Department of Veterans Affairs **VHA DIRECTIVE 2011-016**
Veterans Health Administration
Washington, DC 20420 **March 16, 2011**

PRONOUNCEMENT OF DEATH AND REQUEST FOR AUTOPSY BY A REGISTERED NURSE, ADVANCED PRACTICE NURSE OR PHYSICIAN ASSISTANT IN VA COMMUNITY LIVING CENTER

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy for Registered Nurses (RN), Advance Practice Nurses (APRN) or Physician Assistants (PA) to pronounce the death of Veterans and request permission for autopsy in the limited circumstances defined in subparagraph 4d.

2. BACKGROUND

a. VHA is committed to providing compassionate and palliative care to dying Veterans and ensuring their dignity throughout the dying process up through maintaining the dignity of the Veterans served in pronouncing death and the disposition of their remains. This policy addresses who in the Department of Veterans Affairs (VA) is authorized to pronounce the death of Veterans when they are residents in a VA Community Living Center (CLC), formerly known as VA Nursing Home Care Unit.

b. In current VA practice only medical doctors (as opposed to mid-level practitioners) can pronounce the death of Veterans who die while under VA care. This practice limiting pronouncement of death to medical doctors proves particularly problematic for Veteran residents who die in VA CLCs. The medical doctors assigned this responsibility are often not on site in the CLC when these deaths occur. For instance, these deaths often occur outside of the responsible physician's tour of duty, i.e., nights, weekends, and holidays. In other cases, the responsible physicians are unable to get to the VA CLC in a timely manner to see to this pronouncement of death duty because of commitments elsewhere in the facility. The latter case results in unnecessary transfers of expired Veterans from the CLC to the emergency departments (ED) to obtain the death pronouncements, or in prolonging the death pronouncements until CLC staff can locate a Medical Officer of the Day (MOD) in a distant area of the medical facility to see to this responsibility. Aside from the administrative burdens those steps entail, having to take those measures is far more troubling because of the pain and disruption it causes for the Veterans' families and loved ones, especially for those gathered at the Veterans' bedsides at the time of death.

c. The deaths of a significant portion of residents receiving care and services under the CLC program are often not unexpected, i.e., they are simply the natural course of progression of the Veterans' disease or declining health status. Aware of their prognoses or conditions, many CLC residents have consented to Do Not Resuscitate (DNR) orders being placed in their medical

records. Thus, attempts to revive these residents following cardiopulmonary arrest cannot be taken and their deaths occur relatively quickly. While VA seeks to ensure it abides by the residents' end-of-life treatment wishes and DNRs, it is counter to those very efforts to then prolong the actual pronouncement of death for these residents and hence delay the respectful disposition of their remains. ***NOTE:*** *A DNR order is an order written in the Veteran's medical record by the physician instructing that cardiopulmonary resuscitation is not to be attempted if the Veteran suffers cardiac or respiratory arrest. Aside from the situation where the Veteran directly consents to DNR and such is documented in the Veteran's medical record, if a Veteran lacks decision-making capacity, such an order may be initiated pursuant to the Veteran's valid advance directive, or, absent an advance directive based on the informed consent of the Veteran's surrogate (as identified by VA regulation and policy). VHA Handbook 1004.3 provides extensive guidance on DNR protocols.*

d. Additionally, VHA believes that autopsy is an invaluable component of high quality of care. Therefore, obtaining permission for autopsy, if indicated, is considered an important component of the death pronouncement process according to current VHA policy; this duty must now be performed only by the physician providers responsible for the patients.

e. For the reasons stated, VHA believes an exception to the death pronouncement policy is required to permit RNs, APRNs, and PAs assigned to the CLC to be trained and assigned to make pronouncements of death for CLC residents who have valid DNR orders of record and who expire secondary to cardiorespiratory arrest due to apparent natural causes when their physicians are not on-site at the CLC at the time of the Veteran's death. Such staff would also be responsible for obtaining permission for autopsy, if indicated, and would be trained to do so consistent with the terms of VHA policy. Responsible physicians must also document in the medical record any prior communications with residents and or families about an autopsy.

f. Resuscitation remains, however; the default action for all Veterans who undergo a cardiopulmonary arrest and do not have a valid DNR order of record.

3. POLICY: It is VHA policy that an appropriately trained RN, APRN, or PA assigned to the CLC may perform the death pronouncement only if a responsible physician is not immediately available on-site for a Veteran who has a valid DNR order of record and dies of cardiopulmonary arrest due to apparent natural causes.

4. ACTION

a. **Medical Facility Director.** The medical facility Director is responsible for ensuring that pronouncements of death and requests for autopsy for Veterans dying in VA CLCs are made timely by either the responsible physicians, or in the limited circumstances defined by this policy, by appropriately designated and trained RNs, APRNs, or PAs assigned to the CLC .

b. **Chief of Staff.** The Chief of Staff is responsible for:

(1) Ensuring that physician coverage to provide appropriate care to Veterans in the CLC is sufficient and that Veterans who wish to forgo resuscitation have their wishes honored.

(2) Ensuring DNR orders are determined to be appropriate and entered into the Computerized Patient Record System (CPRS) consistent with the requirements of VHA Handbook 1004.3.

(3) Ensuring PAs are educated and competent in the procedures for assessments necessary for determination of death and related functions, including in the procedures for requesting permission for autopsy.

c. **Associate Director for Patient Care or Nursing Services.** The Associate Director for Patient Care or Nursing Services is responsible for ensuring that RNs and APRNs assigned to the VA CLC, are educated and competent in the procedures for assessments necessary for determination of death and related functions, including in the procedures for requesting permission for autopsy.

d. **RN, APRN, and PA Responsibilities**

(1) When a Veteran-resident of a VA CLC who has a valid DNR of record dies of cardiopulmonary arrest due to apparent natural causes and the responsible physician is not immediately available on-site, an appropriately-trained RN, APRN, or PA employed by VA and assigned to the VA CLC may make the determination of the Veteran's death. This includes establishing the time of death, notifying the Veteran's family of the Veteran's passing, and requesting, as appropriate, permission for autopsy.

(2) The RN, APRN, or PA must document in the Veteran's medical record the time of death, circumstances of death, and notification to the family. More specifically, to make the death-pronouncement, the appropriately-trained RN, APRN, or PA must proceed in the following manner:

(a) Determine if pupils are fixed and dilated.

(b) Immediately check for a carotid pulse. Then using a stethoscope, auscultate for an apical heartbeat for 1 minute.

(c) Using a stethoscope, auscultate lung field for respirations for 1 minute.

(d) Document the findings in the medical record and note the time and date of death.

(e) Notify the attending physician of the death at the first possible opportunity.

(f) Notify the next of kin (NOK) in a timely manner about the death if the NOK is not at the bedside.

(g) Discuss with the NOK if an autopsy is requested or indicated, unless the resident's or NOK's wishes are previously known and documented.

(h) Inform the nursing staff that an autopsy is requested or permission was granted by the NOK.

(i) When the assessment is finished and appropriate notifications are made, enter a progress note with the date, time, absence of heartbeat and respirations, persons notified, if an autopsy is requested, and disposition of body must be entered into the resident's clinical record.

(3) If autopsy is requested by the RN, APRN, or PA, documentation must include notation of the participants in the discussion and whether permission was granted or denied. When permission is denied, the reasons for the denial must be recorded in the medical record.

(4) If an RN, APRN, or PA has cultural or religious reasons precluding them from performing a pronouncement of death or requesting an autopsy, they have the right to request and be granted exclusion from these duties by submitting a request through their supervisor.

(5) When an RN, APRN, or PA pronounces the death of a Veteran-resident under the circumstances described in this Directive and requests an autopsy, the responsible attending physician must be notified of these events as soon as possible.

(6) If the Veteran does not have a valid DNR order, staff must proceed with cardiopulmonary resuscitation as described in the facility's local policy.

5. REFERENCES

a. VHA Directive 1004.3.

b. VAOPGCADV 3-2010. Delegation of Authority to Registered Nurses, Advance Practice Nurses And Physician Assistants to Pronounce Death and Obtain Permission to Perform Autopsies (Gcl 29737).

6. FOLLOW UP RESPONSIBILITIES: The Office of Geriatrics and Extended Care (114) in the Office of Patient Care Services (11), in collaboration with the Office of Nursing Services (108) is responsible for the contents of this Directive. Questions may be referred to Director, VA Community Living Centers ay (202) 461-6779 or to the Office of Nursing Services at (202) 461-6700.

7. RESCISSION: None. This VHA Directive will expire on March 31, 2016.

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