

GUIDELINES FOR PHYSICIAN ASSOCIATES CONFIRMING DEATH

A qualified physician associate is able to confirm death, but cannot complete a death certificate.

The recommendations in the document “A code of practice for the diagnosis and confirmation of death” published by the Academy of Royal Colleges should be adhered to at all times. <http://aomrc.org.uk/wp-content/uploads/2016/04/Code_Practice_Confirmation_Diagnosis_Death_1008-4.pdf>

As with any new procedure it is recommended that the PA first observe prior to undertaking the task under direct supervision in the first instance. Formal feedback should be sought and the procedure not be performed independently until the PA and their supervisor feel they have the competency to do so.

**Procedure**

1. The death may be expected and a DNAR in place or may be following a cardiac arrest call. In either case the procedure is the same.
2. Note the exact time of death as far as possible.
3. Physical examination – pen torch, stethoscope, and gauze swabs are required. A brief inspection of the body (minimum 5 minutes) should be carried to ensure there are no suspicious signs. Within this period the practitioner must confirm:-
* Cessation of cardiorespiratory effort by listening to the chest, with a stethoscope, for 1 minute, checking both right and left lung fields
* Absence of either carotid or femoral pulse, by palpation for 1 minute
* Cessation of heart sounds by listening to heart apex region of the chest, with a stethoscope, for 1 minute. (This may alternatively be confirmed by asystole on a continuous heart rate ECG)
* Absence of pupil reaction to light, by using a pen torch. Pupils should be fixed, dilated, and with no reaction to light. Both eyes should be checked.
* Cessation of motor response. By pressure using finger or thumb to supra-orbital groove (the bony ridge at the top of the eye). No Motor response should be observed.
* Absence of corneal reflexes by corneal stimulation. Gentle touch with gauze to the cornea over the iris. There should be no response (e.g. blinking).
1. Confirm that death has occurred. Inform family / carers if present.
2. Where this has been used prior to death; complete the Verification of Death Section on the ‘Care After Death’ pages of the Individual Plan of Care and Support for the Dying Person in the Last Days and Hours of Life. If this document has not been used make a clear annotation in the generic document for the care setting. In either case this annotation MUST include:-
* date and time of death
* identify any persons present at the death
* person who discovered the death had occurred
* time of verification
* all the clinical signs of death (as above)
* signature, clear name in print, and designation of the verifying practitioner.
1. The care should then follow that designated in the Policy for Care After Death and Support of the Bereaved. (i.e. offering opportunity for tissue donation, offering mementos such as locks of hair / handprints, preparing the body for transfer to the mortuary etc.).

