



Care of the deceased patient and their family

A Guideline for Nursing Practice
in Northern Ireland

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Foreword

Last offices is the term traditionally used in nursing to describe the final acts of care for a deceased person. This guidance reflects that care but also the wider responsibilities that nurses have; before, at the time of and immediately after death.



The principles contained within this document will provide guidance for nurses/midwives working in any setting and who care for dying patients and their families. Nurses/midwives lead in the coordination of this care and are uniquely placed to ensure that these final acts of care for the person and their loved ones uphold standards of good nursing practice.

It is an important opportunity to provide care and attention to the bereaved family, friends and carers ensuring that they receive sensitive and respectful information through good interaction with staff followed up with appropriate written information to support them through that difficult time.

This document provides guidance on how to achieve the delivery of effective, sensitive; person-centred nursing care to a deceased person and their families/friends/carers. The guidance is for everyone in the nursing and midwifery family and will complement existing policies and procedures.

A handwritten signature in black ink that reads 'Charlotte McArdle'.

Charlotte McArdle
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1. Introduction

'Last offices' is the term traditionally used in nursing to describe the final acts of care for a deceased person's body.¹ The term 'personal care after death' is now more commonly used to describe care of the deceased patient's body and also the wider responsibilities that nurses have at the time of and immediately after death.²

Whilst the extent of procedures performed by nurses has changed in recent years, after death care of the deceased patient's body remains an opportunity for nurses to demonstrate respect and sensitivity, including due regard for any required cultural and religious considerations. At this time nurses are in a unique position to liaise with colleagues in other professions and services to coordinate any health and safety, legal and administrative requirements resulting from the death. Providing information and support to bereaved carers and family is also an essential element of nursing care after death.

In Northern Ireland (NI) the HSC Bereavement Network and Trust Bereavement Coordinators (TBCs) support regional implementation of the HSC Services Strategy for Bereavement Care.³ The strategy outlines six standards for care that guide the quality of service and support delivered by HSC staff before, at the time of and after death (Appendix 1).

An example of an initiative introduced to meet the standards was the development of a 'Body Transfer Form' for use in all NI hospitals (Appendix 2). Nurses complete this form prior to the deceased patient being transferred from place of death. The use of the form facilitates safe and effective handling and transfer of a deceased patient's body and communicates important information to those assuming responsibility for the deceased eg. transferring and mortuary staff and family funeral directors.

The introduction of the regional Body Transfer Form provided nursing staff with the opportunity to raise a number of questions in relation to care after death as they are responsible for recording information about the deceased patient (Appendix 2). The TBCs noted a variation in practice across the region and a lack of awareness of the purpose of last offices procedures. Questions were also raised about documenting health and safety information, such as infection control measures, for the attention of staff handling and receiving the body.

Other issues relevant to nursing care after death include reporting the death to medical colleagues and being aware of the legal and professional responsibilities of doctors. These responsibilities include, verification, certification and establishing whether Coroner's requirements will affect how nurses care for the deceased.

Clear and compassionate communication when providing support and information to bereaved relatives is a further element of nursing care after death.

¹ The Royal Marsden Manual of Clinical Nursing Procedures (2015) Care after Death (last offices) in CH 8 Patient comfort and end-of-life care. 9th Ed. Accessed online 03/08/15

www.rmmonline.co.uk/manual/c08-sec-0360#c08-sec-0360

² Ibid. Chapter 8

³ Department of Health, Social Services and Public Safety (2009) HSC Services Strategy for Bereavement Care. Belfast. DHSSPSNI

Nursing literature on the subject of care of the deceased patient's body^{4 5} has also described challenges related to care after death. In 2011 the NHS National End of Life Care Programme and National Nurse Consultant Group recognised the impact that the lack of clear guidance and training can have on practice at this extremely important time. They issued 'Guidance for Staff Responsible for Care after Death (last offices)'⁶ which has since been revised and published by Hospice UK.⁷

It was felt that nursing staff in Northern Ireland would also benefit from similar clear, regional guidance on care after death. This guideline has been greatly informed by that publication with additional material that reflects professional practice, legal requirements and cultural norms in Northern Ireland. This guideline aims to provide nursing staff with a holistic perspective on all the processes associated with care after death and, in doing so, to facilitate the delivery of safe, effective and sensitive care for deceased patients and their bereaved families.

2. Development of the guideline

As part of the development of this guidance nurses, care assistants and midwives within the five HSC Trusts were consulted. The consultation process, which was undertaken between April and May 2016 invited responses from members of Trust Bereavement Forums and the wider nursing population to a draft of the document by way of a questionnaire. The results of the consultation provided the writing group with valuable suggestions and amendments which have informed the documents final content.

3. Who will find this guideline useful?

The guideline has been written for registered nurses and health care assistants as they have responsibility for care and handling of a deceased patient. It complements the information and related theory in **Chapter 8: Patient comfort and end of life care - Care after death (last offices) and the personal care after death procedure** promoted as the gold standard for nursing practice in the Royal Marsden Manual of Clinical Nursing Procedures.⁸

Online access to the manual is available in all HSC Trusts. This guideline will supplement and inform policies and procedures HSC Trusts have in place for care and handling of deceased patients eg. those that guide the delivery of safe and sensitive care dictated by the circumstances, including last offices.

It may also be informative for other healthcare professionals who provide care at the time of and following a patient's death in acute, secondary or primary care settings.

⁴ Clover, B. (2010) Nurse Training ignores emotional impact of last offices. NursingTimes.net

⁵ West, D; Clover, B and Lomas, C. (2010). Last Offices neglected in over half of hospital deaths. NursingTimes.net

⁶ NHS National End of Life Care Programme (2011) Guidance for Staff Responsible for Care after Death (last offices). NEOLCP National Nurse Consultant Group. www.endoflifecareforadults.nhs.uk

⁷ Hospice UK and National Nurse Consultant Group (2015) Care after Death: Guidance for staff responsible for care after death. 2nd Ed. Hospice UK. www.hospiceuk.org

⁸ The Royal Marsden Manual of Clinical Nursing Procedures (2015) Care after Death (last offices) in CH 8 Patient comfort and end of life care. 9th Ed. Accessed online 03/08/15

4. Aim of guideline

The guideline aims to:

- Promote safe and sensitive care of the body at the time of and after death, taking into consideration the wishes of the deceased patient and their family
- Ensure the deceased person is treated with dignity and respect, and that cultural and spiritual needs are met
- Promote effective inter-agency working by outlining the roles and responsibilities of relevant professionals and organisations who are involved in caring for the deceased patient and their relatives
- Promote effective communication and provide information to assist families when dealing with the practical issues that arise as a result of the death eg. registration of death or a death that is referred to the Coroner
- Inform the development of relevant policy, procedures and protocols to guide the practice of health and social care staff
- Provide a resource that will be useful for pre and post registration training and education and contribute to the professional development of nurses in the care of the deceased patient and their family.

5. Principles for care of the deceased and their family

- 5.1** Death may be expected, sudden, peaceful or traumatic. The nature of the death and the context in which it has occurred will determine the level of immediate support and information required by those who have been bereaved.
- 5.2** The following principles should inform nursing practice when death occurs:
- Acknowledgement of the grief of bereaved people and provide emotional support and information appropriate to the circumstances
 - Consideration for the religious, spiritual and cultural wishes of the deceased patient and their family, whilst ensuring legal obligations are met
 - Preparation of the deceased patient prior to family spending time with them and then for transfer to the mortuary or the funeral director's premises
 - Providing family members with the opportunity to participate in this process if they wish, and supporting them to do so
 - Protection of the privacy and dignity of the deceased patient
 - Protection of the health and safety of all coming into contact with the body
 - Liaison with specialist staff in organ and tissue donation processes when indicated
 - Provision of information on post-mortem examination if relevant (ie. Coroners, medico-legal/ or hospital consented)
 - Return of personal possessions of the deceased patient to family in a respectful manner.

6. Preparing for death - Steps to creating a supported experience

- 6.1** Where death is anticipated and predicted, care should be planned in accordance with the five principles for care of the dying person⁹ and NICE guidance for care of the dying person in last days of life¹⁰ (Appendix 3). It is important that agreement is reached between medical and nursing teams, patients and their families about clinical decisions and a plan of care that is appropriate to the needs of the dying individual.
- 6.2** Clear and unambiguous communication in advance ensures there is understanding of the prognosis and allows for appropriate preparation of the dying person and their family.

Decisions documented in the patient's care plan may include:

- Resuscitation status¹¹
 - Management of implanted cardiac devices
 - Preferences for place of death whenever that is possible eg. facilitating discharge to own home or usual residence
 - Any religious, spiritual, cultural or practical wishes - this is particularly important if immediate release for burial or cremation is a faith requirement. Advice on the requirements of a range of faiths and cultures around death is available in the Multicultural and Beliefs Handbook available in all HSC Trusts.¹² Spiritual support for both the dying person and those that matter to them can be provided by their own faith representatives and hospital Chaplaincy Services
 - The individual's wishes regarding chaplaincy support during illness and attendance after death. This should be offered in a timely manner so as to allow for meaningful interaction with the patient, their family and chaplaincy services
 - Contact information for those the dying person would like to have with them at the time of death is discussed, recorded and should be readily accessible by all appropriate staff. It is advisable that more than one contact telephone number is recorded in case relatives cannot be reached
 - In some cases post-mortem examination may have been discussed and documented prior to death and in these situations the decision of the deceased should be respected
 - If known, any wish on whole body donation. This can only be arranged prior to death by individuals themselves and not by anybody else on their behalf after death.¹³
- 6.3** The individual's wishes regarding organ and tissue donation may or may not be formally recorded on the Organ Donor Register (ODR). Each Trust has a specialist nurse for organ donation and clinical lead that must be contacted and involved in consent discussions if donation is an option. They will provide appropriate information, advice and support to staff and relatives. The on call specialist nurse for organ donation can be contacted using the 24 hour pager number for the NI Organ Donation Services Team **07699 748 246**. Further information is available on the National Organ Donation and Transplantation website.¹⁴

⁹ DHSSPS (2014) HSS (MD) 21/2014 Advice to health and social care professionals for care of the dying person in the final days and hours of life - Principles for care of the dying person. Chief Medical Officer/Chief Nursing Officer

¹⁰ NICE NG 31 (2015) Care of dying adults in the last days of life. www.nice.org.uk/guidance/NG31

¹¹ BMA, Resuscitation Council, RCN. 2016. Decisions relating to cardiopulmonary resuscitation (3rd ed-1st revision) www.resus.org.uk/dnacpr/decisions-relating-to-cpr/

¹² HSC Multicultural and Beliefs Handbook

www.southerntrust.hscni.net/pdf/S75.MultiCulturalandBeliefsHandbookMarch2012.pdf

¹³ Body Bequest information. Queens University Belfast. www.qub.ac.uk/schools/mdbs/bms/AboutUs/BodyBequest/ Accessed 23 September 2016

¹⁴ www.odt.nhs.uk

- 6.4** The environment in which a dying person and their family are cared for and supported can have an impact on the experience.¹⁵ Whenever possible a dying patient should be nursed in the quiet of a single room where the family have freedom to visit and stay at any time and where significant conversations can be held in private. This is not always available and where a patient is being cared for in an open ward setting a private space should be identified and used for communication with the patient and family.
- 6.5** When the dying patient is being cared for in an open ward setting, nurses should be aware of the potential impact of this situation on other patients and visiting relatives in the area. Measures should be taken to ensure the privacy and dignity of everyone affected by the situation.
- 6.6** Normal visiting hours should be relaxed for families of dying patients and every effort should be made to accommodate their wishes eg. facilitation of visits from faith representatives or other people important to the patient. Where families are having to spend extended periods at the bedside before death it is important that nursing staff explain where refreshments are available and any options for reimbursement of car parking costs.
- 6.7** In sudden death situations many of the principles outlined above will be relevant. However, nursing staff should be aware of the impact of trauma on an individual's behaviour and need for support in the immediate aftermath of sudden and unexpected death.

7. At the time of death - Steps to creating a supported experience for the family

- 7.1** The patient's family should be told of the death in a clear, supportive and compassionate manner. They should be offered the services of hospital chaplaincy and/or other personnel appropriate to provide support in the circumstances eg. social worker. The use of communication strategies for breaking bad news will reduce the risk of causing further and unintentional distress.
- 7.2** If the family is not present at the time of death they should be contacted by a professional with appropriate communication skills. In those instances where staff are unsuccessful in contacting the family the police service can be of assistance in locating them and breaking significant news. When relatives arrive at the ward/department staff should meet them and accompany them into the presence of the deceased patient.
- 7.3** Preparation of the deceased patient prior to the family spending time with them is a very important aspect of nursing care. Following traumatic death they should be prepared for what they will see eg. the presence of lines, tubes and condition of the body that may be distressing following trauma.
- 7.4** If the family's first language is not English the services of an interpreter will ensure that they receive the information they need to make sense of what has happened, especially if the death was not expected.

¹⁵ Northern Ireland Audit: Dying, Death and Bereavement October 2010 Phase 2: The experiences of bereaved people and those delivering primary care services

- 7.5** The family will require a sensitive verbal explanation of what will happen next, which will be dependent on the circumstances of death ie. formal verification, completion of Medical Certificate of Cause of Death or reporting the death to Coroner's Service and transfer to mortuary. Written information that explains practical matters appropriate to the circumstances of death as well as advice on grief and coping with bereavement should also be offered.
- 7.6** If children were close to the person who has died, adults may require help with how best to tell them.¹⁶ Bereavement Information booklets are available for those supporting children.
- 7.7** Last offices procedures to prepare the deceased patient for transfer to the mortuary should be carried out after death has been verified and the patient's immediate family has had an opportunity to spend some time with them following death, should they so wish.

8. Governance and legal issues relevant to care after death

In Northern Ireland, holding a 'wake', where family and friends come together to view the deceased person in their own home or funeral home, is a common occurrence. This and the expectation that a funeral can be arranged within three to four days of death have deep religious, cultural and social significance. While every effort is made by all services with a responsibility after death to facilitate this practice as far as is possible, a number of statutory and legal processes after death have to be fulfilled prior to a funeral and burial/cremation taking place. Nursing staff caring for deceased patients and their families should be familiar with such statutory and legal requirements. Knowledge of the roles and responsibilities of other relevant healthcare professionals and agencies is essential as they too may inform the actions nurses are required to undertake or coordinate at the time of death.

This section outlines the processes of which nurses need to be aware.

8.1 Verification of Death

All deaths need to be formally confirmed or verified. A medical practitioner or a nurse trained in the criteria for verifying death, in line with national guidance, is required to attend and formally verify that death has occurred¹⁷ ¹⁸prior to the patient being transferred from their place of death.

It is best practice that verification takes place as soon as possible, especially when the family is present, or when death occurs close to midnight as the recorded time and date of verification informs the time and date of death that will be entered on the Medical Certificate of Cause of Death.

HSC Trusts and healthcare providers should have an appropriate policy and procedure in place when verification of death is carried out by registered nurses.¹⁹

¹⁶ When someone close to you dies; A guide for talking with and supporting children, HSC Bereavement Network, 2012

¹⁷ www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/hss-md-8-2008.pdf

¹⁸ Department of Health, Social Services and Public Safety (2008) Guidance on death, stillbirth and cremation certification. DHSSPS

¹⁹ www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/Regulation-in-Practice-Topics/Confirmation-of-death-for-registered-nurses/

8.2 Completion of Medical Certificate of Cause of Death (MCCD)

Registered Medical Practitioners have a legal duty to provide a certificate of cause of death if, to the best of their knowledge, that person died of natural causes for which they had treated that person in the last 28 days.²⁰ The purpose of certification is twofold; it allows the family of the deceased to register the death so that a permanent legal record of the fact of death is recorded and it contributes to statistical information on causes of death used for monitoring the health of the population etc.

It is good practice that the MCCD is issued within one working day so burial or cremation arrangements are not unduly delayed. If cultural or religious practices require completion on the same day, this should be accommodated wherever possible.

Since April 2017 all HSC Trusts have in place a new Regional Mortality and Morbidity Review System. This system will generate an MCCD following the completion of the Initial Record of Death (IRD) form. On completion of the IRD an email will be generated to the responsible Consultant who will be required to review the IRD and, if applicable, the MCCD. The death will then be tabled for review at a monthly Mortality and Morbidity meeting where each death will be discussed.

Nursing staff are often in a position to liaise with the doctor responsible for completing the MCCD and provide bereaved relatives with information relating to when and where it may be available for collection.

8.3 Completion of Cremation Documentation

If the deceased or their family indicate that cremation is their preferred option there is currently a separate Cremation Certification Process. This involves completion of a series of medical forms by two independent doctors, both of whom are required to examine the body after death.

The funeral director nominated by the family will make the necessary arrangements for completion of cremation documentation and will liaise with medical staff and hospital mortuary staff in the process.

Sometimes bereaved relatives may ask nursing staff questions about the process for arranging cremation and nurses should reassure them that their nominated funeral director will assist them with arrangements.

8.4 Reporting Death to the Coroner

When death resulted directly or indirectly from any cause other than natural illness or disease for which the deceased had been treated within 28 days prior to death, medical staff are required to immediately report it to the Coroner's Service and seek advice about next steps. Medical staff should be aware of the criteria for referring a death to the Coroner's Service and also the Registrar General's Extra-statutory List of Causes of Death that should be referred to the Coroner's Service.²¹

²⁰ DHSSPS (2008) guidance on death, stillbirth and cremation certification

www.dhsspsni.gov.uk/publications/guidance-death-stillbirth-and-cremation-certification

²¹ Department of Health, Social Services and Public Safety, General Register Office (Northern Ireland), Coroners Service for Northern Ireland (2008) Guidance on Death, Stillbirth and Cremation Certification.

DHSSPS **www.dhsspsni.gov.uk/publications/guidance-death-stillbirth-and-cremation-certification**

Following report of a death the Coroner in NI will direct one of three courses:

1. Advise doctor to complete MCCD
2. Allow death to be processed under Pro forma System
3. Direct a post-mortem examination.

If the Coroner directs to use the Pro forma System, the family are not given an MCCD. The Coroner will ask the doctor to complete a special Pro forma Form or accompanying letter that briefly sets out the background and circumstances to the death and send it to the Coroner with an unsigned MCCD.

For deaths in hospital, the new Regional Mortality and Morbidity Review System will generate a Clinical Summary in place of the Pro forma for issue to the Coroner on completion of the IRD.

The Coroner will send this information to the Registrar of Deaths who will in turn provide the family with the certificate of death. If a death is being processed using the Pro forma System this will need to be explained to the family.

In order to establish the cause of death the Coroner may direct that a post-mortem examination takes place.²² Brief details of the circumstances of death reportable to the Coroner can be found in Appendix 4.

At this particularly distressing time, bereaved relatives should be given information and help to understand the Coroner's process and what will happen next eg. that they may be spoken to by police officers acting as the Coroner's agents to gather information on the deceased's last minutes/hours and details about where and when the post mortem examination will take place.

Regardless of the Coroner's decision to proceed with a post-mortem any contact with the Coroner's Office should be shared with the family as part of an HSC Trusts obligation of duty of candour.

Nursing staff can support medical colleagues in providing support and information to the family in these situations. They also need to be made aware that, as part of the Coroner's process, they may be required to provide information on the circumstances of death and should follow their organisations policy and guidance for assisting the Coroner's investigations.

Requests for formal statements or medical records are usually requested through Risk Management/Litigation Departments who will follow agreed protocols and assist staff to provide information to the Coroner's Service.

A key consideration for nurses when the Coroner directs a forensic post-mortem examination is the restrictions that will apply to handling of the body. If a forensic autopsy is ordered it is essential that the body is seen by the pathologist exactly as the deceased was at the time of death.²³

²² www.courtsni.gov.uk/en-GB/Services/Coroners/Pages/default.aspx

²³ Working with the Coroners Service of Northern Ireland

www.courtsni.gov.uk/en-GB/Publications/UsefullInformationLeaflets/Documents/Working%20with%20the%20Coroners%20Service%20for%20Northern%20Ireland/Working%20with%20the%20Coroners%20Service%20for%20Northern%20Ireland%20%28PDF%29.pdf

Accessed 3rd October 2016 at 11.17am

8.5 Implications for care of the body when the Coroner orders a post-mortem examination

Liaise with medical colleagues for confirmation of the Coroner's directions and seek advice from the Mortuary Team as necessary.

Where the Coroner requires a post-mortem examination the following measures are advised in relation to caring for the body:

- Do not wash the body. Fluids or discharge should be managed by using absorbent dressings or pads
- Leave all intravenous cannulae and lines in situ and intravenous infusions clamped but intact
- Leave endotracheal (ET) tubes in situ
- Leave any catheter in situ with the bag and contents
- Continue using universal infection measures to protect people and the scene from contamination
- Follow the HSC's Trust policy and procedures for preserving evidence in suspicious circumstances and transfer of the body to the mortuary pending examination.

Sensitively inform the family of the reasons why devices are left in situ and that after examination they will be removed and they will then be able to spend time with the deceased if they wish.

8.6 Serious Adverse Incidents

On occasion a death may be reported as a Serious Adverse Incident (SAI) to the Health and Social Care Board to help identify learning even when it is not initially clear if something has gone wrong. The purpose of an SAI is to find out what happened, why it happened and what can be done to try to prevent it from happening again and to explain this to those involved. Relatives of the deceased will be informed and invited to be involved in this process.

9. Care after death

The body of the deceased person needs to be cared for with dignity. It is helpful if the surrounding environment conveys this respect. This includes the attitudes and behaviour of staff, particularly as bereaved relatives can experience high levels of anxiety and/or distress.

Evidence suggests that the entire end of life care environment - including the journey to the mortuary and how the deceased's possessions are handled has not only an immediate impact on relatives but also affects their subsequent bereavement and grieving.

- 9.1** The care and handling of the deceased patient's body is the responsibility of two people, one of whom will be a registered nurse or suitably trained person.²⁴ The registered nurse is responsible for correctly identifying the deceased person whilst carrying out last offices and communicating accurately with the mortuary or funeral director in line with local policy and protocols.

²⁴ Care after Death (2015) Hospice UK and National Nurse Consultant Group

- 9.2** Personal care after death will be carried out within two to four hours of the person dying, to preserve their appearance, condition and dignity. This is because rigor mortis can occur relatively soon after death and the time period is shortened in warmer environments. Tasks such as laying the deceased flat (while supporting the head with a pillow) and preparing them and the room for the family need to be completed as soon as possible within this time. When the family cannot visit the body on the ward, arrangements should be made for viewing at another appropriate location, such as a viewing room attached to a mortuary. In community settings there may be more flexibility.
- 9.3** Standard infection control precautions should be maintained in the care of all deceased patients. Any additional infection control precautions in place before the patient died should continue after death during hygienic preparation of the body.²⁵ See Appendix 5 for a table of precautions relevant to infection including advice on when a body bag may be required or where viewing of the body is affected.
- 9.4** Patients, residents and staff in clinical settings, such as hospitals, care homes and prison hospitals, have often built significant relationships with each other. Addressing their bereavement needs should be considered within the boundaries of patient confidentiality. If the person has died in an environment where other people may be distressed by the death, they should be sensitively informed that the person has died, with care taken not to provide information about the cause and reason for death.
- 9.5** To encourage a quiet and respectful environment when a patient has died, the display of a recognised image which indicates a death has occurred may be useful to alert other health care staff entering the area.
- 9.6** Personal property should be returned with consideration for the feelings of those receiving it and in line with local policy. Discuss the issue of soiled or cut clothes sensitively with the family and ask whether they wish them to be disposed of or returned. They may wish to be involved in gathering and packing their loved ones personal property and should be given the opportunity to do so. Woven bags designed for the specific purpose of returning a deceased patient's property should be used where available.
- 9.7** Nurses should take time to explain to the family what will happen next. The family should be provided with written information on the processes to be followed after death, including how to collect the MCCD, where to register the death and the role of the funeral director and bereavement support agencies. Staff should be aware of the information available for relatives in their local area and the nurse's role in ensuring that written information ie. Trust Bereavement Booklets are given in a suitable format, whilst offering to guide people through its content and giving them the opportunity to ask questions.
- 9.8** The family should be facilitated to spend time with their loved one if they wish in the period immediately after death. Even after a traumatic death, relatives need the opportunity to view the deceased person. They should be prepared for what they might see and have any legal reasons explained if the body cannot be touched.
- 9.9** When family members are ready to leave the bedside for the last time it is good practice for a member of staff to accompany them as they leave the ward and offer a final word of condolence, support and to answer any questions they may have at that time.
- 9.10** When personal care and identification of the deceased has been completed as per Royal Marsden Care After Death-Last Offices Procedure, the nurse should complete the relevant section on the body transfer form (Appendix 2).

²⁵ The Northern Ireland Regional Infection Prevention and Control Manual
<http://www.niinfectioncontrolmanual.net/>

10. Transfer of the deceased patient from the place of death

At some point after death the deceased person will usually be taken from where they died to a mortuary or funeral home while burial and cremation arrangements are made. The privacy and dignity of the deceased on transfer from the place of death is paramount.

Each service involved is responsible for ensuring that transfer procedures demonstrate respect for the values of personal dignity and that these are incorporated in the design of the concealment trolley, the way the body is covered and how it is moved from place of death to its destination.

This is particularly important as the transfer journey might include public areas such as hospital corridors.

- 10.1** Nursing staff should have discussions with the staff involved in the transfer eg. porters/ contracted Funeral Director, who should be aware of the importance of maintaining the dignity of the deceased, the privacy of relatives and the feelings of other patients and families.
- 10.2** If the family is using a viewing room within a mortuary it is good practice for nursing staff to arrange this with the mortuary prior to their attendance. Staff should accompany the family to the facility.
- 10.3** Mortuary staff and Funeral Directors should be informed about patients who present a serious infection hazard, particularly Tuberculosis or a Category 4 pathogen.

Nursing staff can seek advice from their Infection Prevention and Control Team if required. Detailed guidance is available in the Regional Infection Prevention and Control Manual and Appendix 5 of this document includes information on the infections that require use of a body bag.²⁶

It is vital that processes are in place to protect confidentiality, which continues after death. However, this does not prevent the use of sensible rules to safeguard the health and safety of all those who may care for the deceased.

- 10.4** There needs to be clear communication to mortuary staff and funeral directors regarding infection risk, property on the body, the presence of implanted devices and information relevant to the burial or cremation. This information should be recorded in the Body Transfer Form that accompanies the deceased (Appendix 2).
- 10.5** Universal infection control precautions should be followed during transfer and gloves may be removed when moving the body along corridors as there is no risk of infection once the body is placed in the concealment trolley.
- 10.6** Where a family member wishes to escort their relative on transfer to the mortuary, due consideration should be given to this request and facilitated when possible.

²⁶ <http://www.niinfectioncontrolmanual.net/>

11. Recording care provided after death

It is important that all aspects of care carried out after death are recorded as soon as practical in nursing documentation in keeping with advice on record keeping outlined in the NMC Code of Practice.²⁷

- 11.1** This should include the date, time and who was present at time of death.
- 11.2** Any risks or problems that may have arisen and the steps taken to deal with them should be recorded to ensure continuity of care so that colleagues who use the records have all the information they need.
- 11.3** In addition, issue of the MCCD, contact with the Coroner, the receipt of the HSC Trust Bereavement Booklet and confirmation of information being shared with the deceased's GP should also be documented.
- 11.4** Consideration should be given to the use of a Care After Death Checklist or similar which will act as an aide-memoir for documenting actions taken by nursing staff after death.

12. Education, training and support of staff providing care after death

- 12.1** Education and training on all aspects of care after death should be included in relevant pre registration training curricula for nursing.
- 12.2** The pertinent aspects of care after death including communication and documentation should be included in induction and mandatory training programmes.
- 12.3** The opportunity for debriefing should be available for staff after a death. In places of care where deaths happen frequently eg. acute hospitals, debriefing may take place after exceptionally challenging deaths or when the cumulative effect of many deaths is recognised.
- 12.4** All incidents related to care after death should be reported via HSC Trust structures for Health and Social Care Incident Reporting with outcomes and learning points or actions shared with the staff involved.
- 12.5** All compliments received from families, relating to care at the time of and after death, should be shared with relevant staff to demonstrate the positive impact their care had on the family.

²⁷ www.nmc.org.uk/standards/code/

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14. Acknowledgements

The HSC Bereavement Network wish to acknowledge Jo Wilson and the National Nurse Consultant Group (Palliative Care) for permission to use material from the Hospice UK publication 'Care after Death-Guidance for staff responsible for care after death' 2nd edition, 2015.

Care after death: guidance for staff responsible for care after death (second edition).

Appendix 1

HSC Services Strategy for Bereavement Care (2009) Standards

Standard 1: **Raising Awareness**

Health and Social Care staff will be suitably trained to have an awareness and understanding of death, dying and bereavement. Staff should also acknowledge the fact that grief is a normal process following loss and that needs vary according to an individual's background, community, beliefs, and abilities.

Standard 2: **Promoting Safe and Effective Care**

Health and Social Care staff who have contact with people who are dying and/or those affected by bereavement will deliver high quality, safe, sensitive and effective care before, at the time of and after death according to individuals' backgrounds, communities, beliefs and abilities.

Standard 3: **Communication Information and Resources**

People who are dying and those who are affected by bereavement will have access to up to date, timely, accurate and consistent information in a format and language which will be helpful to their particular circumstances and consistent with their needs, abilities and preferences. Staff will remember that the availability of written or other information does not negate their personal support role.

Standard 4: **Creating a Supportive Experience**

Those who are dying and their families will be afforded time, privacy, dignity and respect and wherever possible, given the opportunity to die in their preferred environment with access to practical, emotional and spiritual support based on their individual needs and preferences.

Standard 5: **Knowledge and Skills**

Health and Social Care organisations recognise the value of a skilled workforce by ensuring that those coming into contact with, or caring for people who are dying and those affected by bereavement are competent to deliver care through continuing professional development; and by having systems in place to support them.

Standard 6: **Working Together**

Good communication and coordination will take place within and between individuals, organisations and sectors, to ensure that resources are targeted efficiently and effectively and that there is integration of care to meet the needs of people who are dying and their families, friends and carers.

Appendix 2

Body Transfer Form



Health and Social Care
in Northern Ireland

BODY TRANSFER FORM (1A) ID number

USE TO TRANSFER ALL DECEASED CHILDREN AND ADULTS

Section A - To be completed before body is moved from place of death			
Hospital/Facility:		Ward/Dept:	Consultant:
Name		Address:	
DOB:			
Male ☐ Female ☐ H&C no.		Date of Death:	Time of Death:
Is Death Certificate issued? Yes ☐ IF NOT, specify reason: _____			
Has death been reported to the Coroner?		No ☐ Yes ☐	
If Yes, has Coroner ordered PM examination?		No ☐ Yes ☐ Unsure ☐	
Is a hospital PM examination to take place?		No ☐ Yes ☐	
Is organ/tissue retrieval to take place?		No ☐ Yes ☐ N/A ☐ Specify: _____	
<u>Additional Information</u> - if yes please specify.		Detail:	
Infection Risk (if pathogen 3 follow protocol)		No ☐ Yes ☐ _____	
Property left on body		No ☐ Yes ☐ _____	
Drains, tubes left in situ		No ☐ Yes ☐ _____	
Cardiac pacemaker/implantable defibrillator in situ		No ☐ Yes ☐ _____	
Spiritual/religious/cultural requirements		No ☐ Yes ☐ _____	
Section A completed by: _____ (PRINT NAME AND DESIGNATION)			
Section B - To be completed at time of transfer from place of death to:			
Hospital mortuary ☐ State Pathology ☐ Family funeral director ☐ Own home ☐ Other ☐			
Patient's name checked by person releasing: _____ and			
person removing the body: _____ Time: _____			
(PRINT NAMES AND DESIGNATIONS)			
Any significant information In Section A has been shared Yes ☐ No ☐ N/A ☐			
Section C - To be completed ONLY if body is transferred to hospital mortuary			
C1 Patient named above admitted into mortuary		Date:	Time:
By: _____ (PRINT NAME AND DESIGNATION)			
C2 Patient released from mortuary		Date:	Time:
Patient's name checked by person releasing : _____ and			
person removing the body: _____ Company Name: _____			
(PRINT NAMES AND DESIGNATIONS)			
Any significant information in Section A has been shared Yes ☐ No ☐ N/A ☐			
Release authorisation: Death Certificate issued ☐ Coroner authorised ☐ Transferring for PM ☐			

Appendix 3

Principles for care of the dying person HSS (MD) 21/2014

A number of principles have been set out below which should underpin quality care in the final days and hours of life.

These five principles reflect the good practice outlined in the *Living Matters; Dying Matters (LMDM) Palliative and End of Life Care Strategy* (DHSSPS, 2010) and should be used in conjunction with the LMDM Strategy and other relevant guidance - including the Department's '*Strategy for Bereavement Care*' (2009) - to support compassionate care for people during the final stages of life and for their families and carers.

The principles are:

1. There should be timely identification that a person is dying and is probably in the final days and hours of life
2. Sensitive and clear communication should be at the centre of quality care
3. People who are identified as dying should have their physical, psychological, spiritual and social needs identified and be involved in decisions about how those needs can best be met. The person's needs should be regularly reviewed and re-assessed throughout the last days and hours of life
4. Care in the last days and hours of life should be planned and co-ordinated with a focus on symptom control, comfort management and ensuring that psychological, social and spiritual support is provided to meet the person's needs
5. Support for family and carers should be provided during their loved one's last days and into bereavement.

These principles should underpin the care provided for people who are dying and support a personalised and compassionate approach to care both for people who are in the final days and hours of life and for their families and carers.

All Ireland Institute of Hospice and Palliative Care professional hub (AIHPC) provides further information and guidance for professionals related to palliative and end of life care.

www.professionalpalliativehub.com/national-guidelines/northern-ireland-palliative-care-tools-guidance

Appendix 4

Reporting Death to the Coroners Service of Northern Ireland

There is a general requirement under Section 7 of the Coroners Act (Northern Ireland) 1959 that any death must be reported to the coroner if it resulted, directly or indirectly, from any cause other than natural illness or disease for which the deceased had been seen and treated within 28 days of death.

The duty to report arises if a medical practitioner has reason to believe that the deceased died directly or indirectly:

- As a result of violence, misadventure or by unfair means
- As a result of negligence, misconduct or malpractice (eg. deaths from the effects of hypothermia or where a medical mishap is alleged)
- From any cause other than natural illness or disease eg. homicidal deaths or deaths following assault; road traffic accidents or accidents at work; deaths associated with the misuse of drugs (whether accidental or deliberate); any apparently suicidal death; all deaths from industrial diseases eg. asbestosis)
- From natural illness or disease where the deceased had not been seen and treated by a registered medical practitioner within 28 days of death
- Death as the result of the administration of an anaesthetic (there is no statutory requirement to report a death occurring within 24 hours of an operation - though it may be prudent to do)
- In any circumstances that require investigation; the death, although apparently natural, was unexpected - Sudden Unexpected Death in Infancy (SUDI).

Doctors should refer to the Department of Health, Social Services and Public Safety, General Register Office (Northern Ireland), Coroners Service for Northern Ireland (2008) Guidance on Death, Stillbirth and Cremation Certification which includes the Registrar General's extra-statutory list of causes of death that should be referred to the Coroner, see pages 6 - 11.

Coroners Service Northern Ireland

Information about the Coroners Service and publications such as 'Working with the Coroners Service - Best Practice Guide' are available from their website:

www.courtsni.gov.uk/en-GB/Services/Coroners/Pages/default.aspx

Appendix 5

Northern Ireland Regional Infection Control Manual

Guidelines for Handling Cadavers with Infections: www.infectioncontrolmanual.co.ni Issue date: Oct 2008

*Adv - Advisable Degree of risk	Infection	Bagging	Viewing	Embalming	Hygienic Preparation
Low	Acute encephalitis	No	Yes	Yes	Yes
	Chickenpox/shingles	No	Yes	Yes	Yes
	Cryptosporidiosis	No	Yes	Yes	Yes
	Dermatophytosis	No	Yes	Yes	Yes
	Legionellosis	No	Yes	Yes	Yes
	Lyme disease	No	Yes	Yes	Yes
	Measles	No	Yes	Yes	Yes
	Meningitis (except meningococcal)	No	Yes	Yes	Yes
	Mumps	No	Yes	Yes	Yes
	Meticillin-resistant Staphylococcus aureus (MRSA)	No	Yes	Yes	Yes
	Ophthalmia neonatorum	No	Yes	Yes	Yes
	Orf	No	Yes	Yes	Yes
	Psittacosis	No	Yes	Yes	Yes
	Rubella	No	Yes	Yes	Yes
	Tetanus	No	Yes	Yes	Yes
	Whooping cough	No	Yes	Yes	Yes
Medium	Acute poliomyelitis	No	Yes	Yes	Yes
	Cholera	No	Yes	Yes	Yes
	Diphtheria	Adv*	Yes	Yes	Yes
	Dysentery	Adv*	Yes	Yes	Yes
	Food poisoning	No	Yes	Yes	Yes
	Hepatitis A	No	Yes	Yes	Yes
	HIV/AIDS	No	Yes	No	No
	Leptospirosis (Weil's disease)	No	Yes	Yes	Yes
	Malaria	No	Yes	Yes	Yes
	Paratyphoid fever	Adv*	Yes	Yes	Yes
	Q fever	No	Yes	Yes	Yes
	Relapsing fever	Adv*	Yes	Yes	Yes
	Meningococcal septicaemia	Adv*	Yes	Yes	Yes
	Scarlet fever	Adv*	Yes	Yes	Yes
	Tuberculosis	Adv*	Yes	Yes	Yes
	Typhoid fever	Adv*	Yes	Yes	Yes
	Typhus	Adv*	No	No	No
High	Anthrax	Adv*	No	No	No
	CJD and TSE	No	Yes	No	Yes
	Group A streptococcal infection (invasive)	No	Yes	Yes	Yes
	Hepatitis B and C	Yes	Yes	No	Yes
	Plague	Yes	No	No	No
	Rabies	Yes	No	No	No
	Smallpox	Yes	No	No	No
	Viral haemorrhagic fever	Yes	No	No	No
	Yellow fever	Yes	No	No	No

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Appendix 6

HSC Bereavement Network Board Members and Trust Bereavement Coordinators

Name	Designation
Dr Tony Stevens (Chair)	Chief Executive Northern HSC Trust
Sinead O’Kane	Interim Head of Governance and Patient Safety Northern HSC Trust
Rachel Maxwell	Licensing and Regulations Manager Belfast HSC Trust
Ray Elder	Strategic Lead for Palliative Care South Eastern HSC Trust
Fiona Wright	Assistant Director Nursing Governance Southern HSC Trust
Therese Brown	Head of Clinical Quality and Safety Western HSC Trust
David Best	Deputy Director Learning, Litigation and Service Framework Development DOH

Trust and Name	Bereavement Coordinators Contact Details
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Western Carole McKeeman	Ward B, Anderson House, Altnagelvin Hospital, Glenshane Road, Derry/Londonderry BT47 6SB Tel: (028) 7134 5171 # 214184 email: carole.mckeeman@westerntrust.hscni.net www.westerntrust.hscni.net/services/1618.htm

Bereavement Network Website:

www.hscbereavementnetwork.hscni.net/

