Policy & Guidance for the provision of Care & Respect in Death

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1 **Introduction**

As a healthcare organisation we must accept the fact that unfortunately patients’ die in hospital despite the best efforts of nursing and clinical staff. Care of the dying and deceased is an integral part of the care that we give and should be held in the same high regard as to the care we give to the living.
This policy applies to all situations where a patient may die unexpectedly, or is expected to die, on Trust premises. The guidance contained within this document has been compiled to assist staff in understanding the issues around death and dying, and to provide them with advice on how to maintain patients' privacy, dignity and respect. Staff are expected to maintain a caring and sensitive attitude to relatives and carers of the dying and deceased patient.

It is vital that a culture of compassion, sympathy and dignity are preserved at all times when caring for a dying patient and friends/relatives. We also need to recognise that we, as care givers and our colleagues, who are involved in the care process, may also be affected at this emotional and stressful time.

The term “relative” used throughout this policy is applicable to all family members and friends of the dying/deceased patient.

2 Scope

2.1 Scope of this Policy

This policy applies to all staff involved with the care provision for the dying and deceased patient and the family. This policy applies to children and adults.

This policy provides guidance for staff at this stressful time to ensure the best possible standard of care for all dying patients, their relatives and friends before, during and after death. By building on existing services and established practices we will provide the highest quality of care to all concerned.

Standards for Better Health (2004) Core Standard C13 (a) states that healthcare organisations should have systems in place to ensure that:

“Staff treat patients, their relatives and carers with dignity and respect”

3 Duties

3.1 Duties within the Organisation

The Chief Executive

The Chief executive has ultimate responsibility for all policies and procedures within the organisation ensuring that all care offered to patients conforms to its expected standards of privacy and respect, and in accordance with all equality and diversity legislation. That responsibility extends to ensuring dying patients; deceased patients and the bereaved are treated sensitively and in accordance with their cultural and religious requirements, as far as is practicable.

General Managers

Responsible for ensuring this policy is disseminated throughout their directorate and identifying any factors that may prevent compliance with the policy within their directorate.

The Department Manager/ Matron/ Ward Sister & Nursing Staff

Ward nursing staff have the day-to-day operational responsibility for nursing patients diagnosed as dying and ensuring that such patients have a full holistic assessment of their needs. They are also responsible for taking the necessary actions once death has occurred. All nursing staff have a responsibility to ensure that the deceased’s body is treated with the utmost respect and sensitivity and that bodies are only removed from the ward in accordance with Trust agreed practice. Staff also have a responsibility:
To ensure that all of their staff are aware of relevant Trust policies and that they are disseminated and implemented appropriately.

To recognise where staff do not have the abilities to perform these difficult duties and arrange for training and support for the staff lacking in some skills.

To ensure that all of their staff are aware of where to seek counselling and support if they need it at difficult times.

To ensure that all staff are able to assess patients with sensitivity regarding disability, gender and race considerations.

**Chaplaincy Department**

The Chaplaincy Department have a responsibility to ensure that once a patient's or relatives spiritual needs have been identified, or a request has been made, appropriate care is provided. This includes facilitating relatives and patients access to chaplains or spiritual leads from other faiths.

**All Staff Involved in Direct Patient Care**

All staff have a responsibility to ensure that they comply with Trust policies.

All staff have a responsibility to seek counselling and support if they feel they need it.

All staff must be competent to assess all patients with sensitivity to disability, gender and race considerations.

All staff have a responsibility to ensure that they give respectful, dignified and compassionate care at all times.

3.2 **Consultation and Communication with Stakeholders**

This policy has been developed following consultation with the palliative care team, senior nurses, mortuary staff, women and children's directorate, the chaplaincy, infection control team and portering staff within the Trust with regard to review and revision of the policy contents.

3.3 **Approval of this Policy.**

This policy has been developed and approved in accordance with the Trust Policy for the Production, Approval and Implementation of Corporate Procedural Documents.

4 **Care of the Dying Patient.**

4.1 **Palliative Care Including the Liverpool Care Pathway**

The Hillingdon Hospital NHS Trust is working closely with the Palliative Care Team to ensure that The Liverpool Care Pathway (LCP) is fully implemented within the Trust. The tool aims to translate the care given to all those patients who are dying and their relatives (renowned in hospices as the gold standard practice) into the District General Hospital. The LCP empowers Doctors and Nurses to deliver high quality care; it facilitates multi-professional communication and documentation. It is underpinned by a rigorous education programme.

“Patients dying in hospital have received standards of care almost comparable to those reached in a hospice” Ellershaw & Wilkinson (2003).

The LCP is being rolled out gradually throughout the hospital. Should a patient be deemed appropriate to be put on the pathway, the following steps need to be taken:

- This is a multi-professional decision.
- The documentation must be signed by a Registrar or above.
• The diagnosis of dying must be made by the Multidisciplinary Team

• The patient/relatives should be informed of the future management of care (this is not consent)

**Resuscitation and Do Not Resuscitate (DNAR) Orders**

Following a clinical assessment and/or diagnosis that a service user has an advanced life limiting illness, a discussion with the service user and/or their carer must take place as soon as possible regarding end of life care. This will be carried out with the utmost sensitivity and include all aspects of care, treatment and resuscitation. A decision on whether or not to attempt resuscitation should then be made and documented as per the Trust Resuscitation Operational Policy Incorporating Do Not Attempt Resuscitation (DNAR) and Patient at Risk (PAR). Policy No 196

**Referral to the Palliative Care Team (Appendix A)**

Any healthcare professional can refer a dying patient to the Palliative Care Team providing that the consent of the consultant and the patient has been given.

The community paediatric team manage care for any child at the end of life and although there is no dedicated Paediatric Specialist Care Team, the palliative care consultants are willing to give advice and support if needed. There are also excellent links with the Great Ormond Street Hospital.

**How to Refer**

Referrals are accepted by:

Telephone : 01895 279412 (Extension 3412 internal)

Fax : 01895 279452 (Extension 3452 internal)

Personal and clinical information is required. Referrals are collected Monday to Friday 08.00 – 16.00 hours

**Referral Criteria:**

1. Patients with diagnosis of cancer at any stage of their illness (diagnosis to terminal phase).

2. If a patient requires specialist palliative care services in the management of their physical symptoms.

3. If the patient should require specialist nurse intervention in the management emotional, psychological, spiritual or social distress related to their illness.

4. Patients with non-cancer diagnosis at the end stage of their disease that would benefit from the specialist palliative care services.

**Out of Hours Palliative Care Service Provision**

There is a Palliative Medicine Consultant on call at all times, and is able to advise on symptom management for a person who is dying. The Consultant is accessible via Michael Sobell House Hospice at Mount Vernon Hospital (01923 844531)

GP services for home via the Harmoni GP service (referral form available on the intranet, under palliative care services.)

Any discharge may be supported by the Michael Sobell House Outreach Team (01923 844531), but this must be agreed with the District Nursing Team who would act as the patient key workers at home.
The LCP incorporates the following points:

a) Are the patient records accurate and up to date?

It is essential that the following information is accurately recorded in the nursing/midwifery records:

Next of Kin - telephone numbers (landline & mobile if available)
- Will they be alone?
- Do they wish to be informed at night?
- Do they wish to know about any deterioration?
- Do they want to be present?
- Is their an alternative contact number?

This information gathering is the responsibility of the nurse allocated to the care of the patient.

b) Is the patient aware of their condition?

Many conscious and semi-conscious patients experience great fear and loneliness near to the time of their death. It is important that patients are offered the time to talk and express these fears.

Staff must be prepared for these times and be willing to talk about these issues as avoidance can cause fear, loneliness and anxiety for the dying patient.

c) Are the relatives aware?

It is essential that relatives are aware of an impending death. This needs to be communicated quietly and tactfully in privacy by asking relatives what their understanding and expectations of the situation are. This can be done by nursing staff and the situation must be reassessed regularly, as relatives can move in and out of denial, and even when faced with the truth, may hold on to false hope. It is important that any discussion is recorded in the patient’s records.

d) Most suitable place for death?

The patient will be placed in the most appropriate part of the ward in discussion with himself, relatives and the staff. If the patient is being nursed in a side room, they must NEVER be transferred as a consequence of pressure on beds.

If the patient does not want to move, or is too close to death, the bed curtains may be closed. If death is imminent, the patient is not to be transferred to another area, with the exception of a move from an emergency area to a more appropriate place.

Other patients on the ward may be distressed to see a very sick or dying patient. This distress can be greatly reduced if time is spent with other patients explaining the deterioration and what might be expected. This can be carried out without divulging confidential information.

e) Does the patient want to go home?

The patient’s right to choose to die in a place of his/her choice, where medically possible will be respected and appropriate support arranged and given.

If it is the wish of the patient or their relatives to go home to die, discussion must be initiated immediately.

Clinical Care Assessment (Sections 2 & 5) will be carried out. District nursing service can be arranged but this may take some time; contact should be made on the following number:
Between 08.00 hours and 16.30 hours (Monday to Friday) on 01895 810918

If a District Nurse needs to be contacted out of hours, please contact 01895 234001 (after 17.00 hours)

If a Package of Care is required a Clinical Care Assessment will need to be carried out by the Discharge Co-ordinator.

A Harmoni Palliative Care Handover Form must be completed by a Doctor from the patients medical team then faxed to 0208 867 1302. This form is available on the Hospital Intranet.

ANTICIPATORY MEDICATION MUST BE PRESCRIBED BY HOSPITAL MEDICAL TEAM FOR A MINIMUM OF 24 HOURS.

If equipment is required, inform the District Nurse as soon as possible as it takes 2 days to receive. Or liaise with Occupational Therapy.

Plan of Care: the District Nurse can visit periodically throughout the day and if necessary will decide if more care is required. Invite District Nurse to the ward to meet the patient and family.

In the case of a child contact the Paediatric Community Team.

Between: 8.00 a.m. - 4.00 p.m. (Mon. - Fri.) on Ext 2941
At other times on 01895 279227 (answer phone)

If the palliative care team have been involved with the patient’s care it may be appropriate to inform them of the patient/family wishes.

The ambulance service may be able to transfer the patient home, as an emergency, without the usual 48 hours notice, in these circumstances.

Between: 9.00 a.m. - 5.00 p.m. (Mon. to Fri.) on Ext 4401 or 4063 (Fax 4801)
After 5.00 p.m. and weekends contact the Clinical Site Manager, Bleep 838

The Social Services Department may be able to arrange additional support at home.

Between: 9.00 a.m. - 5.00 p.m. on Ext 3306

The doctor responsible for the patient must contact G.P. by phone to inform about death.

f) Are the relatives supported?

Relatives will be invited to visit at any time of day, and to stay overnight if they wish, however we are unable at the present time to offer appropriate facilities but they will be offered the following during this time:

- Tea / coffee (not to be charged to relative)
- Use of toilet /bathroom
- Opening hours of restaurant etc.

Relatives, especially if they cared for the patient at home, will be given the opportunity to be involved with their care. Many relatives get much satisfaction from being involved in such things as mouth care, and washing hands and face.

g) Request for wills
Any requests for witnessing the signing of wills must be referred to the Divisional General Manager between 9.00 - 5.00 p.m. After 5.00 p.m. and at weekends the Clinical Site Manager, Bleep 838.

**h) Requests for hospital marriages, christenings etc.**

If a patient who is not expected to recover wishes to get married, and is too ill to be moved to a place registered for the ceremony, then arrangements can be made for the ceremony to take place in the ward.

The patient must be of sound mind and able to make rational decisions.

All requests for religious ceremonies should be made to the Hospital Chaplains via Switchboard.

Requests for non-religious ceremonies should be made to the superintendent registrar at the Civic Centre, Uxbridge.

Requests for christenings, blessings etc. should be made to the chaplains via switchboard.

**i) Organ donation**

Requests for organ donation should be made by the doctor.

All organ donations require signed consent. Refer to UK Hospital policy for organ and tissue donations. [www.uktransplant.org.uk](http://www.uktransplant.org.uk)

**j) Is the patient alone when death is imminent?**

Relatives should always be contacted and informed that death is imminent, unless it is recorded that they do not wish to be.

This contact should be made, if possible, to allow time for relatives to arrive at the hospital and be with the patient before death occurs.

If relatives cannot be present when death is imminent, nursing / midwifery staff should ensure that the patient is not alone.

**4.2 Spiritual Needs.**

As patients prepare for death, many turn to a religious faith/ faith group for support, regardless of whether they are practising, or not. Patients from all faiths should be tactfully helped to die according to the customs and cultural practises of their faith. A family member may provide this information, or a local religious leader, can be contacted through the Chaplaincy, or out of hours via Switchboard.

Our Hospital Chaplains are here to help people of all faiths, and those who declare they have no faith.

Some patients may want a religious person present at the time of death. Where possible this should be accommodated.

(The above may only take place if it is the wish, or thought to be the wish of the patient, at this stage.)

Relatives may request the presence of a religious leader, or chaplain, to pray with them and the deceased and to carry out religious rituals. So long as these do not impinge upon health and safety, or the dignity of other patients, this should be allowed.
Even where a religious leader is not called upon, a family may wish to perform religious/cultural rituals for the dying and deceased. (Appendix B)

4.3 Immediately following Death.

a) Are the relatives aware? (An entry should be made in the nursing record including details of who spoke to the relatives. All entries should be dated, timed and signed.

If the relatives are present with the patient at the time of death, advise the relatives when death has occurred and give as much support as the relatives require. It is appropriate to tell the relatives that a doctor will be called to verify death and explain what will be done. The nurse may advise the relatives that if they do not wish to be present this would be an appropriate time to make necessary telephone calls if they wish to do so.

If the relatives are not present, consider:

a) Were they aware of the impending death?
b) Is this a sudden death?

a) Are relatives aware of impending death?

In most circumstances, if the relatives are aware of impending death, and this has been recently assessed and recorded, they should be informed of the death over the telephone by an experienced nurse / midwife.

Things to consider: Will they be alone? Are they frail or elderly? Is there anyone else we should tell first?

In general it is best to tell relatives that death has occurred:

a) It allows them to come to the hospital in their own time, thus reducing risk of injury in a rushed journey to hospital in a state of shock.

b) It reduces the immense sense of disappointment and guilt of wishing to be at the bedside, only to find they have arrived too late.

b) Sudden death

In most circumstances relatives should be telephoned immediately and asked to attend the hospital as soon as possible.

The Senior Sister/Nurse/Midwife will make a decision if information regarding the patient’s death should be given by telephone.

Things to consider: Will they be alone?
Are they frail or elderly?
Is there anyone else we should tell first?
Do they have transport?
Using the police to call at the house
Time of death is recorded on the death certificate.

c) Confirmation of death

A duty Doctor will confirm death and the Doctor responsible for the care of the patient will issue the death certificate.

d) Support of relatives
The nurse/midwife allocated to the care of the patient will support the relatives whilst on the ward, assessing and discreetly supporting the relatives and where possible providing for their needs, e.g. refreshments, tissues etc.

The Nurse will be sensitive for the need for privacy and protect relatives from further distress and if there are any matters the relatives wish to discuss a doctor may be contacted.

This nurse/midwife should:

- Be familiar to the family if possible
- Be experienced in handling distressed relatives
- Have prepared a “quiet room” see 4.3.6 (Only in maternity, A&E and ITU)
- Be ready to receive relatives when they arrive on the ward
- Introduce herself and her role
- Show relatives to the “quiet room” if applicable
- Remain with/be available for the relatives until they leave the hospital
- Ensure relatives have understood what happens next – give relevant documentation
- Be aware of, and responsible for, all her duties as laid out in this document

e) The quiet room

This is the responsibility of the nurse/midwife allocated to the patient’s care; where possible the room should be prepared to receive the relatives. The room should be:

- Quiet
- Undisturbed
- Comfortable
- Tidy
- Have a telephone not receiving incoming calls
- Have minimal clinical material

If this room is normally used as an office etc. it is essential it is properly prepared in advance of a death, or prior to relatives arriving.

f) Viewing the body on the ward

All relatives will be offered time to spend with the deceased patient.

The deceased person should be laid with head and shoulders slightly raised and made to look comfortable.

Any soiled bed linen will be replaced or covered with clean linen (with minimal disturbance to the patient).

All clinical/medical equipment, including intravenous infusions, should be removed unless otherwise specified.

The nurse must warn the relatives what to expect, i.e. if there is likely to be any leakage of body fluids from the mouth.

**Two Nurses must check the body prior to the relatives viewing the body and ensure that it is appropriately presented. It must be recorded in the notes by the nurse in charge of the patients care that this check has taken place.**
The relatives will be accompanied by the nurse to view the body, who will remain with them if this is their wish however the relatives must be offered the opportunity to spend time with the body on their own to say their goodbyes.

In the event of a sudden death viewing of the body is often very beneficial for the grieving process.

Relatives must never be rushed to leave the bedside or the ward.

Once the relatives have left the body it must be viewed again preferably by the same two nurses and they must ensure that it is in the same condition as prior to the relatives viewing, this must also be documented in the notes.

g) What relatives must do next?

Relatives will be given the Bereavement booklet from the ward and be reassured that there is nothing to be done immediately.

Relatives will be advised to phone Patient Affairs office at 09.30 hours on the next working day. (Direct line 01895 279354. Ext/3354). The relatives will then be given a time to attend the office that morning. This will enable the relatives to collect any personal belongings and to receive the medical certificate of cause of death. They will then be informed of what to do next.

h) Post mortem? (See Sec 5.3)

A doctor or midwife must make all requests for post mortems.

A signed consent is required. Additional information is available at: www.doh.gov.uk/tissue/families&postmortemscode.pdf

i) Telling other patients

Other patients near to the deceased patient should be individually and quietly informed of the death.

This is not breaking patient confidentiality as long as cause of death is not discussed. If they are not told, they will usually guess and then feel unable to express and share their grief openly.

All staff must be continually sensitive and provide support to grieving patients. Many patients will be reassured by the respectful way death is handled in hospital.

j) In the event of an in-patient dying in a diagnostic setting.

Where it is possible and dignified to do so, last offices should be performed in this setting prior to the body being moved to the mortuary using the concealment trolley.

Last offices should be carried out by nurses from the patients’ original ward with support from nurses in the setting. Alternatively, if it is deemed undignified to care for the deceased patient in this setting, the patient may be returned to the ward for last offices using the concealment trolley.

k) In the event of a visitor or ambulatory care patient dying in a diagnostic setting or elsewhere in the hospital

Where is possible and dignified to do so, last offices should be performed in this setting prior to the body being moved to the mortuary using the concealment trolley.
Last offices will be performed by nurses from this area supported by Matron or Nurses from the Nursing Performance Unit. Alternatively, the patient may be moved to the A&E Viewing Room for last offices using the concealment trolley. Last offices will be performed by matron or nurses from the Nursing Performance Unit. PALS may help to support the family and the relatives.

4.4 Care of the Deceased Person.

**Last Offices**

**EQUIPMENT**

- Bowl, soap, towel, two face cloths.
- Razor (electric or disposable), comb, nail scissors.
- Equipment for oral toilet including equipment for cleaning dentures.
- Identification labels (name bands) (x2)
- Deceased Person Cards (x2)
- Shroud or patients' personal clothing: night-dress, pyjama's, clothes previously requested by patient, or clothes which comply with family/cultural wishes.
- Body bag if required (i.e. in event of actual or potential leakage of bodily fluids and/or infectious disease), and labels for the body defining the nature of the infection/disease.
- Tape - if an infected case, yellow infection risk tape.
- Dressing pack and bandages if wounds present and waterproof covering.
- Yellow clinical waste bag.

**PROCEDURE**

- Inform medical staff. Confirmation of death must be given. This is usually done by medical staff. If an expected death occurs during the night, the Clinical Site Manager will verify death. The doctor will confirm death later either on the ward or in the mortuary.

- The attending medical officer must confirm an unexpected death.

- Confirmation of death must be recorded in a patient's medical and nursing notes.

- Inform the appropriate senior nurse/midwife/Supervisor of midwives.

- Allow appropriate time if possible between death occurring and commencing last offices (one hour is optimal)

- Put on gloves and apron.

- Lay the patient on his/her back. Remove all but one pillow. Support the jaw by placing a pillow or rolled-up towel on the chest underneath the jaw. Remove any mechanical aids such as syringe drivers, heel pads etc unless otherwise directed. Straighten limbs.

- Close the patient's eyes by applying light pressure to the eyelids for 30 seconds. If possible leave the body to rest for one hour.

- Drain the bladder by pressing on the lower abdomen.

- All wounds to be covered with clear waterproof dressing, **not** gauze or tape.
• Exuding wounds should be covered with a clean absorbent dressing and secured with a waterproof occlusive dressing (e.g. Tegaderm). If leaking PV or RR pads to be applied.

• Remove drainage tubes, etc. unless otherwise stated. Open drainage sites may need to be sealed with a waterproof occlusive (e.g. Tegaderm). Peg tubes to be clamped and covered with Tegaderm.

• Wash the patient, unless requested not to do so for religious/cultural reasons (please refer to section on individual faiths in the Marsden Manual of Clinical Procedures available on the intranet). If necessary, shave a male patient.

• It may be important to family and carers to assist with washing, to continue to provide the care given in the period before the death.

• Clean the patient’s mouth using toothbrush or gauze swabs to remove any debris and secretions. Clean dentures and replace them with in the mouth if possible.

• Remove all jewellery, in the presence of another nurse, unless requested by the patient's family to do otherwise. Jewellery remaining on the patient should be documented on the “notice of death” form. Record the jewellery and other valuables in the patient’s property book and take with the patient records to the patient affairs office. After 4pm or at weekends take to the security desk. Relatives can take property after signing in property book.

• Dress the patient in a shroud or personal clothing, depending on relative’s wishes; relatives need to be told that these will not be returned.

• Label one wrist and one ankle with a wrist/ankle name band. Complete two cards. Tape one Deceased Person Card securely to shroud.

• Wrap the body in a sheet, ensuring that the face and feet are covered and that all limbs are held securely in position. Secure the sheet with tape. Care must be taken not to wrap sheet too tight as this can cause facial damage.

• Place the body in a body bag if leakage of body fluids is a problem or if the patient has certain infectious diseases. See “Is the patient an infection risk?” sec 4.5.3

• Tape the second Deceased Person card to the outside of the sheet (or into clear pocket at head of body bag).

• Complete the Infection control notification sheet and hand to the porters, this does not need to be in an envelope as the porters need to be aware of risk of infection cases.

• Remove gloves and apron. Dispose of equipment safely and wash hands.

• Amend appropriate nursing / midwifery documentation.

• When the relatives have left the ward and last offices have been performed the porters will be asked to transfer the deceased patient to the mortuary.

4.5 Process for the Transfer of Deceased Patients from the Ward to the Mortuary.

Throughout the transfer the deceased patient must be handled and treated with respect and dignity. Also consideration must be given to the other patients, visitors and staff.
a) Upon receiving a request for the transfer of a deceased patient to the mortuary, ensure that the request is booked on the porters log sheet noting time of call and ward.

b) Two porters obtain the mortuary keys from the Security Office; both are required to sign for the keys. At least one of the porters must be a permanent member of staff and trained in deceased patient handling.

c) The two porters proceed to the Mortuary and collect the concealment trolley (or baby concealment box for maternity) and proceed to the ward. At all times the two porters must remain together.

d) The concealment trolley is left outside the ward. The porters must contact the Ward Manager or Deputy Manager to ensure that the deceased is ready for transfer, ensuring that the bed curtains are fully closed and also other patients bed curtains, that are in close proximity are closed.

e) The ward manager or deputy manager must ensure that the paperwork is completed which includes, an Infection Control Declaration, which details if the patient is infected or not. If the deceased patient is infected the ward staff place the deceased patient in a plastic body bag. If the patient is not infected the patient is wrapped in a sheet for transfer this should be completed before the porters arrive.

f) The patients’ medical records, notice of death and infection control forms are handed over by the designated nurse to the porters. The designated nurse must check that the patient’s detail on the notice of death form and the deceased person cards are identical.

g) The patient is transferred to the concealment trolley and the trolley is covered before transfer. Bariatric patients will be transferred to the mortuary on an appropriate bed.

h) The deceased is transferred to the mortuary. The deceased is transferred to a fridge tray, if the patient has been identified as being infected the body is transferred to the infective fridge.

i) The deceased patient details are entered into the Mortuary register, noting date, time, patients name, age, sex, and ward. Both porters sign to acknowledge the completed transfer. Upon leaving the mortuary ensure that it is securely locked.

j) Both porters return the keys, medical records and Notice of Death form to Security. If Security Officers are not available the keys are placed in the reception drop point and the medical records and Notice of Death form are retained by the porters until security are available. The security officers will sign the safe return of the keys.

k) Infection Control and hand washing procedures must be adopted during all stages of the transfer.

4.5.1 Receipt of Bodies into the Mortuary

On arrival at the Mortuary with the deceased, the Porters must complete all the necessary information in the Mortuary Register (date and time, surname, first name, sex, ward and signature of Porters booking in). The Porters should place the Mortuary Infection Control Notification Sheet into the envelope under the register, with one copy of the notice of death.

The Porter must retrieve an empty tray from the fridge using the hoist (see Mortuary SOP 20). Transfer the body from the concealment trolley onto the tray. Place the body in the fridge and write patient’s surname on the whiteboard.
If the width of the body exceeds the width of the concealment trolley, use a wide or bariatric tray in the walk-in body store numbers 32-39. If the deceased is bariatric, and has been transferred on a bed this has to be put into the walk-in body store.

4.5.2 Is the body an infection risk?

For more detailed information specific to the handling and classifications of infected bodies please refer to The Hillingdon Hospital NHS Trust policy 166 “Policy for the Safe Handling and Removal of Infected Bodies”.

Following Last Offices, the deceased will be placed in a body bag, which must be clearly labelled at the end of the bag to state danger of infection.

The risk of infection should be documented on the mortuary infection control notification sheet (Appendix C) this must be completed by the person certifying or verifying the death and handed to the porters to accompany the body to the mortuary.

The porters, when asked to transfer the body to the mortuary, must be informed that the body is an infection risk.

Patient’s known to be infected (as listed on the Mortuary Infection Control Notification Sheet) must be placed in the Infective Fridge numbers 44-49 (unless they are too large).

If the body is not in the Infective Fridge a “DANGER of INFECTION” sticker must be placed on the corresponding white board.

The mortuary staff do not feel it necessary to inform them of the risk of infection unless the risk is so high that they should not open the body bag then staff should inform mortuary staff in advance by telephone.

If the relatives are aware of the presence of an infective disease they should be tactfully informed that future viewing of the body, in the mortuary viewing room and at the undertakers might not be possible. They should therefore be encouraged to spend time with the deceased whilst on the ward.

If the relatives are not aware of the presence of the disease this information will have to be passed on with the utmost care and sensitivity to maintain confidentiality. This may require the assistance of the doctor or senior nurse / midwife.

If you have any concerns please contact the Infection Control Nurse: Between 09.00 – 17.00 hours (Monday – Friday) extension 3767; Bleep 718 or at other times via switchboard.

4.5.3 Receipt of Babies

Maternity/ward staff will accompany the Porters to the Mortuary.

The baby (and placenta if post-mortem is requested) is placed in Baby Fridge number 13-15.

The babies surname must be written on the white board. If the parents of foetus are not married the mothers surname must always be written and also use mothers surname in non-viable gestation at delivery.

If non-viable foetus, the “Babies Less Than 24 Weeks Gestation” form should be sent to the Mortuary with the baby.
The Porter will complete the Mortuary Register; however both the Midwife and Porter must sign the Register.

Porters will then return the keys to Security Office.

4.5.4 Viewing the body in the viewing room

If relatives wish to view the body they should contact the nursing staff of the appropriate clinical area (ward or A&E). In all cases, a nurse should be allocated to care for the bereaved relatives, and should accompany them to the mortuary for viewing.

N.B A&E department nursing staff may contact PALS (Patient and Liaison Service), requesting that a PALS officer accompanies the bereaved relatives during times of extreme pressure and high clinical work load within A&E. If relatives have to visit the Patients Affairs Office they should be advised to do this first prior to viewing.

Between 8.30 a.m. - 1.00 p.m. & 2.00 p.m. - 4.00 p.m. (Monday to Friday) the request should be made by the ward staff to the mortician on: Bleep 610.

**During mortuary hours**: Monday to Friday 8.30am-1pm 2pm-4pm (except Bank holidays)

- The relatives have to be on the hospital site for the viewing to be requested
- Mortuary staff are contacted by ward staff/ Patient Affairs when relatives want to view
- Mortuary staff prepare the viewing
- Mortuary staff contact the ward staff/ Patient Affairs to inform them the viewing is ready and relatives can be brought down
- Ward staff use the intercom to alert mortuary staff to their arrival
- If any assistance is required during the viewing mortuary staff can be contacted by the phone in the waiting area via bleep 610
- When the viewing is over ward staff inform mortuary via bleep 610 before escorting relatives out (Do not leave before mortuary staff arrive to secure the viewing room)

**Out of Hours**

After 16.00 hours, between 13.00 – 14.00 hours, at weekends and bank holidays the charge hand porter should be contacted by the ward staff (Bleep 843).

The charge hand porter should then inform the on call Clinical Site Practitioner

Two porters will collect the keys to the mortuary from security and sign them out. The porters will then go together to the mortuary, take the body out of the fridge and sign the register in the “view column” besides the deceased person’s name with the date and time they arrived.

They will wheel the body on the hoist into the viewing room and then transfer the body to the viewing trolley. The porter must unlock the door between the waiting and the viewing room. They will lock the doors to the viewing room and the mortuary and together, return the keys to security. They will inform the ward that the body is in the viewing room.

Two nurses/midwives from the ward will go to the security office to collect the key to the viewing room and sign it out. They must each be wearing a valid Trust identification badge. They will together prepare the body for the relatives to view, ensuring it is the correct body and well presented. Gloves, clean linen and laundry bags etc are available in the viewing room store cupboard.

Together the nurses/midwives will ensure that the viewing room is kept secure at all times.
Ward staff allocated to support the relatives accompanies them to the viewing room reception. The Nurse will stay with the relatives. The relatives should be reassured that they may touch the body, but to be prepared that the skin will feel very cold. This may not be possible if it is an infected death, however the body will be prepared with the body bag open to expose the head and face; the body bag will be covered with sheets and the pall.

The relatives will be prepared for any disfigurement if the death was traumatic.

The accompanying nurse / midwife should stay with the relatives if they so wish it, however the nurse should allow the relatives time on their own with the body but should remain close by.

All nurses/midwives will be familiar with the mortuary viewing room. This should be part of local induction when they join the Trust and can be arranged with the mortician.

Before calling the porters to replace the body in the fridge the nurse/midwife will ensure the patient is covered by the sheet. The deceased notice will be attached to the top side of the sheet. If an infected case the nurse/midwife will re-zip the body bag and seal the two zip rings with yellow “infection risk” tape (in store cupboard in viewing room) and ensure that the deceased person card is in the clear pocket at the head of the body bag.

(Danger of infection yellow tape should be ordered from supplies for use on the ward.)

The nurse/midwife should accompany relatives to the main entrance when they are ready to leave. She will lock viewing room when leaving, return the keys to security and security will sign them back.

The porters will be informed that the body is ready to be placed back in the mortuary fridge. The same pattern for collecting and returning the key from security will be followed.

If relatives are anxious to begin making arrangements for the funeral, they can contact an undertaker before visiting Patient Affairs and receiving the medical certificate of cause of death.

Trust staff must not recommend undertakers. Relatives should be advised to choose an undertaker that they wish to use or alternatively from the bereavement booklet obtained from Patient Affairs.

In very exceptional circumstances a medical certificate of cause of death can be issued out of normal working hours, contact the Clinical Site Practitioner on duty (bleep 838) to do so.

4.5.5 Movement/ Transfer of Deceased Patients from Trust Hospital Sites.

The majority of deceased patients will be transferred from the ward environment to the hospital mortuary. Sometimes for religious, cultural or other reasons some relatives request that their deceased are not put into the body store and will be collected straight away. The deceased must however come into the mortuary via the concealment trolley and be logged into the mortuary register and released to the Funeral Directors by the mortuary staff or out of hours by the Clinical Site Manager, in the usual way.

Please refer to The Hillingdon Hospital NHS Trust policy NCR 82 Procedure for the Removal of a Body from the Hospital Out of Hours.

5 Administrative Details.

5.1 Nursing Administrative Details.

This is the responsibility of the nominated nurse.
Inform the doctor responsible for the patient soon after death (or inform on call doctor if night/weekend). Ensure that the Doctor verifies that the patient has died.

Complete details of death in “Notice of Death” book making sure to record date and time of death. Ensure medical notes are in good order and that all relevant details are recorded.

Attach one copy of Notice of Death form to the front of the notes and place in a sealed envelope. Attach two further copies of the Notice of Death forms to the outside of this envelope.

When the porters remove the body from the ward they will take the notes in the envelope with the attached Notice of Death form to the main security desk, who will then pass them on to the Patient Affairs office the morning of the next working day.

The mortuary infection control notification sheet is to be left in an envelope in the mortuary Register with one copy of the Notice of Death form.

5.1.1 Patient's property

The locker/property will be checked at the bedside while the deceased patient is still on the ward.

Two nurses will check and list all property in the “Patients Property Book” and sign the book. No valuables/property will be given to relatives at this time.

Checked property must be neatly put into the patient’s own bag, or in a Trust “patient’s property bag”. All bags must be clearly labelled.

Property must never be stored in yellow clinical waste bags or black non-clinical waste bags.

Food and perishables should not be included within the patient’s property, but should be kept on the ward in case relatives ask for them when collecting property.

Soiled and damp clothing should be disposed of and noted on the property sheet.

Property and the “Patients Property Book” must be taken before 10.00am, (before the relatives arrive to collect the certificate etc.) to the Patient Affairs Office to ensure safe, documented handover of patient property.

No property can be removed from the deceased once the body has been transferred to the mortuary. The request must be made through the patient’s affairs office so it can be signed for.

Valuables should be checked in the same manner, documenting the exact amount of money, and stating “yellow metal” instead of gold and “white metal” instead of silver.

Valuables must be put in a clearly labelled envelope and taken to the security office if the Patient Affairs Office is closed. It will be placed in the safe until it is taken with the patient records etc to Patient Affairs.

5.2 Responsibility of the Patient Affairs Office

Relatives will be given an appointment to attend the office at a suitable time to ensure minimum waiting.

The medical cause of death certificate, property and other documents should be prepared before relatives arrive.
Relatives should not normally wait to be seen for more than 10 minutes and the waiting area must be comfortable and private.

Relatives should be seen in a suitable room, which must be:
- Quiet
- Undisturbed
- Comfortable
- Tidy

Relatives will be given all relevant documents and information about what to do next.

Property will be returned to relatives in a sensitive manner.

An opportunity will be given for relatives to view the body in the Mortuary viewing room, if requested. (See section 4.5.3). If the patients’ affairs staff are aware that relatives wish to view the body of their relative, they should make the relevant ward staff aware so preparation can be made to free a member of ward staff to accompany the relatives to the mortuary.

5.3 Post Mortems

5.3.1 Post Mortem at Doctors request

All requests for post mortems must be requested by a doctor.

Unless requested by the coroner, relatives can refuse permission. The nurse/midwife/Patient Affairs officer must ensure relatives are aware of this, and that they are not making a decision, which they may regret.

If the relatives are particularly distressed at the time of death, the request should be made at the discretion of the senior nurse.

The doctor will discuss and obtain signed consent from relatives and would need to complete a request / summary form.

Relatives should be told that results of the preliminary findings will normally be available within a few days of the post mortem. Final results are often not available for several months.

Relatives will be asked if they want to be notified of preliminary or final results, and the means by which they wish to be notified recorded (i.e. telephone, letter or appointment).

5.3.2 Post Mortems at Coroners request

In the case of an unexpected death the doctor will inform the coroner’s office.

The coroner’s officer now expect the patients Doctor to approach the relatives and inform them of the decision/need to hold a post mortem. The body will then be transferred to the coroner’s mortuary, usually Uxbridge Public Mortuary, Kingston Lane, and will not be returned to the hospital after removal.

When the post mortem has been completed the coroner will inform relatives, G.P. and the Consultant.

5.4 When the deceased has no relatives

5.4.1 Registering the Death
It is the responsibility of the Patient Affairs officers to register the death.

5.4.2 Funeral Arrangements

The Hillingdon Hospital N.H.S. Trust as a provider unit has a duty in Common Law to arrange for disposal of the body of patients who die in the hospital under the following circumstances:

- There are no relatives
- Relatives are unable to pay (and do not qualify for Social Fund Funeral Payments).

If relatives are unwilling to arrange and pay for the funeral but the Hospital believes they can afford to do so the local authority should be asked to arrange and pay for it.

Arranging funerals is the responsibility of the Patient Affairs officer.

The Hospital normally chooses a cremation.

If the Hospital holds no funds on behalf of the deceased patient, then the Hospital must pay for the funeral.

If there are any funds held by the Hospital belonging to the deceased (i.e. money in their possession at time of death), then the cost of the funeral will be deducted before handing any funds over.

If there are funds in the estate but not held by the Hospital, the Hospital will claim the expense of the funeral from the estate executor.

5.4.3 Property of the deceased

The Hospital must keep all effects and possessions of deceased patients until told how to dispose of them by someone entitled to administer the estate.

The Hospital has no responsibility for deceased patient’s property not in their possession at the time of death.

Further enquiries can be made to:
Treasury Solicitor (BV)
Queen Anne’s Chambers
28 Broadway
London SW1H 9JS
Tel: 0207 210 3000
Email: Treasury solicitor treasury - solicitor-gsi@gov.uk

5.4.4 Transport of the deceased

The cost of transport of the body when the death occurs a long way from home is always the responsibility of the relatives.

The hospital only has responsibility, when the relatives are unwilling to pay for transport if:

- They have been transferred to The Hillingdon Hospital from a more local hospital for treatment.
- Relatives are only willing to pay for a funeral in their home area, and the cost of transport is less than the cost of the hospital arranging a funeral locally.

5.5 Responsibility of medical records department
On receipt of completed “bed state return”, the date and time of death will be entered on the PAS.

On receipt of a weekly mortality list from Kirk House (which includes all deaths occurring within the borough) the date of death will be entered on PAS.

All existing appointments on the computer will automatically be cancelled and no further appointments will be made.

These procedures are aimed to ensure rapid entry of death into the computer system thus ensuring:

- All existing appointments/admissions are cancelled enabling them to be reallocated to other patients.
- Relatives of the deceased do not receive appointments or correspondence from the hospital, which will add to their distress.

Coding staff will make a daily check of patient notes in the Patient Affairs office to enable the same day coding of notes of deceased patients.

6 Stillbirths, Miscarriages and Termination of Pregnancy

6.1 Still births and terminations for foetal abnormality

After 18 weeks gestation all pregnancies should be delivered in labour ward (unless the woman would prefer not to).

6.1.1 Before the delivery

A quiet and comfortable double room should be used.

Care must be delivered by an experienced midwife whose particular responsibilities include:

- Explaining the stages of labour and relevant procedures
- Inviting the partner to stay throughout labour and delivery
- Offering analgesia of choice
- Discussing the actual birth and their likely wishes regarding seeing and holding the baby etc.
- Documenting patients wishes
- Keeping parents informed of progress throughout
- Offering the services of chaplain or leaders of other faiths (via Hospital Chaplains or switchboard) before and/or after the delivery.
- Listening and respecting the wishes of the parents at all times

6.1.2 Following the delivery

The parents must be offered time to spend alone with their baby.

The parents may want to bath/dress the baby themselves. If not, this can be done for them.

The baby should be laid in a small basket.

At least three photographs should be taken of the baby, suitably dressed, being nursed by the parents or lying in the basket. This will be done following verbal consent; this will be recorded in the woman’s maternity records.

Two photographs are offered to the parents. The remaining photograph is attached securely, in an envelope, inside the records. If the parents choose not to have any photographs they will be kept in the records and given to the parents at a later date if requested.
Hand and foot prints of the baby and a lock of hair, if available, will be offered. This will have been discussed with the parents before the baby is born and their wishes recorded in the records. Parents must be able to spend as long as they want, together with their baby in privacy, overnight if necessary.

The services of the Chaplain are available as soon as the couple are ready if they choose.

The wishes of the parents will be adhered where possible.

The parents will be told of all the relevant administrative details in a sensitive manner, and preferably also in writing.

Parents will be offered all relevant information sheets/booklets, including information from, and a contact number for, relevant “help” organisations. i.e. SANDS, ARC/ The Caring Booklet.

6.1.3 Post Mortem requests

This should be asked for by the obstetrician, paediatrician or midwife. It is good practice for the midwife to discuss this with the parents before the baby is delivered.

Signed consent must be obtained and a request / summary form completed.

The signed consent and request forms, placenta and the baby need to be in the mortuary by 10am to be sent the same day (Mon-Fri) to Oxford. This is done by internal hospital transport. These babies are returned to the Hillingdon Hospital Mortuary.

6.1.4 Transfer of the baby to the mortuary

This remains the responsibility of the midwife/nurse.

Parents usually express a wish for their baby to be dressed in her own clothes, however if they prefer hospital baby clothes may be used or whatever their custom requires.

The baby must be properly labelled, with a name band to one wrist and one ankle or via the umbilical clamp if the baby is too small for the bands to stay in place. The baby will then be wrapped in a sheet secured by tape. The deceased person notice card will be secured by tape to the head end of the sheet.

The baby will be transferred to the mortuary in the baby concealment box.

Two porters are asked to transfer the body.

If the baby is non-viable (pre – 24 weeks gestation) “Babies less than 24 weeks gestation” form should be sent to the mortuary with the baby.

A midwife must accompany the porters to the mortuary.

On arrival the mortuary register will be completed to state female/male infant (if known) and the mother’s name, gestation/age. The baby will be placed in the fridge and the mother’s surname written on the door. If multiple birth, each baby must be entered into the mortuary register.

Parents will be advised that they may visit the Trust to view their baby again. They should be informed that they will need to ring the labour ward to arrange a time.
Before transfer home into community midwifery care (unless declined) women will be given the date and time of the Cremation service for pre viable babies (prior to 24 weeks gestation) who have shown no signs of life. This is held on the first Tuesday of every month in the hospital chapel at 09.15am. A signed consent form from the Mother is required for cremation. If the mother chooses a burial, the midwife will inform the parents of the date once arrangements have been made.

There is a memorial service, which is held at 11.00am on 1st Saturday in March, June, September and December. The service is held in the Hospital Chapel.

Parents may choose to make private arrangements.

6.2 Miscarriages

Any women with threatened miscarriages under 18 weeks should be admitted to Marina Ward, the gynaecology ward.
A bed will be selected to provide where possible:
- Privacy
- Quietness
- Freedom for partner to visit

The bed should not be near to other patients admitted for requested termination of pregnancy.

Care should be provided where possible by an experienced nurse.

If the pregnancy is 12 weeks gestation or less and the miscarriage is inevitable then the mother will discuss all options available to her, at length, with the Early Pregnancy Assessment Team. The options may include the mother being taken to theatre for Evacuation of Retained Products of Conception (ERPC) or if preferred the woman may await events and have a follow up USS after 2 weeks.

If the pregnancy is over 12 weeks gestation and it is necessary to deliver the foetus vaginally, the guidelines for stillbirths apply. (See Section 6.1)

All women will be given the following details in writing:
- Bereavement Information for Babies who are under 24 weeks gestation Booklet
- Invitation to attend Miscarriage Support Group
- Invitation to attend Memorial Service.

The Hospital Chaplaincy offers a Memorial service; this is held at 11.00am on 1st Saturday in March, June, September and December. The service is held in the Hospital Chapel.

All patients will complete a consent form (Consent for Histopathological Examination and Disposal of Tissue Following Early Pregnancy Loss. Trust policy 220). This will provide information on disposal/funeral arrangements. The patient’s wishes as stated on the consent form will be followed.

This consent form records that the patient understands the reasons for examining tissue from their lost pregnancy and that they understand the options available to them with regards to the respectful disposal of the tissue.

6.3 Administrative details for the loss of a baby.

6.3.1 Pre-viable babies (under 24 week’s gestation)
The hospital mortuary will keep all pre-viable babies individually and suitably identified for up to 2 months.
Babies are not always suitable for viewing by parents at a much later date. Parents are offered a hospital cremation service. The baby will be kept for 1 calendar month from the delivery date. The baby will then be included in the next cremation service, which is held on the first Tuesday of every month at 9.15 in the Hospital Chaplaincy centre.

Following this service the baby will be transferred to the Breakspear Crematorium where cremation will take place. Relatives are not invited to attend the cremation.

A signed consent from the Mother is required for cremation.

Following cremation, the ashes of the baby are scattered in the baby memorial garden. Parents can visit the memorial garden at a later date.

There are often no or very few ashes following cremation. Should parents ask about retaining ashes, they must be warned of this. Ashes will not be routinely offered to parents.

In special circumstances a hospital burial can be arranged. Mortuary staff would need to be contacted. The parents are notified of the date and invited to attend the burial which will be in a common grave.

The hospital will cover the cost incurred, unless a private funeral is arranged. If parents do not wish to have a hospital cremation/burial then they need to arrange their own private funeral.

The parents do not receive a certificate of birth or death.

The parents do not need to visit the Patient Affairs office.

After cremation/burial of the body the parents will be invited in writing to attend a memorial service. (See section 6.2)

6.3.2 Still births over 24 week’s gestation

Parents of infants stillborn after 24 weeks have to attend the Patient Affairs office to receive a certificate of stillbirth.

Mothers are still entitled to receive all maternity benefits.

Parents may wish to arrange and pay for a private funeral.

If the parents do not wish to hold a private funeral, the hospital will then contact the contract undertakers who will arrange a simple funeral, and the body will be buried at Cherry Lane Cemetery, or cremated at Breakspear Crematorium.

These funerals are arranged through the Patient Affairs office. Parents are notified of the date of burial and are invited to attend.

6.3.3 Live babies that die

If any baby is alive at birth, even if only for a few minutes, they must be registered as a birth and a death.

Parents must be asked to attend the Patient Affairs office to receive relevant certificates, and then to visit the Civic Centre to register the birth and death.
Parents will be advised about how to organise funeral arrangements by staff in the Patients Affairs Office.

7 **Support for Staff**

Caring for the dying and their relatives and dealing with death can cause staff distress. It is important to ensure all staff receive appropriate support through debrief, discussion, midwifery supervision and reflection, one 2 one or group as required. Support can also be found through Occupational Health Services.

**Employee Assistance Programme: Helpline Number 0800 181 392**

8 **Development & Production of this policy**

8.1 **Development of Care & Respect in Death Policy**

This policy has been developed by consulting with identified stakeholders to update the original policy and incorporate recognised best practices regarding end of life care and bereavement. Dignity and respect for all patients and their families is the overarching principle that supports this policy.

The Internet was used to benchmark best practice in other organisations and to ensure that latest legislation or guidance was considered.

Once drafted the policy was circulated to Identified stakeholders for consultation with their clinical colleagues, and was taken to the Nursing & Midwifery Board to ensure nursing and midwifery staff were able to contribute and comment on the content.

8.2 **Identification of Stakeholders**

A stakeholder analysis identified the following as key stakeholders in the provision of care and respect in Death to all Trust patients

- Our patients and the public
- All hospital staff who deal directly with patients and their relatives

8.3 **Equality Impact Assessment**

See attached. Performed with advice from Equality & diversity Lead.

9 **Dissemination and Implementation**

9.1 **Dissemination**

Staff will be informed of revisions to this policy via a general information email. Awareness will be raised by discussion at staff forums, such as Senior Sisters / Matrons meetings and Clinical Governance Forums. Trust publications such as the Core Brief Bulletin and The Pulse will also be utilised to raise awareness.

The policy will be located on the Trust intranet under ‘Trust Policies’ and will be accessible to all staff.

New staff will be made aware of this policy during the corporate induction programme and local induction process.

Previous versions of the policy will be archived by the Governance Support department.

9.2 **Implementation of Care and Respect in Death Policy**
All staff are to be made aware of the requirements of this policy and their responsibility within the policy. This policy will be accessible to all staff via the Intranet under ‘Trust Policies’. Further training needs will be identified by the department manager/ward sister during local induction for new staff and continually at staff appraisals. It is the responsibility of all staff members to ensure that they are up to date and compliant with Trust policies.

10 Process for Monitoring Compliance and Effectiveness

This policy will be monitored on an ongoing basis by monitoring progress and reviewing compliance against:

Review of formal incident reporting using the Trust Datix system. Any incidents relating to care & respect of the dying or deceased patient.

The number of formal and informal complaints related to end of life care and bereavement (Complaints Team).

The number of hospital contract funerals occurring per annum. (Patient Affairs Team)

The Lead Practice Development Nurse will also be vigilant with regards to new national policies or guidelines that may produce a need for the policy to be updated.

11 References & Further Reading


Improving Supportive and Palliative Care for Adults with Cancer. (2003) National Institute for Clinical Excellence.


http://www.ethnicityonline.net/

12 Associated Trust Policies/Procedures

<table>
<thead>
<tr>
<th>Policy ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Viewing Policy - CCTV in Mortuary &amp; Body Viewing Areas</td>
</tr>
<tr>
<td>21</td>
<td>Chaplaincy and Pastoral Care</td>
</tr>
</tbody>
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Equality Impact Assessment Report Outline

1. **Name of Policy or Service**
   
   Policy & Guidance for the Provision of Care & Respect in Death

2. **Responsible Manager**
   
   Lead Practice Development Nurse

3. **Date EIA Completed**
   
   17th August 2009

4. **Description and Aims of Policy/Service (including relevance to equalities)**
   
   The policy is for all staff involved with the care of the dying and deceased patient and their relatives. The aim of the policy is to ensure that all staff have the knowledge and information required to ensure that all patients are treated with dignity and respect and at the time of death that procedures are followed to ensure a dignified end to life.

5. **Brief Summary of Research and Relevant Data**
   
   - End of Life Care Strategy promoting high quality care for all adults at the end of life. (2008) DOH
   - NHSLA Risk Management Standard requirements
   - United Kingdom Hospital Policy for Organ and Tissue Donation. (2003). NHS UK Transplant

6. **Methods and Outcome of Consultation**
   
   The policy has been reviewed by senior nurses, the mortuary team, the palliative care team, the portering team, chaplaincy, and medical & therapy staff.

7. **Results of Initial Screening:**

<table>
<thead>
<tr>
<th>Equality Group</th>
<th>Assessment of Impact</th>
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<tr>
<td>Age</td>
<td>This policy applies to all age groups including children. The Liverpool Care Pathway, at present, is applicable to care of the adult patient. There are plans to adapt the Pathway for other</td>
</tr>
</tbody>
</table>
areas, but uncertainty around paediatrics.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>No</td>
</tr>
<tr>
<td>Race</td>
<td>No</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>No</td>
</tr>
<tr>
<td>Religion or belief</td>
<td>The impact on differing religions &amp; cultures has been considered and addressed within the policy.</td>
</tr>
<tr>
<td>Disability</td>
<td>Potential negative impact on people with learning difficulties &amp; people with a compromised level of understanding. All efforts will be made to recognise people with disabilities and all steps taken to minimise any negative impact on the individual and their family.</td>
</tr>
<tr>
<td>Deprivation</td>
<td>No</td>
</tr>
<tr>
<td>Dignity and Human Rights</td>
<td>No</td>
</tr>
</tbody>
</table>

9. Decisions and/or Recommendations (including supporting rationale)

The Policy provides an effective framework for meeting the needs of equality groups and the need for staff to be aware of and have the ability to recognise people’s individual beliefs and treat accordingly.

The need to respect and adhere to individual patient needs is embedded throughout the policy.

10. Monitoring and Review Arrangements (including date of next full review)

This policy will be reviewed after 6 months to ensure there are no immediate changes required based on initial concerns that may be raised following the policy launch. The policy will be reviewed following on any new guidance or statutory requirements that will affect the information provided within the policy.

The Trust’s Equality & Human Rights statement

What does Equality & Diversity mean for Hillingdon Hospital?

Hillingdon Hospital NHS Trust aims to treat people as individuals in accordance with their personal health needs. We will not base assumptions about a person’s needs on the fact of their belonging to a particular group or community.
We aim to make services sensitive and appropriate to the diverse cultures, languages and individual needs of patients. We aim to reduce inequalities in health, in partnership with all sectors and communities.

We are committed to becoming a model employer, welcoming, valuing and learning from the diversity of our staff.

We will tackle unfair or unlawful discrimination on the basis of any relevant factors, in particular race, ethnicity, nationality, colour, gender, marital status, disability, age, religion and sexual orientation.

We aim to be a force for positive change in public services, to lead by good example and to learn from best practice.

Hillingdon recognises that some groups face particular risk of discrimination in health services. Such groups include black and minority ethnic communities, refugees and asylum seekers, travellers, homeless people and people with disabilities.

As an Acute Trust we will work with providers and contractors to ensure that valuing diversity and promoting fair access are core elements of care.
### Legislation Screening Grid

<table>
<thead>
<tr>
<th>Equality Area</th>
<th>Key Equalities Legislation (see summary sheet)</th>
<th>Is this policy or service RELEVANT to this equality area? YES / NO</th>
<th>Assessment of Potential Impact: HIGH MEDIUM LOW NOT KNOWN</th>
<th>Reasons for Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Sex Discrimination Act 1975</td>
<td>NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Equal Pay Act 1970</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Equalities Act 2006</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gender Recognition Act 2004</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>Race Relations Act 1976</td>
<td>NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Race Relations (Amendment) Act 2000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td>Disability Discrimination Act 1995 and 2005</td>
<td>YES</td>
<td>Difficulties with levels of understanding in some disabled people</td>
<td>To ensure that all patients have the opportunity to state their wishes &amp; needs at this time. That equality is achieved.</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------------</td>
<td>-----</td>
<td>------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Age</td>
<td>Age Regulations 2006</td>
<td>YES</td>
<td>This policy applies to all age groups including children. The Liverpool Care Pathway, at present, is applicable to care of the adult patient. There are plans to adapt the Pathway for other areas possibly to include paediatrics.</td>
<td>To keep abreast of changing, updates in practices and ensure that best practice is recognised and implemented.</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>Equalities Act 2006</td>
<td>NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion and beliefs</td>
<td>Equalities Act 2006</td>
<td>NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>Human Rights Act 1998 (relevant articles)</td>
<td>NO</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Addressograph here

Date started LCP …… /……/……

Next of Kin – Name………………………………………………………………………………………………………………

Tel No.………………………………………………………………………………………………………………………

Wishes to be contacted at night  Y  N  

GP informed of Pt condition  Y  N

Ward……………………… Consultant…………………………. Consultant…………………………. Cancer / Non Cancer (circle)

Signed by SpR/Cons…………………………. (Print name)………………………… Date …… / ……/……

Signed by Nurse in Charge………….……..… (Print name)……………….……… Date …… / ……/……

LCP Inclusion Criteria – The MDT, patient (if appropriate) and family (or advocate) have;

a) Agreed the patient is likely to die during this episode of care and;

b) Two of the following may apply:

Diagnosis of Dying

- Bed bound  Y  N  Sips of fluids only  Y  N

- Semi-comatose  Y  N  No longer able to take pills  Y  N

Other state…………………………………………………………………………………………………………………………

Do not resuscitate decision  Y  N

Are the following interventions still necessary?

Blood Tests  Y  N

Antibiotics  Y  N

IV Fluids / Drugs  Y  N

Parental / Enteral Feeding  Y  N

Observations + TPR  Y  N

Blood glucose monitoring  Y  N

Routine position changes  Y  N

If Yes to any of above, please state rational:-

……………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………
# Liverpool Care Pathway
## The Hillingdon Hospital
### NHS Trust

### Appendix A

## Symptom Assessment

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vomiting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breathlessness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incontinence</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Agitation</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Sore/Dry Mouth</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Chest secretions</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Spiritual Issues

Has the patient been asked if they have fears/anxieties/questions about life or death?  

Y N

Has the family been asked if they have fears/anxieties/questions about life or death?  

Y N

If NO, state reason ………………………………………………………………………………………………………………………………………

## Religious Issues

Does the patient have a faith?  

Y N

Specific requirements (e.g. diet, rituals, privacy issues etc.)  

……………………………………………………………………………………………………………………………………………………………………

Support identified - Name: …………………………………………………………………………………………………………………………………

Tel No: …………………………………………………………………………………………………………………………………………………

## Medication

Appropriate oral drugs converted to **subcutaneous route**  

PRN subcutaneous medication prescribed  

Y N

- Morphine – For pain/breathlessness  

Y N

- Midazolam – For agitation  

Y N

- Glycopyrronium/Hyoscine hydrobromide – For chest secretions  

Y N

- Haloperidol or Cyclizine – For nausea/vomiting  

Y N

Dr. ………………………………………………………………………………………………………………………………………………………………………Date…… /…… /……

Nurse in Charge………………………………………………………………………………………………………………………………………………………Date…… /…… /……
<table>
<thead>
<tr>
<th></th>
<th>Preparing for death</th>
<th>Imminent death</th>
<th>After death</th>
<th>Burial/cremation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buddhism</td>
<td>A dying Buddhist needs peace and quiet. They may wish to see a religious leader, or monk. They may chant passages of scripture.</td>
<td>A Buddhist needs to die with a clear and conscious mind. They may refuse pain killers. Someone may chant to bring peace.</td>
<td>There are no specifics, this is based upon culture. Ask the family for advice.</td>
<td>Both, according to local tradition.</td>
</tr>
<tr>
<td>Christianity</td>
<td>Some Christians recite prayers; others may request a religious leader. Some will want to be anointed with holy oils by a minister/priest.</td>
<td>A chaplain, minister or priest may be requested to give Holy Communion, or recite the prayers of Commendation.</td>
<td>Some relatives may wish for the body to be blessed and the prayers of the dead said. Relatives may wish to say special prayers, place the deceased hands together and place a cross on them.</td>
<td>Both.</td>
</tr>
<tr>
<td>Hinduism</td>
<td>Hindus will want their family present. They may wish to lie on the floor. They may read from their holy books and sing hymns.</td>
<td>A priest may be requested by a Hindu family. A dying patient should be given Ganges water and a relative may place a Tulsi leaf in their mouth. The name of God should be recited. Where possible they should die at home.</td>
<td>Do not remove jewellery or religious objects. The family should be allowed to wash the body.</td>
<td>Cremation. Only children under three years are buried.</td>
</tr>
<tr>
<td>Islam</td>
<td>Family and friends will recite passages from the Qur’an. A dying Muslim should be facing Mecca (south east).</td>
<td>The Declaration of faith (Shahada) is recited. The dying patient should be helped to respond ‘I bear witness that there is no God but God and Muhammad is His Messenger.’</td>
<td>Non Muslims should not touch the body with bare skin. The body must be kept covered. It should be washed by a person of the same sex. of the same sex.</td>
<td>Burial.</td>
</tr>
<tr>
<td>Judaism</td>
<td>A rabbi may be requested to help a Jewish patient recite their death bed confession.</td>
<td>They must not be left alone. Psalms should be recited. Upon death a Declaration of Faith should be recited.</td>
<td>The body should be covered with a white sheet. The body should be touched as little as possible. The Jewish Burial Society will collect the body and perform ritual washing.</td>
<td>Burial</td>
</tr>
<tr>
<td>Sikhism</td>
<td>A dying Sikh, or their relatives, may wish to recite hymns and prayers from their holy book.</td>
<td>A Sikh should die with the name of God, Waheguru, Wonderful Lord, being recited. Some may want Amrit, holy water, in their mouth.</td>
<td>Cover the body in plain white sheet. Do not trim any hair. The 5Ks should remain on the body. Relatives may want to wash the body.</td>
<td>Cremation</td>
</tr>
</tbody>
</table>
Mortuary Infection Control Notification Sheet

Name of Deceased: .................................................................
(addressograph label if possible)
Address: .............................................................................
Hospital Number: .................................................................

Date and Time of Death: ......................................................
Ward: ...................................................................................
Contact No: .........................................................................

Does the deceased have any of the following infections?

**DO NOT CIRCLE SPECIFIC INFECTION**
- Meningococcal septicaemia
- Tuberculosis
- Hepatitis B, C and non-A non-B
- HIV/AIDS
- Rare diseases to Hillingdon: Plague, Rabies, SARS, Smallpox, Viral
  Haemorrhagic fever (inc. yellow fever), Invasive group A streptococcal infection,
  VCJD

YES / UNKNOWN (Please Circle)

If circled YES a body bag IS necessary according to Hospital policy 74.

The mortuary staff will phone on their next working day to confirm the specific infection.

Please tick where appropriate:

- The body is bagged because of infection. ☐
- The body is bagged because of leaking. ☐

The doctor who is certifying the death or the nurse verifying the death must sign this form.

Signed: ..............................................................................
Print Name: ........................................................................

Mortuary APT
Ex 3431
Bleep 610

This form MUST come to the mortuary with the deceased.
Please ensure the deceased has at least ONE ID band on and is suitably clothed (eg, a shroud/gown).

This form MUST come to the mortuary with the deceased.
Please ensure the deceased has at least ONE ID band on and is suitably clothed (eg, a shroud/gown).