Level of support
required: Non-ICU

ICU: Refer to ICU algorithm

Identify yourself to the patient’s family and tell them you plan to examine the patient.

Identify patient via wristband

Perform the death exam

• Provide verbal or tactile stimulus
• Feel for carotid or brachial pulse
• Listen to heart and lungs for 1-2 minutes
• Assess pupillary light reflex or other brainstem reflex

Announce death in an unambiguous manner

Express sympathy to family if present; call family if not present

Write death note in chart*

Words to express sympathy at time of death

• “I’m sorry for your loss”
• “I had hoped things would have turned out differently”
• “I wish this could have been different.”
• “I’m glad you were here for her/him.”

• Offer social work and spiritual care support or bring them to you prior to the exam.

Important tasks at time of death

• Notify any family not present
• Notify attending physician
• Notify social work
• Fill out death certificate
• Call gift of life/organ donation
• Ask family about autopsy (may be initiated prior to death)
• Notify Medical Examiner if necessary (varies by location)

Filling out a death certificate

• Cause of death is the ultimate final illness, disease or injury and NOT symptom or mechanism (pneumonia NOT respiratory distress)
• List anything directly contributing to cause of death/sequence of events leading to the death
• Time between onset and death, may put “unknown”
• May use “probable” or “presumed” if final cause not known

*Writing a death note

• State the reason you were called for assessment (apnea, asystole, death)
• Record your physical exam findings
• Note date and time of death (which is the date and time that YOU did your exam)
• Note time between staff/family concern for death and time of exam
• Document that the attending has been notified
**Assess the Situation**

Identify Key Players and Appropriate Location

Confirm “Allow Natural Death” Order and Clarify Patient and Family Wishes

**Continuous IV Infusion:**

<table>
<thead>
<tr>
<th>Type of Intervention</th>
<th>Mode of Death</th>
<th>Appropriate for...</th>
<th>Advantages</th>
<th>Disadvantages</th>
<th>Don’t forget</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-Escalation of Life-Prolonging Therapies</strong></td>
<td>Progression or culmination of underlying disease – usually respiratory or hemodynamic compromise</td>
<td>Patient with terminal progressive disease whose family is uncomfortable with withdrawing any life-prolonging therapies beyond their control</td>
<td>This appropriately allows family to recognize dying as a consequence of disease progression beyond their control.</td>
<td>Can prolong suffering: this method often decreases control over exactly when and how death will occur.</td>
<td>Some families cannot say no to any offered therapy and depend on clinical teams not to offer or not escalate some therapies.</td>
</tr>
<tr>
<td><strong>Discontinue Dialysis (HD/PD/CRRT)</strong></td>
<td>Hypertension progressing to acidosis, shock, and coma</td>
<td>Patient in significant hemodynamic support</td>
<td>Hypoxia can cause significant sedation, making patients more comfortable.</td>
<td>Can be slow to progress (days) thereby can prolong suffering</td>
<td>If a patient on CRRT has not recovered renal function by approximately 3 months and is not a PD or transplant candidate, some medical services would decline to offer further CRRT.</td>
</tr>
<tr>
<td><strong>Discontinue Hemodynamic Support (Inotropes, Vasopressors, VA ECMO)</strong></td>
<td>Hypotension progressing to acidosis, shock, and coma</td>
<td>Patient in significant hemodynamic support</td>
<td>Hypoxia can cause significant sedation, making patients more comfortable.</td>
<td>Can be slow to progress (days) thereby can prolong suffering</td>
<td>If a patient on CRRT has not recovered renal function by approximately 3 months and is not a PD or transplant candidate, some medical services would decline to offer further CRRT.</td>
</tr>
<tr>
<td><strong>Compassionate Extubation</strong></td>
<td>Controlled and gradual hypoventilation, hypercarbia and acidosis with secondary hemodynamic collapse</td>
<td>Patient with irreversible pulmonary disease</td>
<td>Hypoxia, hypercarbia, and acidosis progress more gradually.</td>
<td>Prompt extubation can result in severe respiratory failure, and acute air hunger that requires prompt reintubation and rapid titration of therapies, especially in the patient with intact CNS.</td>
<td><em><strong>Important to stop paralytics first in most cases</strong></em> Premedication is helpful to alleviate symptoms.</td>
</tr>
<tr>
<td><strong>Stepwise Ventilator Wean Before Compassionate Extubation</strong></td>
<td>Controlled and gradual hypoventilation, hypercarbia and acidosis with secondary hemodynamic collapse</td>
<td>Patient with irreversible pulmonary disease</td>
<td>Hypoxia, hypercarbia, and acidosis progress more gradually.</td>
<td>Prompt extubation can result in severe respiratory failure, and acute air hunger that requires prompt reintubation and rapid titration of therapies, especially in the patient with intact CNS.</td>
<td>Achieving a comfortable death in the neurologically and hemodynamically intact patient with bad pulmonary disease is particularly challenging. Symptoms AND family support will require constant attention.</td>
</tr>
</tbody>
</table>