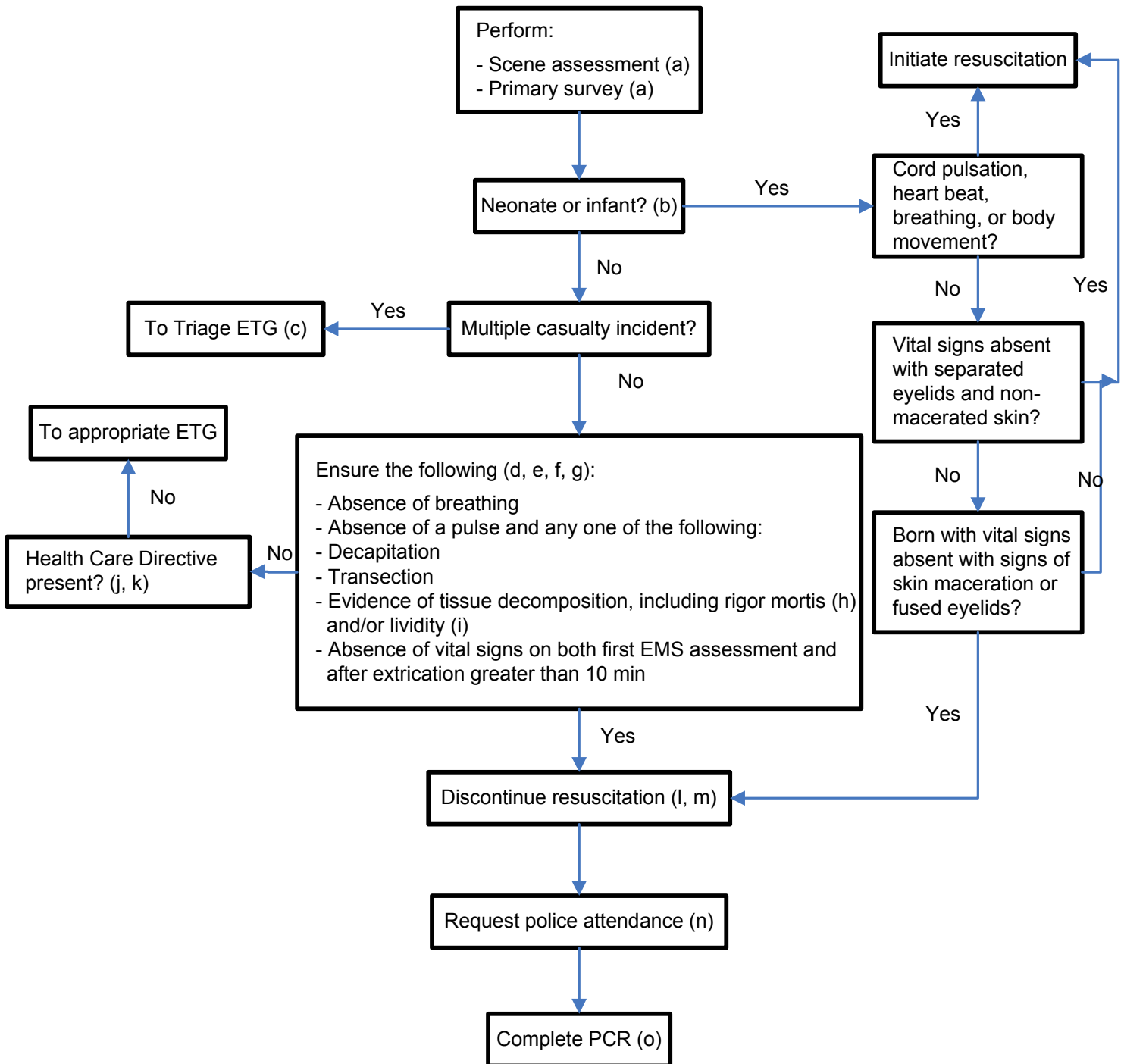


# GENERAL: Determination of Death



## GENERAL: Determination of Death

- a. Refer to appropriate Emergency Treatment Guideline for a complete description and/or application.
- b. Back up should be called as there are usually two patients to care for, i.e. the neonate/infant and the mother.
- c. EMS personnel may withhold patient care for a pulseless, apneic patient in a multiple casualty situation for the period of time when resources are required for the stabilization of living patients (see Triage Emergency Treatment Guideline).
- d. The determination of death of a patient in the field must be done by strictly following the Emergency Treatment Guidelines. If there is any doubt as to the status of the patient, life saving interventions must be started immediately.
- e. CPR may be discontinued when instructed by a physician licensed to practice in Manitoba (identity and credentials must be confirmed), performing CPR would place EMS personnel at risk, EMS personnel are exhausted and cannot continue, or if specifically outlined with a Health Care Directive.
- f. Patients who are hypothermic must be assessed for respirations and a pulse for longer periods of time, up to 45 seconds. CPR should be considered for any pulseless, apneic patient who exhibits the signs or symptoms of hypothermia.
- g. If there are any doubts whether a hypothermic patient meets the criteria for determination of death in the field, EMS personnel must initiate full resuscitation efforts (including defibrillation, if appropriate - see Environmental Emergencies – Cold Related Emergency Treatment Guideline) and transport to a health care facility.
- h. A cold environment will usually delay the onset of rigor mortis while a hot environment may accelerate the process and may be more difficult to detect in obese individuals but may be rapidly evident in infants.
- i. Lividity is harder to detect on a person with dark skin pigmentation and may be absent if death was preceded by large blood loss.
- j. Also referred to as “advance directives” or “living wills” - EMS personnel must be familiar with current legislation governing Health Care Directives (see Appendix – Health Care Directives Act, Response to an Expected Death at Home Emergency Treatment Guideline and End of Life Directive). Certain procedures that are permitted under the Health Care Directive should be initiated, if appropriate.
- k. When a Health Care Directive form is presented or the patient’s proxy informs the EMS personnel of the existence of Health Care Directive, EMS personnel must ensure:
  - the form and the information provided clearly identifies the person to whom the Health Care Directive applies
  - the patient is the person referred to in the Health Care DirectiveEMS personnel must then identify what, if any, procedures are authorized or prohibited by the patient in the Health Care Directive, and follow the instructions outlined, including the discontinuation of resuscitation if required.
- l. When a determination of death has occurred, the deceased ceases to be a “patient” and should not be transported by ambulance unless certain criteria are present, these include, but are not limited to: death has occurred in a public place where it is not possible to ensure privacy and the dignity of the deceased or, a request is made by police to transport the deceased to the nearest hospital morgue for medical pronouncement of death. Routine transport of deceased to a funeral agency or morgue is an unacceptable use of an ambulance.
- m. If work load permits, it may be appropriate to remain on the scene until a support person arrives but, unless unusual circumstances exist, once a death has been determined in the field the crew should be considered available to accept additional assignments, and should notify their dispatch agency.
- n. Although an out of hospital death may appear to be of natural causes, any such death requires notification to legal authorities. Until such authorities arrive, the scene should be protected as much as possible to avoid disturbance.
- o. Document who provided the Health Care Directive and their relationship to the patient along with the information on the Health Care Directive. Any patient assessments, vital signs, and treatments provided also must be document.