discussion of end-of-life care will be possible in which individuals should be helped to understand the severity of their condition. However, it should be emphasised that this does not necessarily require explicit discussion of CPR or an "offer" of CPR." (National Consent Policy, 2014 Section 4.2, p.102)

**Dying person**

The term 'dying person' is used throughout this policy. For the purpose of this policy, the term 'dying person(s)' incorporates the terms 'patient(s)' and 'resident(s)'. It is acknowledged that resident is the term most appropriately used in long-term and residential facilities. Reference may also be made to the deceased within the Policy.

**End-of-life care**

End-of-life care is the term used to describe care that is provided during the period when death is imminent, and life expectancy is limited to a short number of hours or days. (HSE, 2014)

### Expected death

Expected death is defined as death following a period of illness that has been identified as terminal, where nurses and doctors have been involved in providing palliative care, and where there is an agreement between the dying person, those important to the dying person, and medical and nursing teams that no active intervention to prolonging life is ongoing, a 'Do not attempt resuscitation' (DNAR) decision has been made, and the decision is recorded in the dying person's healthcare record and has been communicated to the entire team.

### 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 his/her care (HSE, 2011).

### HSE or Health Service Executive

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.

### 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.
- **Generalist palliative care providers:** Generalist providers refers to all services and health and social care providers who have a primary or first contact relationship with the person with life-limiting illness and palliative care needs. The use of the term 'generalist' in this context refers to general practitioners, primary care team members and staff in residential care services. (HSE, 2014)
- **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).

**Local Policy for Pronouncement of Expected Death by Registered Nurses** is a policy developed between the doctor (s) (General Practitioner/Physician), local coroner, HSE Service Manager and Director of Nursing in a specific HSE service site which plans to implement the National Policy for PEDRN. The aim of the local policy is to articulate the local arrangements in relation to communication between the doctor(s), coroners and local HSE service site. The local policy is developed in advance of implementation of the national policy. The local policy will not be in conflict with the guidance and procedures within the national policy and is a supporting policy for site specific communication arrangements.

### PEDRN

PEDRN is the acronym for the term Pronouncement of Expected 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, and it may allow for the removal of the deceased's remains. Pronouncement of death (as distinct from certification of death) need not be undertaken by a registered doctor.

**Verification of death** is not pronouncement of death. Verification refers to the process of establishing the truth, accuracy, or validity of something. In certain jurisdictions, the term 'verification of death' is used interchangeably with 'nurse pronouncement of death'. In the Irish context, where a pre-hospital death is managed by emergency ambulance personnel, verification of death is taken to mean deciding whether a person is actually deceased, but requires pronouncement of death by a doctor; it does not allow for the removal of the person's remains. Rather, the remains are brought to the local hospital/preserved in situ while awaiting medical examination.

**Registered nurse (hereafter referred to as a 'nurse')** is a person registered in any of the registers held by the Nursing and Midwifery Board of Ireland (NMBI). A person cannot call themselves nurse or midwife, or use the title of nurse or midwife, without being registered with the NMBI. The individual must be registered with the NMBI in order to commence employment or to practise as nurse/midwife 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'.

**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). For the purpose of this policy, the service settings are HSE long-term and HSE specialist palliative care facilities (as also defined at 1.2 Scope).

Those important to the dying person/Those important to them

Those important to the dying person'/'Those important to them' are terms used throughout this policy document. For the purpose of this policy, the term may incorporate the next of kin, a person's closest living blood relative, relatives or close friend.

**Unexpected death**

Unexpected death is a death other than an 'expected death' as defined in the Policy, or a death where there was no expectation that the person was likely to die in the manner or at the time at which they did.

## 3.0 PRONOUNCEMENT OF EXPECTED DEATH

**3.1** For the purpose of the National Policy for Pronouncement of Expected Death by Registered Nurses, expected death is defined as death following a period of illness that has been identified as terminal, where nurses and doctors have been involved in providing palliative care, and where there is an agreement between the dying person, those important to the dying person, and medical and nursing teams that no active intervention to prolonging life is ongoing, a 'Do not attempt resuscitation' (DNAR) decision has been made, and the decision is recorded in the dying person's healthcare record and has been communicated to the entire team.

**3.2** Discussion on end-of-life care, and documentation of this discussion, should have taken place between the dying person (or those important to them), their doctor and their nurses. 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 resuscitation (DNAR) decision should be recorded in the healthcare record and should be communicated to the entire team. Wherever possible, the dying person and those important to them should be made aware of the dying person's deteriorating condition, and of the dying person's care plan.

**3.3** 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 religious/spiritual/cultural needs.

**3.4** The process of pronouncement of expected death is embarked upon on a case-by-case basis.

**Pronouncement may be undertaken by a nurse where:**

(i) Death is expected (as outlined above), and is considered to be imminent (within the next 14 calendar days).

(ii) The dying person will have been seen by a doctor within the past 14 days.[1] The doctor has agreed to collaborate with nursing colleagues in this process, and in doing so has completed and signed the relevant documentation.

(iii) The Section 1 Advance Agreement of the PEDRN Form is completed and signed by the Certifying Doctor (Appendix VII).

(iv) The nurse has completed the relevant Pronouncement of Death CPD programme and can demonstrate competence. The nurse is accountable for his/her own professional practice in accordance with the NMBI Code of Professional Conduct and Ethics (2014) and the NMBI Scope of Practice Framework (2015).

(v) Death actually occurred as expected, is not accompanied by any suspicious circumstances, and no exclusion criteria (as set out below) apply.

---

[1] Based on evidence explored in the development of the policy, and following consultation with experts, 14 days is the length of time that that has been identified for the purpose of implementing the policy. It is noted that under Irish legislation a Death Certificate of Cause of Death may be issued if the deceased was seen and treated by a registered medical practitioner up to 28 days before the death.

**Pronouncement of death by a nurse may not be undertaken if the following exclusion criteria exist:**

(i) 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* (see Appendix V).

(ii) Any death where cremation is planned.

(iii) Any death where the remains are being donated to medical science/organ donation.

(iv) Where the death is not an "expected death" as defined in the Policy, or, more generally, where Death did not occur as expected (for example, if a dying person's death is caused by an unforeseen or unexpected incident).

(v) Any death of persons under 18 years of age.

(vi) Death occurred in a person's home, where specialist palliative care community services are NOT involved.

(vii) The preference of those important to the dying person is for a doctor to pronounce death.

(viii) The nurse has NOT completed the relevant Pronouncement of Expected Death education programme and cannot demonstrate competence.

(ix) The advance agreement section of the Pronouncement of Expected Death Form has NOT been completed and signed, or there has been deviation from any part of the PEDRN procedure as outlined in this policy.

**Box1. Reporting to the Coroner**

**Reporting to the Coroner**

**1. Identified reportable deaths (see Appendix V):**

Where it has been identified prior to a person's death that their death is reportable to the Coroner, the PEDRN procedure should not be carried out. Death should be pronounced and reported by a medical practitioner in the usual manner.

**2. Unexpected deaths:**

It is the responsibility of everyone (i.e. attending doctor or nurse) to report all sudden and unexpected deaths to the Coroner.

Unexpected deaths expressly include all cases required by rule of law and rule of practice to be reported to a coroner (see Appendix V). In cases of unexpected death (as defined in this Policy), the PEDRN procedure should not be carried out.

**3. Deaths occurring in a nursing home or residential care setting:**

All deaths occurring in a nursing home or residential care setting are reportable to the Coroner. Where the sole reason for death being reported to the Coroner is that the death occurred in a nursing home or residential care setting, but the death is an **expected** death and the correct procedures (as outlined in this Policy) are followed, pronouncement of death by a registered nurse may occur. **The Coroner must be notified in the usual manner and the body can be transferred to the care of a funeral director in accordance with local policy and the coronial procedure therein.**

## 4.0 INSTANCES WHERE DEATH IS NOT EXPECTED

Where a death does not meet the criteria falling within the definition of expected death, or where there is some element of uncertainty, the nurse is obliged to adhere to his/her professional responsibilities and follow all procedures in relation to responding to an unexpected death.

**4.1** Health professionals will make all reasonable efforts to attempt to revive the person unless a DNAR order is in place.

**4.2** The emergency ambulance service must be called whenever there is a chance of survival, however remote. Resuscitation should be commenced by the nurse within his/her scope of practice.

**4.3** In all cases where death was not expected the doctor is informed. Where appropriate the coroner is informed. If death occurs in a designated centre for older people or in a centre for people with disabilities, HIQA is informed.

## 5.0 PROCEDURE FOR PRONOUNCEMENT OF EXPECTED DEATH BY REGISTERED NURSES

The implementation of the procedure for pronouncement of death by a nurse is determined on a case-by-case basis, and is dependent on the specific circumstances of each dying person. Communication with the dying person and those important to them has occurred in advance of the procedure (DNAR decision). The procedure for pronouncement of death by a nurse is a collaborative process between the nurse and the attending doctor.

### Procedures Prior to the dying person's death

Refer to Appendix VI: Guidance for Doctors and Algorithm: Procedure for Pronouncement of Death by Registered Nurses'.

The **Doctor** must:

(i) Determine that the dying person's death is expected, have certainty as to the cause of this expected death, and be prepared to certify death.

(ii) Examine the dying person and be satisfied that the dying person's death is imminent (i.e. within the next 14 days).

(iii) Discuss end-of-life care with the dying person and/or those important to them.

(iv) Record the discussions and decision(s) in the healthcare record, with reference to the view that no further active interventions are required to be undertaken in order to attempt to prolong life. A DNAR decision must be recorded in the healthcare record.

(v) Ensure that, for the dying person, all the inclusion criteria for the PEDRN procedure are met, as outlined in this policy.

(vi) Complete the Advance Agreement Section 1 of the Pronouncement of Expected Death by Registered Nurse Form (Appendix VII). In doing so, the doctor agrees to:

a. Be notified by direct telephone (or face-to-face) contact upon the person's death. If the doctor is not satisfied that death actually occurred as expected, or if the doctor wishes to examine the body for any reason, he/she should take the opportunity to do so.

b. Give permission, following the above notification, for the removal of the dying person's remains to the care of a funeral director, without medical examination of the body if the doctor is satisfied that medical examination of the body is not necessary to determine cause of death.

c. Complete the Death Notification Form in a timely manner.

If clinical or other circumstances determine that the PEDRN procedure is no longer applicable, the doctor assumes responsibility for pronouncement of death, in the usual manner. See Appendix VI 'Guidance for Doctors'.

The **Nurse** must:

(i) Ensure that the Advance Agreement Section 1 of the PEDRN Form (see Appendix VII) has been completed and signed by the doctor.

(ii) Ensure that the doctor has seen the dying person within the previous 14 calendar days.

(iii) In the event that the dying person is nearing the end of the 14 calendar days time period, alert the doctor of the need to review the dying person. The Advance Agreement Section 1 of the PEDRN Form should be completed and signed again in full.

(iv) As appropriate, explain the procedure to those important to the dying person. Establish if those important to the dying person understand, and are comfortable with, the procedure of nurse pronouncement of death. Discuss and alleviate any concerns that those important to the dying person may have with the procedure, and respect their expressed wishes. Reconfirm at this point that no cremation or donation of the body to medical science (if applicable) is planned.

(v) Where possible, liaise with a funeral director in advance of the expected death. In particular, the nurse should explain that the PEDRN procedure is being implemented.

**Procedures following the dying person's death**

The **nurse** must:

(i) Establish that there are no *new* contraindications for pronouncement of death by a nurse arising after death.

(ii) Ensure that the doctor has seen the person within the 14 calendar days prior to death[2].

(iii) As appropriate, explain the process to those important to the person, who may be present. Establish if those important to the dying person understand, and are comfortable with, the procedure of nurse pronouncement of death. Discuss and alleviate any concerns they may have with the procedure and respect their expressed wishes.

---

[2] Based on evidence explored in the development of the policy, and following consultation with experts, 14 days is the length of time that has been identified for the purpose of implementing the policy. It is noted that under Irish legislation a Death Certificate of Cause of Death may be issued if the deceased was seen and treated by a registered medical practitioner up to 28 days before the death.

(iv) Check for clinical signs of death, using a stethoscope and penlight or ophthalmoscope. Repeat the check for clinical signs of death after 10 minutes (box 2).

(v) Note and document the date and time of death, where possible. In the case of nurses not being present at the death, the time of death should be established, as close as possible, from persons who were present (box 3).

(vi) The occurrence and circumstances of death must be formally communicated to the certifying doctor as soon as possible, in accordance with local policy. If the death occurs out of hours, this communication may take place the following morning.

- Contact with the certifying doctor may be by direct telephone contact, or face-to-face. This contact MUST occur before removal of the body to the care of a funeral director. This contact affords the doctor the opportunity to examine the body, if he/she wishes to do so.
- If the certifying doctor is satisfied that death occurred as expected, he/she will indicate his/her intent to issue the Death Notification Form. The PEDRN procedure can proceed. The remains may be removed to the care of the funeral director without medical examination of the body.
- If the certifying doctor is *not* satisfied that death actually occurred as expected, he/she should ask to examine the body. In such circumstances, the PEDRN procedure is deemed no longer applicable and the Certifying Doctor assumes responsibility for pronouncement and certification of death, in the usual manner.

(vii) In a residential care setting, once the death has been pronounced, the nurse formally communicates with the coroner in accordance with local policy.

(viii) The nurse informs those important to the dying person. If those important to the dying person are not present, the nurse should contact them using the local procedure, unless it is specified that those important to the dying person do not wish to be contacted at a particular time. It may be necessary to explain to those important to the dying person the administrative aspect of recording date and time of death and date and time of pronouncement if there is a significant variance.

(ix) If, after the death has been pronounced, a change in circumstances arises which affects the operation or applicability of the Policy (for example a decision is taken that the deceased person's remains are for cremation or for donation to medical science) the body must not be removed from the place of death without a doctor's consent. The certifying doctor is required to view the body in order to complete the necessary documentation in accordance with defined procedures. The nurse must not pronounce death. The nurse documents the decision in Section 2 of the PEDRN Form (Appendix VI).

(x) The designated nurse (as per local policy) must contact all professionals involved in the care of the dying person, so that they are aware of the death.

**Box 2. Clinical Signs used when pronouncing death**

The following are the recognised clinical signs used when pronouncing death.

**All signs must be present before death is pronounced:**

1. Absence of a carotid pulse for over one minute
2. Absence of heart sounds for over one minute
3. Absence of respiratory movements and breath sounds for over one minute
4. Fixed pupils (unresponsive to bright lights)No response to painful stimuli (e.g. sternal rub)

If there is any uncertainty, repeat the steps in the above checklist within 30 minutes.

If after 30 minutes there is still uncertainty about pronouncement of death, confer with a colleague. The assessment and declaration that 'death has occurred' should be undertaken in a calm and unhurried manner. Gurgling noises etc. may occur immediately after death, which may make pronouncement of death more difficult.

**Box 3. PEDRN form details**

When pronouncing death, the nurse must record the following details on the Pronouncement of Death by a Registered Nurse Form: (see Appendix VII):

- The date and approximate time of death.
- Name, unique health identifier and date of birth of the deceased.
- Date and time of pronouncement.
- Name of the doctor informed, and the time and date that this took place (it is imperative that this is the doctor who signed the PEDRN Advance Agreement).
- Name of the coroner informed (where relevant) and the time and date that this took place.
- Name of those important to the dying person informed.
- Name of funeral director, if contacted, and any details relating to this contact.
- Name of pastoral support if contacted and any details relating to this contact.

## 6.0 CPD ASSESSMENT

Nurses are responsible for undergoing a continuing professional development (CPD) process, in order to achieve competence to deliver safe, effective care in the pronouncement of expected death. The Blended Learning Continuing Professional Development Education Programme for PEDRN is designed to respond to the CPD requirements.

Before a nurse carries out this clinical procedure he/she must undertake an approved e-learning programme, supervised practice and competency assessment session(s) and be deemed competent by an approved assessor.

A standardised CPD blended learning (e-learning) education programme has been developed for registered nurses who will be undertaking the expanded role of pronouncement of expected death in specific circumstances, within their scope of practice and within the law.

The programme has four components, namely:

A. Registered Nurse e-learning Module

B. Confirmation of Competence Assessment (Learning Management System)

C. Self Certification of Continuing Competence Assessment

D. Handbook containing guidelines for Assessors

### A. Registered Nurse e-learning module

The Registered Nurse Programme must be completed by nurses who will be taking on the expanded role of pronouncement of expected death.

The nurse must:

- Complete and pass the e-learning programme, achieving a mark of 80% overall, and a mark of 100% for questions related to clinical assessments and on the 'criteria for exclusion' segment of the programme.
- Undertake the procedure for pronouncement of death under the supervision of an assessor on at least one occasion.
- Be deemed competent in pronouncing death by an approved assessor.
- If, **after three supervised practice and competence sessions**, the nurse is not deemed competent, then he/she must re-enrol and repeat the e-learning programme on HSELanD.
- After being deemed competent, the nurse must print out a Certificate of Completion from the e-learning system.
- Present the Certificate to his/her line manager for safe keeping, in accordance with local policy.

### B. Confirmation of Competence Assessment (Learning Management System) for PEDRN

The assessor must complete a 'Record of Supervised Practice and Competence Assessment Form' each time a supervised practice session takes place.

A nominated representative must input the results of the practice observation and competence assessment session(s) once only in the Learning Management System.

When the nurse successfully completes this component of the programme, he/she can print a Certificate of Completion from HSELanD. This Certificate will include the name and Nursing and Midwifery Board of

Ireland Pin Number of the nurse completing the programme, as well as the name and Nursing and Midwifery Board of Ireland Pin Number/Irish Medical Council number of the assessor and the date of programme completion.

This Certificate must be given to the nurse's line manager for safe keeping, in accordance with local policy.

### C. Self certification of continuing competence

After the nurse has successfully completed the online learning programme and has been deemed competent, he/she must complete a self certification of continuing competence statement every **two years**. This will be recorded in the Learning Management System and a certificate will be automatically issued.

### D. Handbook – Guidelines for Assessors: Assessing the Clinical Competencies of Registered Nurses in Pronouncing Expected Death

The handbook titled *Guidelines for Assessors: Assessing the Clinical Competencies of Registered Nurses in Pronouncing Expected Death* is aimed at doctors and registered nurses who have pronounced death on a mini**mum of three occasions**.

From a governance perspective, to become an assessor, the doctor/registered nurse must be familiar with the Registered Nurse e-learning Module. It is recommended that the assessor should also complete the Continuing Competence certification process every two years.

The aim of the handbook is to equip doctors and registered nurses to perform a supervised practice and competence assessment session for the pronouncement of expected death using evidence-based practice in accordance with national and local policies.

Having read the handbook the doctor/registered nurse must sign a statement that they have read and understood the guidelines in the handbook.

**PART B:**

## 1. Initiation

### 1.1. Purpose

**1.1.1.** The purpose of this policy is to:

**1.1.2.** Provide a framework for safe pronouncement of death by registered nurses across HSE residential, long-stay and specialist palliative care services.

**1.1.3.** Outline the extent of the registered nurses scope of practice in undertaking the pronouncement of death in the identified services.

**1.1.4.** Outline the necessary governance procedures to facilitate, enable and ensure safe pronouncement of death by registered nurses, to include: education, competence assessment and application of a local policy.

**1.1.5.** Promote a quality, safe environment for the dying person.

**1.1.6.** Provide support to those important to the dying person.

**1.1.7.** Enable those important to the dying person to commence burial arrangements.

### 1.2. Scope

**1.2.1.** The Policy will apply to registered nurses working in HSE residential, HSE long-stay and HSE specialist palliative care services only. The adoption of the policy is voluntary, with decisions to implement the policy based on service need and agreement by the doctor, director of nursing and coroner.

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

**1.2.3.** HSE services' are any services which the HSE provides directly. This policy does not apply to services provided by private institutions, 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).

**1.2.4.** In the palliative care context, specialist palliative care is delivered in many settings, including specialist inpatient palliative care units and the person's home. This policy will apply to registered nurses working in HSE specialist palliative care units. Where HSE specialist palliative care community teams are involved, this policy will also apply to expected death that takes place in the dying person's home. Where death occurs in such circumstances, the registered nurse may be a community-based specialist palliative care nurse, a public health nurse or a community registered general nurse.

**1.2.5.** Registered nurses are nurses who are currently registered on the Live Register of the Nursing and Midwifery Board of Ireland, Hereafter, a registered nurse will be referred to as 'nurse' in this policy.

**1.2.6.** A nurse cannot legally certify death. The nurse may, however, pronounce that death has occurred when the Policy is applied. A nurse can only pronounce expected death as outlined in this policy, and with the application of a local supporting policy.

**Exclusion criteria**

The policy does **NOT** provide for pronouncement of death by a nurse in the following circumstances:

1. 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* (see Appendix V).
2. Any death where cremation is planned.
3. Any death where the remains are being donated to medical science/organ donation.
4. Where the death is not an "expected death" as defined in the Policy, or, more generally, where death did not occur as expected (for example, if a dying person's death is caused by an unforeseen or unexpected incident).
5. Any death of persons under 18 years of age.
6. Deaths occurring in a person's home where specialist palliative care community services are NOT involved.
7. The preference of those important to the dying person is for a medical doctor to pronounce death.
8. The nurse has NOT successfully completed the Pronouncement of Expected Death continuing professional development education programme.
9. The advance agreement section of the Pronouncement of Expected Death Form has not been completed and signed, or there has been deviation from any part of the PEDRN procedure as outlined in this policy.

### 1.3. Objective

The objective of this Policy is to enable registered 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.

### 1.4. Outcome

The Policy provides a framework for safe pronouncement of expected death by registered nurses in HSE residential, long-stay and specialist palliative care services. Historically, pronouncement has been carried out by doctors; however, in recent years, there has been recognition that a registered nurse who has undertaken specified education, and has been assessed and deemed competent, should be empowered to perform this role. There are circumstances where a person's death is inevitable, 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.

**Certification (as distinct from pronouncement) of death is and remains the legal responsibility of the dying person's doctor.**

The ability for registered nurses to pronounce the death of a person, where death is expected, will provide continuity of care, and will support those important to them during the bereavement period. Registered nurses in HSE residential, long-stay and specialist palliative care services provide end-of-life care as an integral part of the complete spectrum of nursing care. The ability for registered nurses to confirm the death of a person will provide continuity of care at the final stage of a person's life.

### 1.5. PEDRN National Working Group

The National Working Group for PEDRN Project undertook the work of the project within an agreed project plan and under the guidance of a Project Lead. Refer to Appendix II for Membership of the National Working Group for PEDRN Project. See Appendix III for PEDRN Policy Conflict of Interest Declaration Form.

### 1.6. PEDRN National Advisory Group

The National Advisory Group for PEDRN Project provided governance for the project and policy development. Refer to Appendix IV for Membership of the National Advisory Group for PEDRN Project.

### 1.7. 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 Guidance to Nurses and Midwives* (An Bord Altranais, 2002)
- *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives* (Nursing and Midwifery Board of Ireland, 2014)
- *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)
- *General Guidance on the National Standards for Safer Better Healthcare* (Health Information and Quality Authority, 2012a)
- *National Standards for Safer Better Healthcare* (Health Information and Quality Authority, 2012b)
- *National Standards for Residential Services for Children and Adults with Disabilities* (Health Information and Quality Authority, 2013)
- *Health Service Executive Standards and Recommended Practices for Healthcare Records Management* (HSE, 2011)
- *HSE National Framework for Developing Policies, Procedures, Protocols and Guidelines (PPPGs)* (HSE, 2016)
- *National Consent Policy* (National Consent Advisory Group, HSE, 2014)
- *Making end-of-life care central to hospital care: quality standards for end-of-life care in hospitals* (Irish Hospice Foundation, 2010)
- *Palliative Care Competence Framework (Palliative Care Competence Framework Steering Group,* HSE, 2014)

## 2. DEVELOPMENT OF PEDRN POLICY

### 2.1. Literature Review

The National Project Working Group undertook an extensive literature review. This literature review sets out objectives and methodology. It includes definitions and outlines examples for current best practice in a national and the international context. In addition the review refers to different legal frameworks in other jurisdictions. The objective of the literature review was to establish current evidence and best practice, and seek new and emerging evidence, in relation to pronouncement of death by registered nurses nationally and internationally. The literature review was supported and assisted by Ms Bennery Rickard, HSE Library Services Manager and Ms. Laura Rooney Ferris, Information Manager of the Irish Hospice Foundation.

### 2.2. Literature search strategy

A literature search was undertaken by the national project team in 2015 and revised in 2016. The search terms were 'pronouncement of expected death', 'verification of expected death', 'VOED', 'nursing' and 'nurses'. The terms were used interchangeably within the search strategy. The term pronouncement of death is used within this policy. There was no limit to date or language. Resources searched were PubMed, CINAHL, EBSCO, Web of Knowledge and PsycINFO to access relevant peer reviewed articles. The Cochrane Library was searched with no evidence of systematic reviews or protocols relating to the topic. There is little evidence of research publications relating to the topic, and those sourced were qualitative studies exploring the views of nurses in relation to the topic. There were no studies examining the impact of pronouncement of expected death by nurses on service users or the organisation. Internet search engines were used to identify grey literature related to the topic. The search yielded policies and guidelines for verification and pronouncement of death by nurses primarily UK based, with some from the Australia, US and Canada. Literature accessed were predominantly articles, commentaries or health organisation policies or guidance.

### 2.3. Method of Evidence Appraisal

As there was a dearth of research based literature the literature was reviewed and categorised by definition and by country of origin. The results were deemed applicable to the population within the PEDRN Policy.

### Definitions

This section sets out the definitions relevant for this review as found in the literature as they are applied in different jurisdictions.

*Expected Death:*

Death occurring at a stage in the patient's disease process when death is inevitable, and no active treatment is planned or appropriate (Byron and Hospkin, 2013). To be regarded as an expected death, it must be known that the deceased was suffering from a terminal illness and death must be identified as being imminent e.g. within the next two weeks. The patient must not have been undergoing any active intervention to prolong life. The medical practitioner must have seen the patient in the 14-days prior to death and a do-not-resuscitate-order should be in place (Walton, 2009).

*Verification of Death:*

Verification of Death can be defined as the procedure for affirming the absence of Cardiac, Respiratory and Neurological function. It is also referred to as confirmation of death (NHS, 2009; NHS, 2011; NHS, 2012). Verification of death, or confirmation that death has occurred under certain circumstances, can be performed by a clinically trained staff member; other than a medical practitioner (Walton, 2009). Verification of death is a procedure to determine whether a person is actually deceased (NHS, 2016). Verification of Death: is a clinical assessment process undertaken to establish that a person has died. A registered medical practitioner, registered nurse / registered midwife or qualified paramedic can establish and document that death has occurred. Verification of Death is required to enable a person's body to be transported by a funeral director or government contractor, in circumstances where there may be a delay in completing the Medical Certificate of Cause of Death (New South Wales Government, 2015). In different National Health Service Trusts verification of death is defined as:

1. Deciding whether a patient is actually deceased and does not require a medically registered practitioner to undertake verification (NHS, 2012b).
2. Pronouncing death or confirming death is the procedure of determining whether a person is actually deceased. All deaths should be subject to verification that life has ended (NHS, 2010).

The Royal College of Nurses (2013) defines verification as deciding whether a person is actually deceased.

*Pronouncement of Death:*

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 (Nurse Association of North Brunswick, 2014). It is a convention used to formalise the occurrence of death, and to provide assurance to relatives and the public that appropriate measures are being taken to ensure that individuals are indeed deceased before being treated as such (NANB, 2014). Is the determination that, based on a physical assessment, life has ceased. There is no official requirement for pronouncement of death. Pronouncement of death is within the scope of practice of nurses registered with the College of Registered Psychiatric Nurses of British Columbia (CRPNBC) and limits and conditions of practice are outlined (CRPNBC, 2014). CARNA (2011) recommends a common approach that appropriately trained professional groups such as senior registered nurses or paramedics have the authority to verify death. This would allow the removal of the body from the place of death such as their residence or nursing home rather than an undue wait, perhaps overnight, for the GP to verify the cause of death (CARNA, 2011).

*Certification of Death:*

Is part of a legal process which can only been undertaken by a qualified medical practitioner who attended the deceased during the last illness (Civil Registration Act, 2004). On the death following an illness of a person who was attended during that illness by a registered medical practitioner, the practitioner shall sign and give to a qualified informant a certificate stating to the best of his or her knowledge and belief the cause of the death, and the informant shall give the certificate to any registrar together with the form specified in section 37(1) containing the required particulars in relation to the death (Byron and Hoskins, 2013). All human death involves the irreversible loss of the capacity for consciousness, combined with the irreversible loss of the capacity to breathe (Gardiner et al., 2012).

The results of the literature review were categorised and analysed by country of origin. The predominance of valid and relevant literature was sourced from Ireland, the United Kingdom, Australia and Canada.

*Ireland*

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 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. In Ireland, 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.

However the legislation does not specifically require a medical practitioner to certify or declare the *fact of death.* Irish legislation, similar to other jurisdictions, requires that a medical practitioner to complete a certificate of the *cause of death* to the best of the doctor's knowledge and belief (Civil Registration Act, 2004).

There is no provision in Irish legislation preventing a nurse to pronounce death (Department of Justice, Equality and Law Reform, 2004, Civil Registration Act, 2004). The aim of this Policy is to enable registered 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.

The investigation of specified deaths by coroners (chiefly unexpected or untoward deaths) is governed by the Coroners Act, 1962. The Coroners rules also stipulate that all deaths in nursing homes, irrespective of the cause or whether the death is certifiable or not by the attending medical practitioner must be reported to the local Coroner. It is the responsibility of everyone (i.e. attending doctor or nurse) to report all sudden and unexpected deaths to the Coroner.

Unexpected deaths expressly include all cases required by rule of law and rule of practice to be reported to a coroner. The Health Act Regulations 2013 and the national standards for residential care for older persons require appropriate end-of-life care for residents in the services it governs (Health Act, 2007; HIQA, 2009). It requires, on a quarterly basis, a notification of any death and its cause to the Health Information and Quality Authority (HIQA) using the information from the Death Notification Form.

Nursing practice is governed by the Nurses & Midwives Act (2011). The regulating body for nurse is the Nursing & Midwifery Board of Ireland (NMBI). NMBI provide professional guidance for nurses and midwives practice, including their professional responsibilities for caring for patients in a safe, ethical and effective way (NMBI, 2014, NMBI 2015). Relevant principles in the *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives* (2014) are:

- Respect and dignity of the person;
- Professional responsibility and accountability;
- Quality of practice
- Collaboration with others.

The *Scope of Nursing and Midwifery Practice Framework* (NMBI, 2015) sets out the procedures, actions and processes that the registered nurse is allowed to perform. It includes relevant aspects such as accountability, necessary skills, experience and knowledge to undertake an identified role or task. There is evidence of local guidelines and policies for verification or pronouncement of death in residential services for older people in Ireland (Mayo, Clare, Longford, Dublin)(Butler, 2013: McTiernan, 2013). The procedures outlined within these documents are similar to polices for verification/pronouncement of death by nurses in other jurisdictions. McGinn (2013) outlines the distinction between verifying and certifying a death. There is no evidence of research or peer reviewed publications relating to pronouncement of death by nurses in the Irish context.

*United Kingdom*

Similar to Ireland, legislation in the United Kingdom requires that only a registered medical practitioner can certify death, and complete a certificate of the *cause of death* to the best of the doctor's knowledge and belief, but does not require a medical practitioner to certify the *fact of death* or to view the body of the deceased person (BMA, 2009).

The United Kingdom public inquiries including the Bristol Royal Infirmary and Alder Hey hospitals and the inquiry into practices of Dr. Harold Shipman (Home Office, 2004) have led to a review of death certification practices in the UK. Under the new system a death may be verified by a doctor, paramedic, or senior nurse, who will then complete a verification form (The Shipman Inquiry, 2003: Dyer, 2004; DoH, 2016). The doctor who had treated the dead person in the immediate past will then issue a certificate of the medical cause of death. The medical examiner will seek relevant information from the family and elsewhere, to confirm the cause of death and authorises burial or cremation, without having to refer the death to the coroner.

The Nurses and Midwifery Council (2008)(NMC), governing nursing practice in the UK, state that a nurse cannot certify death as it is required by law to be carried out by a registered medical practitioner. In the event of death, a registered nurse may confirm or verify death has occurred, providing there is an explicit local protocol in place to allow such an action, which includes guidance on when other authorities, e.g. the police or the coroner, should be informed prior to removal of the body (Nursing and Midwifery Council, 2008). The Code governing nursing contains the professional standards of practice for nurses (NMC, 2015). It states that nurses must practice in line with best available evidence, act in the best interest of people, recognise and work within the limits of competence, and uphold position as a registered nurse. Similar to the NMBI in Ireland, nurses undertaking specific roles and responsibilities must only do so providing they have received appropriate education and training, and have been assessed as competent in accordance with the NMC code. The Royal College of Nursing (2013) have provided guidance for registered nurses to verify death, notify relatives, arrange last offices and arrange for the removal of the deceased to the mortuary. The RCN defines verification as deciding whether a person is actually deceased (RCN, 2013).

There are opinions and review articles published relating to verification of death by nurses which refer to the development and implementation of protocols and policies for verification of expected death by nurses into trusts and practices in the UK (Ayris, 2002; Phair, 2002; Dimond, 2004; Horner, 2005; Vaughan, 2007; McGeehan, 2007; Walton, 2009). Byron & Hoskins (2013) undertook a qualitative study of district nurses on their experiences of implementing a VEDRN policy in clinical practice in Scotland. Individual interviews were carried out with a purposeful sample of community nurses (12 participants) seeking their views on the VEDRN policy. According to these nurses, implementation was not difficult if the nurse knew the patient and their family well. This made end-of-life discussions easier because of the therapeutic relationship between the nurse and the patient. Although nurses were sometimes anxious about discussing death, their professional responsibility to the patient and relatives took precedence over any personal feelings (Byron and Hoskins, 2013). Wakefield and Osborne (2013) completed an audit cycle on verification of death in East Sussex NHS. Their aim was to audit the compliance around verification of death against the Code of Practice for the Diagnosis and Confirmation of Death published by the Academy of Medical Royal Colleges in the UK. A poster presentation demonstrated the results of an audit cycle within a hospital trust with an initial compliance of 20%. After the deficiencies were identified a plan of changed was implemented with re-audit result s demonstrating a compliance of 94%.

*Australia*

The Australian government published a guidance (DoH, 2010a) and supporting document (DoH, 2010b) for nurses and paramedical staff for the verification of death. Although there is no legal restriction on the verification of death by nurses in Australia, current practice is to await the completion of the medical certificate of the cause of death by the attending medical practitioner before the remains is moved from the place of death to a more appropriate location. General and Psychiatric nurses are permitted to verify death as they are deemed to have undertaken relevant training. A suite of clinical judgment determinants act as a minimum guideline for the clinical assessment necessary to establish that death has occurred ('verify death').

*Canada*

Different legislation covers the hospital, nursing homes and death in the community (CARNA, 2011). Expected deaths are more common in a private home or nursing homes. CARNA identified the need for a policy to give direction and guidance for regulated members such as those practising as palliative or home care nurses. Where a policy exists registered nurses can pronounce death. The certification of death must be signed and completed by a physician within 48 hours. The policy should include:

1. the needs of the client
2. context of care
3. service delivery model
4. knowledge and competency of the health care professional
5. availability of health professionals in the healthcare setting.

Assessment of the clinical situation may indicate that it would be reasonable for a regulated member to do this in a specific practice setting when there is an expected death.

### 2.4. Recommendations

The National Project Working Group reviewed the results from the literature review in relation to pronouncement of death by registered nurses in the Irish context. The evidence supported the objectives of the project in developing a Policy for PEDRN. Key recommendations from the literature review are:

1. Adopt the terminology of pronouncement of death for the Irish context as one of the key objectives is notification of death to family members so they can prepare to make arrangements for removal to a mortuary and thereafter for burial.
2. Adopt the definitions on an expected death as formulated by the North Somerset Trust for the HSE national policy on the pronouncement of expected death by registered nurses.
3. Adopt the practice used in several jurisdictions that registered nurses should be able to pronounce death after successfully completing an appropriate education programme.
4. Develop a national policy to be implemented and applied with a local supporting policy which articulates local communication arrangements between the doctor, director of nursing and the coroner.

### 2.5. Summary of the evidence from the literature

The terms pronouncement and verification appear to be interpreted as similar in the literature reviewed. Verification appears to be the preferred terminology in the UK. Pronouncement appears to be applied in US law and US and Canadian literature. All documents have a similar statement regarding nurses ability to pronounce a death if there is a written policy in place, jointly developed and approved by medical and nursing staff and specifying under what circumstances the nurse can make a pronouncement of death.

The policies all mention the measurement of vital signs and neurological observation before a clinical judgement is made as to whether a patient / resident is deceased. There was significant reference to the need for training.

## 3. GOVERNANCE AND APPROVAL

### 3.1. Formal Governance Arrangements

The National Advisory Group for Pronouncement of Death by Registered Nurses Project provided formal governance for the project. Ms. Mary Wynne, Director ONMSD is designated chairperson for the group. The National Advisory Group worked to an agreed scope and terms of reference. Roles and responsibilities of advisory group members and the process of meeting were clearly outlined and agreed. The Project Lead reported to the National Advisory Group. The project plan and work of the National Working Group was presented by the Project Lead at all meetings. Refer to Appendix IV for Membership of the National Advisory Group for PERDN Project.

### 3.2. Policy development standards

The Policy was developed within the template of the *HSE National Framework for developing PPPGs* (2016) and adhered to the standards as set out.

### 3.3. Permission from NHS North Somerset Community Partnership

Written permission was sought to adopt contents from the NHS North Somerset Community Partnership (NSCP) *Policy of Verification of Death by Registered Nurses* (2014). Written confirmation of permission was received from Thelma Howell, Director of Operations NSCP, in June 2015.

## 4. COMMUNICATION AND DISSEMINATION

A communication and dissemination plan was developed within the project and endorsed by the National Advisory Group.

### 4.1. Communication and dissemination plans

Staff will be made aware of this policy through HSE Directorate communication mechanism, nursing forums and the Office of Nursing and Midwifery Services Directorate (ONMSD) communication process. The Policy will be available on http://www.hse.ie/eng/about/Who/ONMSD/

## 5. IMPLEMENTATION

### 5.1. Implementation

The National Policy for Pronouncement of Death by Registered Nurses will apply to registered nurses working in HSE residential, HSE long-stay and HSE specialist palliative care services only. The adoption of the policy is voluntary, with decisions to implement the policy based on service need and agreement by the doctor, director of nursing and coroner.

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

### 5.2. Education plans required to implement the PEDRN Policy

A standardised CPD blended learning (e-learning) education programme has been developed for registered nurses who will be undertaking the expanded role of pronouncement of expected death in specific circumstances, within their scope of practice and within the law.

Nurses are responsible for undergoing a continuing professional development (CPD) process, in order to achieve competence to deliver safe, effective care in the pronouncement of expected death. The Blended Learning Continuing Professional Development Education Programme for PEDRN is designed to respond to the CPD requirements. Before a nurse carries out this clinical procedure he/she must undertake an approved e-learning programme, supervised practice and competency assessment session(s) and be deemed competent by an approved assessor.

### 5.3. Specific roles and responsibilities.

All HSE-employed staff are responsible for adhering to the National Policy for Pronouncement of Expected Death by Registered Nurses.

#### 5.3.1. HSE senior management: Corporate and CHO area

HSE senior management is responsible for:

- Ensuring that employees are aware of the National Policy for Pronouncement of Expected 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 an expected death safely.

### 5.3.2. Director of Nursing/Person in Charge

The Director of Nursing/Person in Charge is responsible for:

- Developing a local policy for pronouncement of expected 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 Continuing Professional Development Programme for PEDRN.
- Ensuring that any statutory requirements for reporting have been implemented.
- Assisting with risk assessment where complex decisions are required.
- Ensure a communication process is in place to inform the local coroner of nurses in the service who are deemed competent at pronouncement of expected death according to local and national policy.
- 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.

### 5.3.3. Clinical nurse manager

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, i.e. during their induction and/or probation period.
- Ensuring that the relevant CPD assessment completed by each nurse is recorded.
- Satisfying him/her 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 his/her 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 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

### 5.3.4. Nurse

It is the responsibility of each nurse 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 by undertaking the Continuing Competence Self-Assessment Programme every two years.
- Make himself/herself aware of the content and ramifications of the Policy during their induction, if they have been recently appointed.
- Accept accountability for his/her practice, and acknowledge any limitations in his/her practice, and consequently seek the necessary support to develop his/her practice in consultation with his/her manager.
- Develop safe nursing practice and therefore support the implementation of, and adherence to, this policy within his/her clinical practice environment.
- Raise any concerns regarding the implementation of the Policy with his/her clinical nurse manager in a timely manner.
- Follow the procedure for pronouncement of expected death on a case-by-case basis. Each case is considered in consultation with the nurse manager and doctor and those important to the dying person.

### 5.3.5. Administrative officers (or designated responsible person)

Administrative officers are responsible for:

- Ensuring that each nurse supplies a certificate of competence following successful completion the HSELand e-learning module, Blended Learning Continuing Professional Development Programme for PEDRN.
- 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 his/her refresher session is due.

### 5.3.6. Doctor

The doctor is responsible for:

- Agreeing to the procedure of Pronouncement of Expected Death by a Registered Nurse for a specific named dying person. The agreement identifies that this contact must be with the certifying doctor who signed the PEDRN advance agreement, and may not be with a locum or out-of-hours doctor. If the certifying doctor is expected to be unavailable during the period when death is anticipated, arrangements must be made at local level for an advance agreement to be completed and signed by another doctor.
- Contributing to the development of a local policy.

Applying the Guidance for Doctors (Appendix VI) as per the Policy

## 6. MONITORING, AUDIT AND EVALUATION

According to the Nursing and Midwifery Board of Ireland's (NMBI) Code of Professional Conduct and Ethics "Patients have a right to receive quality care by competent nurses and midwives who practise in a safe environment" (NMBI, 2014, p.20). All nurses who pronounce 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).

Each service area/organisation which implements the Policy must ensure robust governance and accountability processes for monitoring and evaluation are established.

### 6.1. Audit

As per Section 6.0 of this policy, the Director of Nursing / Person in Charge is responsible for the development of local policy for the pronouncement of expected death by registered nurses in which the governance structures and procedures to enable, support and monitor safe practice within their area of remit are identified.

**Aim:**

The aim of the audit is to:

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

**Frequency:**

Audit must be completed for **all** expected deaths pronounced by Registered Nurses and be undertaken six monthly within the organisation.

**Data Source(s)**

- National policy for pronouncement of death by registered nurses
- Patient/Client records
- Local policy for 'Pronouncement of expected death by registered nurses'
- Record of Supervised Practice Competence Assessment Record
- Local register of nurses who have successfully completed the requisite e-learning programme and competence assessment within past 2 years.
- Complaint reports.
- Adverse Incident reports.
- Evidence that the Algorithm: Procedure for Pronouncement of Death by Registered Nurse chart is located in key clinical areas. Sample Clinical Audit Tool attached (see Appendix VIII).

### 6.2. Monitor

Monitor this policy using the Clinical Audit Tool (sample audit tool Appendix VIII) under the following indicators:

- **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 protocol and flow chart relating to pronouncement of death by registered nurse is available in all clinical areas (where applicable).
- **Indicator 6:** Existing structures for reporting adverse incidents are used for pronouncement of death by registered nurse when appropriate. Evidence of any adverse incidents are recorded on the clinical audit protocol.
- **Indicator 7:** The protocol for pronouncement of death by registered nurse is reviewed every two years.
-

### 6.3. 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 PEDRN Policy is undertaken every two years.

## 7. REVISION/UPDATE

### 7.1. Procedure for the update of the PEDRN Policy

The National Policy for PEDRN will be due for revision three years from publication. The procedure for update will be aligned to the HSE PPPG Policy (2016).

### 7.2. Method for amending PEDRN 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.

## 8. REFERENCES AND BIBLIOGRAPHY

### REFERENCES


An Bord Altranais (2002) *Recording Clinical Practice Guidance to Nurses and Midwives*. An Bord Altranais.

Ayris, W.W. (2002) Verification of expected death by district nurses. *British Journal of Community Nursing*, 7(7):370-373.

British Medical Association (2009) *Confirmation and Certification of Death: Guidance for GPs in England & Wales.* London: BMA General Practitioners Committee.

Butler M. (2013) Policy on death verification and the nurse - Raheen CNU, Scarriff, County Clare (unpublished).

Byron S, Hoskins, R. (2013) Implementing the 'verification of expected death' policy in clinical practice. *British Journal of Community Nursing,* 18(10):505-511.

*Civil Registration Act 2004* Available at: http://www.irishstatutebook.ie/eli/2004/act/3/enacted/en/pdf (Accessed: 15 April 2015)

College & Association of Registered Nurses of Alberta (2011) *Pronouncement of Death: Guidelines for Regulated Members:* Alberta, Canada: College & Association of Registered Nurses of Alberta (CARNA).

College of Registered Psychiatric Nurses of BC (2014) *Limits and Conditions on RPN Practice: Pronouncement of Death.* College of Registered Psychiatric Nurses of BC https://www.crpnbc.ca/wp-content/uploads/2014/04/SLC-pronouncement-of-death.pdf (Accessed 12 November 2016).

*Coroners Act,* 1962 Irish Statute Book. Available at www.irishstatutebook.ie/eli/1962/act/9/enacted/en/html (Accessed: 15 April 2015)

Coroner Service (2015) *Deaths which must be reported to the Coroner.* Available at: http://www.coroners.ie/en/CS/Pages/Deaths+Which+must+be+Reported+to+the+Coroner. (Accessed: 15 April 2015)

Department of Health and Children (2001) *Report of the National Advisory Committee on Palliative Care 2001*. Dublin. Department of Health and Children.

Department of Health (Australia) (2010a). *Guidance note for the 'Verification of Death':* Victoria, Australia: Department of Health. http://www.health.vic.gov.au/__data/assets/pdf_file/0006/356667/Feb-2011-Guidance-Note-for-the-Verification-of-Death.pdf (Accessed 10 May 2015).

Department of Health (Australia) (2010b). *Frequently Asked Questions (FAQs): Guidance note for the 'Verification of Death':* Victoria, Australia: Department of Health. http://www.health.vic.gov.au/__data/assets/pdf_file/0007/356668/Frequently-Asked-Questions-Verification-of-Death-Feb-2010.pdf (Accessed 10 May 2015).

Department of Health (UK) (2016) *Guidance: An overview of the death certification reforms* London, UK: Department of Health. https://www.gov.uk/government/publications/changes-to-the-death-certification-process/an-overview-of-the-death-certification-reforms (Accessed December 2016).

Department of Justice, Equality and Law Reform (2004) *Review of the Coroner Service: Report on the Working Group.* Dublin: Department of Justice, Equality and Law Reform.

Dimond, B. (2004) Legal aspects of death. The law and the certification, verification and registration of death.*British Journal of Nursing*13 (8): 480-1.

Dyer C. (2004) New coroner's system will require two people to verify cause of death. B*MJ - international edition*: 328:727.

Gardiner D, Shemie S., Manara A., Opdam, H. (2012) International perspectives on the diagnosis of death. *British Journal of Anaesthesia:*108:14-28.

*Health Act 2007* (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2010 S.I. No. 36/2010 . Available at www.irishstatutebook.ie/2007/en/act/pub/0023/ (Accessed: 15 April 2015)

Health Information and Quality Authority (2009) *National Quality Standards for Residential Care Settings for Older People in Ireland* 2009. Health Information and Quality Authority. Available at: http://www.hiqa.ie/system/files/HIQA_Residential_Care_Standards_2008.pdf. (Accessed: 15 April 2015)

Health Information and Quality Authority (2012a) *General Guidance on the National Standards for Safer Better Healthcare 2012*: Ireland: Health Information and Quality Authority. Available at: www.hiqa.ie/system/.../Safer-Better-Healthcare-General-Guidance_0.pdf (Accessed: 15 April 2015)

Health Information and Quality Authority (2012b) *National Standards for Safer Better Healthcare 2012.* Ireland. Health Information and Quality Authority. Available at http://www.hiqa.ie/system/files/Safer-Better-Healthcare-Standards.pdf (Accessed: 15 April 2015)

Health Information and Quality Authority (2013) *National Standards for Residential Services for Children and Adults with Disabilities 2013*. Health Information and Quality Authority. Available at: http://www.hiqa.ie/system/files/Standards-Disabilities-Children-Adults-Plain-English.pdf. (Accessed: 15 April 2015)

HSE (2011) *Health Service Executive Standards and Recommended Practices for Healthcare Records Management 2011.* Health Service Executive. Available at: http://www.hse.ie/eng/about/Who/qualityand patientsafety/resourcesintelligence/Quality_and_Patient_Safety_Documents/v3.pdf. (Accessed: 15 April 2015)

HSE (2014) *National Consent Policy 2014:* National Consent Advisory Group, Health Service Executive. Available at: http://www.hse.ie/eng/about/Who/qualityandpatientsafety/National_Consent_Policy/National%20Consent%20PolicyMay14.pdf. (Accessed: 15 April 2015)

HSE (2016) *HSE Procedure for developing Policies, Procedures, Protocols and Guidelines 2016*. Health Service Executive

Home Office (2004) *Reforming the Coroner and Death Certification Service - A Position Paper.* London: Home Office, Norwick, UK: Stationery Office, 2004.

Horner, J. and Clennell, J. (2005) Nurse verification of expected death. *Cancer Nursing Practice* 4 (4): 29-33.

Irish Hospice Foundation (2010) *Quality standards for end-of-life care in hospitals: Making end-of-life care central to hospital care*: 2010. Irish Hospice Foundation. Available at: http://hospicefoundation.ie/wp-content/uploads/2013/04/Quality_Standards_for_End_of_Life_Care_in_Hospitals.pdf. (Accessed: 15 April 2015)

*Medical Practitioners Act,* 2007. Available at: http://www.irishstatutebook.ie/eli/2007/act/25/enacted/en/html (Accessed: 15 April 2015)

McGeehan, R. (2007) Verification of expected death. *Nursing standard* 22(11):35-6

McGinn, P. (2013) Verifying a death. *World of Irish Nursing & Midwifery* 13 (11): 49.

McTiernan E. (2013) *Verification of death by registered nurses in St. Joseph's Care Centre, Longford.* Longford: HSE-DoN PPPG development Team /Working Group.

New South Wales Government (2015) *Policy Directive: Death – Verification of Death and Medical Certificate of Cause of Death.* Sydney, Australia: NSW Government.

NHS Southern Health and Social Care Trust (2009) *Procedure for verification of death by a registered nurse.* UK, National Health Service. Southern Health and Social Care Trust.

NHS North Somerset Community Partnership (2014) *Verification of death by Registered Nurses*. UK National Health Service North Somerset Community Partnership.

NHS (2011) *Guidance for staff responsible for care after death.* London: NHS/National End of Life Care Programme/RCN/Royal College of Pathologists/National Nurse Consultant Group (Palliative Care).

NHS East Sussex Healthcare (2012) *Verification of Expected Death by Registered Nurses Policy (Adult Services Only)*. UK, National Health Service East Sussex Healthcare Trust.

NHS East Cheshire Trust (2016) *Policy for Verification of Expected Death by a Registered Nurse Working Within the Community Setting (Community Nursing Service or Nursing Homes),* Version 3. UK National Health Service East Cheshire NHS Trust.

Nurses Association of New Brunswick (2014) *Position statement: Registered Nurses Pronouncing Death (revised).* Nurses Association of New Brunswick, Canada.

*Nurses and Midwives Act,* 2011. Dublin: Irish Statute Book. http://www.irishstatutebook.ie /eli/2011/act/41/enacted/en/html (accessed 10 May 2015)

Nursing and Midwifery Board of Ireland (2014) *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives 2014*. Nursing and Midwifery Board of Ireland.

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

Nursing and Midwifery Council (2008) *Confirmation of Death by Registered Nurses*.

London: *Nursing and Midwifery Council.* [Online] Available from: http://www.nmc-uk.org/Nurses-and-midwives/Advice-by topic/A/Advice/Confirmation of-death-for-registered-nurses/ (accessed 10 May 2015)

Nursing and Midwifery Council (2015) *The Code: Professional standards of practice and behaviour for nurses and midwives.* London, UK: Nursing & Midwifery Council.

Palliative Care Competence Framework Steering Group (2014) *Palliative Care Competence Framework 2014.* Palliative Care Competence Framework Steering Group, Health service Executive. Available at: http://www.hse.ie/eng/about/Who/clinical/natclinprog/palliativecareprogramme/Resources/competencyframework.pdf (Accessed: 15 April 2015)

Phair, L. (2002) Death duties a responsibility too far? *Nursing Older People, 1*4(5): 32-34.

Royal College of Nursing (2013) *Confirmation and verification of death by a registered nurse.* London, UK: RCN.

*The Shipman Inquiry: independent inquiry into the issues arising from the case of Harold Fredrick Shipman* (2003) http://www.shipman-inquiry.org.uk/ (accessed 10 May 2015).

Vaughan, C. (2007) Verification of expected death: the role of the nurse. *Nursing Residential Care*, 9(5): 216-217.

Wakefield D. and Osborne, G. (2013) *Verifying death, implementing a successful change in practice; a complete audit cycle.* Poster presentation, Young Doctor Awards.

Walton W.J. (2009) Verification of death by nurses in community care settings. *End-of-life care Journal.* 3(2):16-21.

WHO (2015) *WHO Definition of Palliative Care*, http://www.who.int/cancer/palliative/definition/en/ (Accessed 15 April 2015)

## BIBLIOGRAPHY


Banks G. (2000) Verifying a death. *Nursing Standard*. 14(33):22.

Betz M.E., Kelly S.P. and Fisher J. (2008) 'Death Certificate Inaccuracy and Underreporting of Injury in Elderly People' J*ournal of the American Geriatrics Society.* 56(12): 2267-2272.

Griffith R. (2004) An introduction to the law of death and the body as property. *British Journal of Community Nursing* 9 (12): 535-9.

Hughes, M.E. (2013) Decriminalising an Expected Death in the Home: A Social Work Response. *British Journal of Social Work.* doi: 10.1093/bjsw/bct016.

Johnson, M., Attree, M., Jones, I. AlGamal, E. and Garbutt, D. (2014) 'Diagnosis, prognosis and awareness of dying in nursing homes: towards the Gold Standard?' *International Journal of Older People Nursing.* 9(2):95-105. DOI:10.1111/opn.12024

Partridge J. (2008) 'Why are nursing home residents sent in to hospital to die?' *Postgraduate Medical Journal. 84 (99*2): 281.

Potts, K. (2016) Verification of death: what nurses need to know. *Nursing and Residential Care*, 18(3): 158-160.

Smith-Stoner, M. and Hand, M.W. (2012) 'Expanding the Concept of Patient Care: Analysis of Postmortem Policies In California Hospitals . *MEDSURG Nursing*. 21 (6): 360-6.

VWS (1993) *Wet op de beroepen in de individuele gezondheidszorg.* Den Haag/The Hague, Ministry of Health, NL.

Young R. (2010) 'Nurses may verify death at home in most cases... Should nurses be given powers to certify death?' *Nursing Standard*. 25 (1): 33.

## 9. APPENDICES

**Appendix I:**

**Signature Sheet**

*I have read, understand and agree to adhere to this Policy for Pronouncement of Expected Death by Registered Nurses:*

| Print Name | Signature | Area of Work | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Appendix II:

| Name | Title | Organisation | Representing |
|---|---|---|---|
| Dr Lucy Balding | Consultant in Palliative Medicine, Our Lady's Hospice & Care Services and St James's Hospital and DML regional lead for the NCPPC | Royal College of Physicians of Ireland and HSE Clinical Strategy and Programmes Division | Royal College of Physicians of Ireland and HSE Clinical Strategy and Programmes Division |
| Ms Marissa Butler | Director of Nursing | Raheen Community Hospital, Scarriff, Co Clare | Raheen Community Hospital, Scarriff, Co Clare |
| Ms Catherine Cannon | Director, Centre of Nursing and Midwifery Education | HSE Centre of Nursing and Midwifery Education North West | Directors, Centre of Nursing and Midwifery Education |
| Dr. Brendan O'Shea* | Director Postgraduate Resource Centre ICGP | Irish College of General Practitioners | General practitioners |
| Ms Eilis Carroll | Director of Services | Presentation Sisters, North East Province, Shalom Nursing Home Kilcock, Co Kildare | Irish Association of Directors of Nursing and Midwifery |
| Ms Vanessa Clarke | Project Officer | Nursing and Midwifery Planning and Development Unit | HSE NMPD |
| Dr David Hanlon** | General practitioner | National Clinical Strategy and Programmes Division | HSE Primary Care |
| Dr Marian Hanrahan-Cahuzak | Director of Nursing | St Anne's Community Nursing Unit, Clifden, Co Galway | National Nurse Practice Development Forum |
| Ms Emma Willcock*** | Practice Development Nurse/ Acting Assistant Director of Nursing | Marymount University Hospital and Hospice, Curraheen, Cork | National Nurse Practice Development Forum |
| Mr John Kelly | HSE Solicitor | HSE Legal Department | HSE Legal Department |
| Ms Anne Lynott | Director of Public Health Nursing/ Chair of the National Director of Public Health Nursing Forum | PHN Department Dublin West, Cherry Orchard, Ballyfermot, Dublin 10 | National Director of Public Health Nursing Forum |
| Ms Mary Manning | Director Nursing and Midwifery Planning and Development (NMPD) | HSE, Unit 4, Central Business Park, Clonminch, Tullamore, Co Offaly | National Directors, Nursing and Midwifery Planning and Development |
| Ms Deirdre Mulligan | Project Lead/Interim Director NMPD | Nursing and Midwifery Planning and Development (NMPD) | Project Lead ONMSD |
| Ms Bernie O'Sullivan | Director of Nursing | Cope Foundation, Cork | Irish Association of Directors of Nursing and Midwifery |
| Ms Margaret Codd **** | ONMSD Nursing Lead | Nursing Lead for National Clinical Programme for Palliative Care HSE ONMSD | HSE Office of Nursing and Midwifery Services Director |
| Ms Melissa Redmond | Patient Safety Champion | Patients for Patient Safety Ireland | Patient Advocate |
| Ms Sinéad Morrissey ***** | Practice Development Facilitator | Nursing Homes Ireland, Unit A5, Centre Point Business Park, Oak Road, Dublin 12 | Nursing Homes Ireland |
| Ms Geraldine Walsh | A/Director Of Nursing, Bellvilla Community Unit | Bellvilla Community Unit | HSE Social Care Division |
| Ms Mary Wynne**** | Area Director, Nursing and Midwifery Planning and Development | Area Director, Nursing and Midwifery Planning and Development, Stewarts Hospital, Dublin | ONMSD |

**Membership of the National Working Group**

* The ICGP was not in a position to nominate a representative to the National Working Group. The ICGP Quality in Practice Committee are gratefully acknowledged for consideration of versions of the Policy. Dr. B. O'Shea reviewed the final Policy.
** Dr David Hanlon invited to join the Project Groups in August 2015, representing HSE Primary Care,
*** Ms Emma Wilcock replaced Ms Kathryn Hanly in October 2015
****Ms Margaret Codd replaced Ms Lorna Peel- Kilroe replaced by in November 2015
*****Sinéad Morrissey replaced Gaynor Rhead in June 2015 for Nursing Homes Ireland.
*****Ms Mary Wynne replaced Dr Michael Shannon as project commissioner and Chairperson of the Advisory Group in September 2015.

**Appendix III: Conflict of Interest Declaration Form**

**CONFLICT OF INTEREST DECLARATION**

**National Policy for the Pronouncement of Expected Death by Registered Nurses**

**2 [For use in HSE residential, HSE long-stay and HSE specialist palliative care services only]**

**Please circle the statement that relates to you**

**1. I declare that I DO NOT have any conflicts of interest.**

**2. I declare that I DO have a conflict of interest.**

**Details of conflict (Please refer to specific PPPG)**

_____

_____

_____

_____

_____

_____

**(Append additional pages to this statement if required)**

**Signature** _____

**Printed name** _____

**Registration number (if applicable)** _____

**Date** _____

The information provided will be processed in accordance with data protection principles as set out in the Data Protection Act. Data will be processed only to ensure that committee members act in the best interests of the committee. The information provided will not be used for any other purpose.

A person who is covered by this Policy is required to furnish a statement, in writing, of:

(i) The interests of the person, and

(ii) The interests, of which the person has actual knowledge, of his or her spouse or civil partner or a child of the person or of his or her spouse which could materially influence the person in, or in relation to, the performance of the person's official functions by reason of the fact that such performance could so affect those interests as to confer on, or withhold from, the person, or the spouse or civil partner or child, a substantial benefit.

## Appendix IV: Membership of the National Advisory Group

| Name | Title | Organisation | Representing |
|---|---|---|---|
| Ms Mary Wynne* | Chairperson/Director of Office of Nursing and Midwifery Services | HSE | Nursing and midwifery |
| Ms Eilis Carroll | Director of Services | Presentation Sisters, North East Province, Shalom Nursing Home Kilcock, Co Kildare | Irish Association of Directors of Nursing and Midwifery |
| Ms Suzanne Dempsey | Group Director of Nursing for Children's Nursing | Irish Association of Directors of Nursing and Midwifery | Irish Association of Directors of Nursing and Midwifery |
| Dr Lucy Balding | Consultant in Palliative Medicine, Our Lady's Hospice & Care Services and St James's Hospital and DML regional lead for the NCPPC | Royal College of Physicians of Ireland and HSE Clinical Strategy and Programmes Division | Royal College of Physicians of Ireland and HSE Clinical Strategy and Programmes Division |
| Dr David Hanlon** | General Practitioner | National Clinical Strategy and Programmes Division | HSE Primary Care |
| Dr Phillipa Ryan Withero | Deputy Chief Nurse | Department of Health | Office of Chief Nurse DoH |
| Dr Maura Pidgeon | CEO | Nursing and Midwifery Board of Ireland | NMBI |
| Dr Myra Cullinane | President of the Coroners Society of Ireland | Coroners Society of Ireland | Coroners Society of Ireland |
| Ms Sarah Murphy | Think Ahead Project Manager, Research and Development, Forum on End of Life in Ireland | Irish Hospice Foundation, National Forum on End of Life | National Forum on End of Life |
| Dr. Brendan O'Shea*** | Director Postgraduate Resource Centre ICGP | Irish College of General Practitioners | General practitioners |
| Mr Barry O'Sullivan | Deputy Director and Registrar, PHECC | Pre-Hospital Emergency care Council (PHECC) | Pre-Hospital Emergency care Council (PHECC) |
| Ms Geraldine Walsh | Director of Nursing, Bellvilla/ Mount Carmel Hospital | HSE Social Care Division | HSE Social Care Division |
| Mr John Kelly | HSE Solicitor | HSE Legal Department | HSE Legal Department |
| Mr Michael Crowley | President of the Irish Association of Funeral Directors | Crowley Funeral Directors | Irish Association of Funeral Directors |
| Ms Deirdre Mulligan | Project Lead/Interim Director NMPD | Nursing and Midwifery Planning and Development (NMPD) | Project Lead |

*Ms Mary Wynne replaced Dr Michael Shannon September 2015
** Dr David Hanlon invited to join the Project Groups in August 2015, representing HSE Primary Care
*** The ICGP was not in a position to nominate a representative to the National Advisory Group. The ICGP Quality in Practice Committee are gratefully acknowledged for consideration of versions of the Policy. Dr. B. O'Shea reviewed the final Policy.

## Appendix V: DEATHS WHICH MUST BE REPORTED TO THE CORONER

Sudden, unnatural, violent or unexplained deaths have to be reported to the Coroner. Doctors, funeral undertakers, the Register of Deaths, any householder and every person in charge of an institution or premises where the person who died was residing at the time of death have to inform the Coroner. Deaths are reported to the Coroner under the Coroners Act, 1962 (rules of law); in addition, there are local rules which require that other deaths must be reported (rules of practice).

1. Sudden, unexpected or unexplained deaths.
2. Where the appropriate registered doctor cannot sign a medical certificate of the cause of death (i.e. a deceased person was not seen and treated within one month before death, or the cause of death is unknown or death may be due to an unnatural cause).
3. Even where the deceased had been attended by a registered doctor for a documented illness, if the doctor is not satisfied in relation to the cause of death or death has occurred suddenly or unexpectedly, it must be reported.
4. Sudden infant death. Although the doctor may believe that an infant has died of sudden infant death syndrome (SIDS "cot death"), such diagnosis can only be made following a post-mortem examination: this applies also to so-called "sudden adult death syndrome" (SADS).
5. Where a death was directly or indirectly due to unnatural causes (regardless of the length of time between injury and death), including:
    - o Road traffic crash or collision;
    - o Any accident in the home, workplace or elsewhere;
    - o Any physical injury;
    - o Falls and fractures;
    - o Fractures in the elderly;
    - o Drug overdose or drug abuse;
    - o Neglect, including self-neglect;
    - o Burns or carbon monoxide poisoning;
    - o Starvation (including anorexia nervosa);
    - o Exposure and hypothermia;
    - o Poisoning from any cause – occupational, therapeutic, accidental, suicidal, homicidal and also food poisoning;
    - o Drowning;
    - o Hanging;
    - o Firearms injuries
6. Death resulting from an industrial or occupational disease or accident.
7. Deaths which are directly or indirectly the result of any surgical or medical treatment or any procedure. Where such treatment or procedure may have contributed in any way to death, the matter must be reported to the Coroner regardless of the time that has elapsed between the event and death. Any allergic reaction to a drug administered therapeutically, and any toxic reaction or side-effect of a drug which may have caused or contributed to a death must be reported.
8. Where there is any allegation of medical negligence, misconduct or malpractice on the part of any registered doctor, nurse or other person.
9. Septicaemia, which may be caused by injury.

10. Death occurring during a surgical operation or anaesthesia.
11. Abortions (other than natural) and certain stillbirths.
12. Acute alcohol poisoning (chronic alcoholism is reportable, but a medical certificate of the cause of death will normally be accepted, unless there is some element of neglect [including self-neglect] or injury).
13. Deaths connected with crime or suspected crime.
14. Where death may be due to homicide or occurred in suspicious circumstances.
15. Death of a person in prison or legal custody, including deaths in hospital while sentence is being served, and deaths in Garda stations.
16. Death of a patient in a mental hospital.
17. Death of a child in care or detention.
18. A death which may be due to CJD.
19. Where a person is found dead.
20. Where human remains are found.
21. Where the cause of death is unknown or obscure.
22. Where a body is to be removed from the state.
23. Where a person is brought in dead (BID), DOA (dead on arrival) to the Accident and Emergency department of a hospital.
24. Deaths occurring in an Accident and Emergency department.
25. Where death occurs within 24 hours of admission to hospital.
26. Where death occurs within 24 hours of the administration of an anaesthetic, surgical procedure or any procedure. (Note: where death may be due to a complication of an anaesthetic, surgical procedure, drug reaction or injury, it must be reported to the Coroner, notwithstanding when death occurs, i.e. whether days, weeks, months or years after the event).
27. Certain deaths which occur in a department of a hospital, e.g. radiology department, outpatients, physiotherapy, ECG, EEG, etc.
28. Maternal deaths.
29. Where a patient dies in hospital, having been recently transferred or discharged from a nursing home or other residential institution (including mental hospital or prison).
30. Where there is any doubt as to the cause of death.
31. A death in any public or private institution for the care of elderly or infirm persons.
32. Any death involving a healthcare-associated infection.

Adapted and available from:

http://www.coroners.ie/en/CS/Pages/Deaths+Which+must+be+Reported+to+the+Coroner

## APPENDIX VI : GUIDANCE FOR DOCTORS

### Legislation

Under Irish legislation, a doctor's certification duty is limited to certification of the cause of death "to the best of [the doctor's] knowledge and belief". Thus, legislation presents no obstacle to plans to enable another person, such as a registered nurse, to pronounce (as distinct from certifying) death in certain circumstances for the purposes of notifying family members of the death, and allowing release of the body to the care of a funeral director.

**Ensuring death occurred as expected:** A doctor who attended the deceased during his/her last illness has a statutory duty to ascertain and record the cause of death. The primary medico-legal concern must obviously be to prevent any case arising where, due to pronouncement of death under this policy, a body is subsequently interfered with, buried, or destroyed, before a doctor was afforded adequate opportunity to decide whether a body should be viewed or medically examined before he/she determines and certifies the cause of death, or indeed before it can be determined whether the death ought to be the subject of a coronial enquiry.

With this in mind, four prerequisites are central to this procedure and the Policy has been written with these considerations as core. Namely that:

(1) The dying person was seen by a doctor 14 calendar days prior to death[3];

(2) The doctor 'confirmed' that death was to be expected;

(3) The death actually occurred as expected; and

(4) The nurse has first obtained the approval of the certifying doctor to removal of the body to the care of the funeral director without medical examination.

### Exclusion criteria

Pronouncement of death by a nurse may not be undertaken when the following exclusion criteria apply:

1. 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 (see Appendix 1).
2. Any death where cremation is planned.
3. Any death where the remains are being donated to medical science/organ donation.
4. Where the death is not an "expected death" as defined in the Policy, or, more generally, where death did not occur as expected (for example, if a dying person's death is caused by an unforeseen or unexpected incident).

---

[3] Based on evidence explored in the development of the policy, and following expert consultation, 14 days is identified for the purpose of the policy. It is noted that under Irish legislation a Death Certificate of Cause of Death may be issued if the deceased has been seen and treated by a registered medical practitioner up to 28 days before the death.

5. Any death of persons under 18 years of age.
6. Deaths occurring in a person's home where specialist palliative care community services are NOT involved.
7. The preference of those important to the dying person is for a medical doctor to pronounce death.
8. The nurse has NOT completed the Blended Learning Continuous Professional Development Programme for Pronouncement of Expected Death by Registered Nurses and cannot demonstrate competence.
9. The advance agreement section of the Pronouncement of Expected Death Form has not been completed and signed, or there has been deviation from any part of the PEDRN procedure as outlined in this policy.

**Procedure**

The procedure of pronouncement of death by a nurse is a collaborative process between the nurse and the attending doctor.

The implementation of the procedure is determined on a case-by-case basis, and is dependent on the specific circumstances of each dying person.

**Prior to the death of the dying person, the doctor must:**

1. Agree to the Pronouncement of Expected Death by Registered Nurses procedure, for a specific named dying person. In doing so, the doctor must be in agreement with all the procedures outlined below, and his/her responsibilities inherent therein.
2. Determine that the dying person's death is expected, have certainty as to the cause of this expected death, and be prepared to certify death.
3. Examine the dying person and be satisfied that the dying person's death is imminent (i.e. within the next 14 days).
4. Discuss end-of-life care with the dying person and/or those important to them.
5. Record the above in the dying person's medical notes, with reference to the view that no further active interventions are required to be undertaken to attempt to prolong life. A DNAR decision must be recorded in the healthcare record.
6. Ensure that, for this dying person, all the inclusion criteria for the Pronouncement of Death by Registered Nurses procedure are met, as laid out in this policy.
7. Complete the 'Advance Agreement' Section of the Pronouncement of Death by Registered Nurse Form (Appendix VII). In doing so, providing that the nurse strictly adheres to the PEDRN policy and procedures, the doctor agrees to:
    a. Be notified by direct telephone (or face-to-face) contact upon the person's death. If the doctor is not satisfied that death actually occurred as expected, or if he/she wishes to examine the body for any reason, he/she should take the opportunity to do so.
    b. Give permission, following the above contact and if satisfied that the death occurred as expected, for the PEDRN procedure to proceed. The remains may be removed to the care of the funeral director without medical examination of the body
    c. Complete the Death Notification Form in a timely manner.

**Following the death of the dying person:**

1. The doctor is contacted by telephone (or face to face) by the nurse to notify him/her that death occurred.
    a. This contact must be with the certifying doctor who signed the advance agreement, and may not be with a locum or out-of-hours doctor. If the certifying doctor is expected to be unavailable during the period when death is anticipated, arrangements must be made at local level for an advance agreement to be completed and signed by another doctor.
    b. If death occurred out of hours, this contact may be made the following morning; arrangements must be made at local level.
    c. This contact MUST occur before removal of the body to the care of a funeral director. By receiving this notification that the death occurred, the doctor is afforded the opportunity to examine the body, if desired.
2. If the doctor is satisfied that death occurred as expected, he/she will indicate their intent to issue the Death Notification Form. The PEDRN procedure can proceed. The remains may be removed to the care of the funeral director.
3. If the doctor is not satisfied that death actually occurred as expected, or if he/she desires to examine the body for any reason, he/she should take the opportunity to do so. The PEDRN procedure is deemed no longer applicable and the doctor assumes responsibility for pronouncement and certification of death, in the usual manner.
4. The Death Notification Form must be issued in a timely manner. The body should not be embalmed or interred until the certifying doctor has been afforded the opportunity to view the body and confirms that he/she will issue the Death Notification Form, as agreed. The procedure described facilitates this opportunity.

If clinical or other circumstances determine that the PEDRN procedure is no longer applicable, the doctor assumes responsibility for pronouncement of death, in the usual manner.

Local policy must be agreed between the doctor, coroner and care centre/organisation. Specific reference to local arrangements regarding communication will be included in the local policy.

# Appendix VII: PRONOUNCEMENT OF EXPECTED DEATH BY REGISTERED NURSE FORM

**Section 1: Advance Agreement** | **Section 2: Pronouncement of Expected Death by RN**

| Name of Person | DOB |
|---|---|
| Address | |
| Name of Doctor | Unique Health Identifier |

## Section 1a: Advance Agreement

*To be completed by certifying doctor prior to death*

✓ *Tick appropriate box*

| Advance Agreement Criteria | Yes | No |
|---|---|---|
| This person's death is expected, and is thought to be imminent (within the next 14 days). I have recorded this in the person's healthcare record | | |
| No further active interventions are required to attempt to prolong life and a DNAR decision has been made, and documented. | | |
| I have discussed end-of-life care with the dying person and/or those important to them and I have recorded the outcome of that discussion in the healthcare record | | |
| This case meets the inclusion criteria for the PEDRN procedure | | |
| Exclusion Criteria | | |
| **1.** 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 (see Appendix 1). | | |
| **2.** Any death where cremation is planned. | | |
| **3.** Any death where the remains are being donated to medical science/organ donation. | | |
| **4.** Where the death is not an "expected death" as defined in the Policy, or, more generally, where Death did not occur as expected (for example, if a dying person's death is caused by an unforeseen or unexpected incident). | | |
| **5.** Any death of persons under 18 years of age. | | |
| **6.** Deaths occurring in a person's home where specialist palliative care community services are NOT involved. | | |
| **7.** The preference of those important to the dying person is for a medical doctor to pronounce death. | | |
| I am satisfied that a nurse (who has been formally deemed competent) can pronounce death as per PEDRN Policy | | |
| I am prepared to certify death should this death occur as expected. | | |
| Following death, the nurse who pronounced death, the Director of Nursing or the designated Deputy, must notify me that death as occurred, as per Local Policy.<br>• If I am satisfied that death actually did occur as expected, I will complete the Death Notification Form. The PEDRN procedure can proceed. I give permission for the remains to be removed to the care of the funeral director without medical examination.<br>• If I am not satisfied that death actually occurred as expected, or I desire to examine the body for any reason, I will take the opportunity to do so. The PEDRN procedure is deemed no longer applicable and I assume responsibility for pronouncement and certification of death, in the usual manner. | | |

| Doctor Signature | | MRCN |
|---|---|---|
| Doctor's Name (PRINT) | Date | Contact No(s) |

## Section 1b: Pronouncement of Expected Death by Registered Nurse abandoned prior to death.

| Reason PEDRN abandoned | | | |
|---|---|---|---|
| Doctor who signed advance agreement informed | By Whom: Signature<br>Name (PRINT) | Date | Time |

## Section 2: Pronouncement of Expected Death by Registered Nurse Care after Death

*To be completed by nurse following death*

| Date and approximate time of death | Date and time death pronounced | Place of death |
|---|---|---|
| Person was last seen by Doctor | | Date: |

Death occurred as expected Yes ☐ No ☐

Are there any new contraindications for pronouncement of death by a nurse, such as the body being for cremation? Yes ☐ No ☐

If yes, complete Section 2 Decision made to abandon PEDRN after Death:

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

## Clinical observation of absence of life (to be repeated after 10 mins)

| Respiration | ASSESSMENT First | Second |
|---|---|---|
| There are no signs of spontaneous respiration (one minute) (Initials) | | |
| There are no breath sounds (one minute using a stethoscope) (Initials) | | |
| | | |
| Other Clinical Signs of Death | | |

| Cardiac | ASSESSMENT First | Second |
|---|---|---|
| There is no femoral or carotid pulse palpable (one minute) (Initials) | | |
| There are no heart sounds (one minute using a stethoscope) (Initials) | | |
| | | |
| | | |

| Cerebral | ASSESSMENT First | Second |
|---|---|---|
| There is no response to painful stimuli (Initials) | | |
| Pupils are unresponsive to light (Initials) | | |
| Pupils are fixed (Initials) | | |
| | | |

## Absence of life pronounced by Nurse

Nurses Signature | NMBI PIN

Nurses Name (PRINT) | Date | Grade/Position

Doctor who signed the PEDRN Advance Agreement was notified by RN as per policy: Name | Date | Time

Doctor satisfied that death occurred as expected? Yes ☐ No ☐

Doctor requested to view the body? Yes ☐ No ☐

Doctor indicated intent to complete the Death Notification Form Yes ☐ No ☐

Where applicable, coroner notified as per local policy and coronial procedure therein Yes ☐ No ☐

## Decision made to abandon PEDRN after Death (complete if applicable)

By whom: | Identify reason(s):

Doctor who signed advance agreement informed: | RN Signature

Date: Time: | Name (PRINT)

## Notification

| | | | | |
|---|---|---|---|---|
| Those important to the person | Yes ☐ No ☐ | Say whom: By whom: | Date | Time |
| Funeral Director if applicable | Yes ☐ No ☐ | Funeral Director Name: By whom: | Date | Time |
| Pastoral support | Yes ☐ No ☐ | Pastoral Support Name: By whom: | Date | Time |

Carry out any requested specific religious/spiritual/cultural needs Yes ☐ No ☐

Procedures for last offices followed in accordance with relevant policy or discussion with those important to the person Yes ☐ No ☐

Those important to the person given information, if required, on next steps, e.g. (any/all of the following) Yes ☐ No ☐

- Explain mortuary viewing
- Collection of Death Notification Form

Body was moved Date: Time: By:

Necessary written documentation given to the appropriate person, e.g. Yes ☐ No ☐

- What happens next
- Bereavement support
- Other (identify):

## APPENDIX VIII: Sample Clinical Audit Tool - PRONOUNCEMENT OF EXPECTED DEATH BY REGISTERED NURSE

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Audit must be completed for all expected deaths pronounced by a Registered Nurse and be undertaken six monthly within the organisation (Please complete this form in block capitals if not typed).

| | |
|---|---|
| **Name of Organisation/Care Home/Service** | **Period of Audit** (maximum 6 months):<br><br>**Date of Audit:** |
| **Location of audit** (e.g. ward/ unit/room number) | **Audit completed by** (Name and Role) |

| **Protocol** | **Compliance Expected** | **Supporting documentation/ evidence** | **Patient 1 Unique ID** | **Patient 2 Unique ID** | **Patient 3 Unique ID** | **Patient 4 Unique ID** |
|---|---|---|---|---|---|---|
| 1. Discussion regarding burial or cremation has taken place between the person and/or next of kin, and preference regarding burial or cremation is documented in the patient record. | 100% | *Patient record, care plan.* | | | | |
| 2. The Advance Agreement (Section 1 of the PEDRN form) is completed as per protocol within 14 days of expected death and is available within the patient's record. | 100% | *Advance Agreement (Section 1 of PEDRN) of Death Form* | | | | |
| 3. Pronouncement of death by Registered Nurse (Section 2 of PEDRN form) is completed as per protocol and available within the patient's record. | | *Section 2 of Pronouncement of Expected Death by registered nurses Form* | | | | |
| 4. Following death, the doctor who signed the advance agreement was notified by the nurse who pronounced death, Director of Nursing or their deputy, that death had occurred within 24 hours? | 100% | *PEDRN* | | | | |
| 5. Was death as expected? | 100% | | | | | |
| 6. Is the nurse who pronounced death registered with NMBI | 100% | *NMBI register* | | | | |
| 7. Has the nurse who pronounced death successfully completed the requisite e-learning programme and competence assessment and/or completed the continuing competence self-assessment programme within past 2 years. | 100% | *Record of Supervised Practice Competence Assessment Record* | | | | |

## APPENDIX IX: Death Notification Form

Name of Deceased:..... PPS No: ..... Age or Date of Birth: .....
Last Seen on: ..... Died on: ..... Place of Death: .....
Cause of Death: I: (a) .....
(b) .....
(c) .....
II: .....

THIS IS NOT A DEATH CERTIFICATE

### Death Notification Form

To register a death and obtain a Death Certificate it is the duty of the relative (where available and capable) to complete Part 2 of this form (overleaf) and bring it to any Registrar within 3 months of the death. After 3 months any other qualified informant (as defined overleaf) must do so.

**Part 1**

**Medical Certificate of Cause of Death – To be completed by a Registered Medical Practitioner**

**Details of Deceased**

Forename(s): ..... Home Address: .....

Surname: ..... .....

Date of Birth: ☐☐/☐☐/☐☐☐☐ Age: ..... .....
(The Date of Birth should be entered)

Date of Death: ☐☐/☐☐/☐☐☐☐ .....

Place of Death (in full): .....

Last seen alive by me on: ☐☐/☐☐/☐☐☐☐ P.P.S. No.: ☐☐☐☐☐☐☐-☐☐

Whether seen after death by me (Answer "yes" or "no" in all cases) ☐ yes ☐ no

If the deceased was female, was she known to have been pregnant at the time of death, or within the previous 42 days? (Answer "yes" or "no" in all cases) ☐ yes ☐ no

**Medical Cause of Death Details**

- **Please use Block Capitals**

| | | Approximate interval between onset and death |
|---|---|---|
| **I** | | |
| **Disease or Condition directly leading to death** (This does not mean the mode of dying, e.g. heart failure, asthenia etc. It means the disease which caused death.) | (a) .....<br>.....<br>due to (or as consequence of ) | |
| **Antecedent Causes** (morbid conditions if any, giving rise to the above cause, stating the underlying condition last.) | (b) .....<br>.....<br>due to (or as consequence of )<br>(c) .....<br>..... | |
| **II** | | |
| **Other Significant Conditions** contributing to the death, but not related to the disease or condition causing it. | .....<br>..... | |

**Details of Registered Medical Practitioner**

Forename: ..... Business Address: .....

Surname: ..... .....

Registered Qualifiction: ..... .....

Signature: ..... Date: ..... Daytime Telephone No. .....

THIS IS NOT A DEATH CERTIFICATE

Name of Relative / Next of Kin .....

Address .....

.....

## Death Notification Form

To register a death and obtain a Death Certificate it is the duty of the relative (where available and capable) to complete Part 2 of this form and bring it to any Registrar within 3 months of the death. After 3 months any other qualified informant (as defined hereunder) must do so.

**Part 2**

**Personal Details of Deceased – To be completed by the Qualified Informant – (see note below)**

Forename(s): ..... Home Address: .....

Surname: ..... .....

Birth Surname: ..... .....

Date of Birth: ☐☐/☐☐/☐☐☐☐ .....

(The date of birth should be entered)

Age: ..... P.P.S. No.: ☐☐☐☐☐☐☐-☐☐

(Note: If age at death is less than 1 year insert age in hours, days, weeks, months, as appropriate)

Date of Death: ☐☐/☐☐/☐☐☐☐ Male ☐ Female ☐

Place of Death (in full): .....

Place of Birth of Deceased: .....

Marital Status: Never Married ☐ Married ☐ Married – Separated ☐ Widowed ☐ Divorced ☐

Occupation: ..... Retired ☐

Occupation of spouse if married or widowed: ..... Retired ☐

If under 18 years,

Occupation of Parent/Guardian 1: ..... Retired ☐

Occupation of Parent/Guardian 2: ..... Retired ☐

Forename(s) and birth surname of father of deceased: .....

Forename(s) and birth surname of mother of deceased: .....

For Official use

☐☐☐ home

☐☐☐ age

☐☐ infant

☐ sex

☐ pleoc

☐ mar

☐☐ occ

cod

**This Part to be completed only in the presence of the Registrar**

**Details of Qualified Informant (see note below)**

Forename(s): ..... Address: .....

Surname: ..... .....

Qualification to Act as Informant see note below: ..... .....

..... .....

I, hereby declare that the above details are to the best of my knowledge correct.

Signature: .....

**Note:** A Qualified Informant is a person who has knowledge of the particulars required to register a death **(a)** a relative of the deceased who has knowledge of the required particulars concerned **(b)** a person present at the death **(c)** any other person who has knowledge of the required particulars **(d)** if the death occurred in a building used as a dwelling or part of a building so used, any person who was in the building or part at the time of death **(e)** if the death occurred in a hospital or other institution or in a building or a part of a building occupied by any other organisation or enterprise, the chief officer of the institution, organisation or enterprise (by whatever name called) or a person authorised by the chief officer to perform his or her functions **(f)** a person who found the body of the person concerned **(g)** a person who took charge of that body (h) the person who procured the disposal of that body, or **(i)** any other person who has knowledge of the death.

**For Registrar's Use Only**

State whether certified ☐ or uncertified ☐ inquest ☐ or post mortem ☐

**Complete Part A or B**

**A: Computerised Offices:** If notification is to be entered electronically enter the system notification number in the adjacent box:

**B: Non-Computerised Offices:** If the notification is not being entered electronically then the information in the section below should be completed, and this form should then be sent to the Central Statistics Office

**Date of Registration:** .....

**Entry Number in Register:** ..... **Signature of Registrar:** .....

REGSTMP