University Hospitals of Leicester NHS
NHS Trust

Infection Prevention in the Mortuary Policy

Approved By:	CSI Quality and Safety Board
Date of Original Approval:	**15/04/2016**
Trust Reference:	**C29/2016**
Version:	V3
Supersedes:	V2
Trust Lead:	Matthew Rogers, Mortuary Manager
Board Director Lead:	Collette Marshall, Corporate HTA Licence Holder
Date of Latest Approval	September 2021
Next Review Date:	**July 2025 6 Month Extension Granted at CSI Cat C Meeting February 2025**

CONTENTS

REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

- Standard Precautions- now includes further guidance on the safe handling of patients where exposure to droplets and aerosols could occur, section 5.2
- Contact with the Deceased- revised guidance on the use of PPE where exposure to aerosols could occur, section 5.3
- Assessment Controls - additional guidance on the safe handling of group four pathogens, section 5.5
- Body Bags – revised guidance of use and now includes the use of envelope and hermetically sealed bags, section 5.6
- Communicating the Risk and Nature of Infection – includes a summary of the process of releasing confidential information to funeral directors by bereavement services, section 5.8
- Inclusion of IPC training module – section 6.1
- Change of Board Director Lead

KEY WORDS

Mortuary, infection, prevention, post-mortem, body bag, micro-organism, pathogen, deceased, standard precaution

1 INTRODUCTION AND OVERVIEW

1.1 This document sets out the University Hospitals of Leicester (UHL) NHS Trusts Policy and Procedures for infection prevention practice within the Mortuary.

1.2 It is designed to supplement existing advice given in the Health Services Advisory Committee's: Safe Working and the Prevention of Infection in the Mortuary and Post-mortem Room.

1.3 The policy gives advice to mortuary staff on how to care for patients with a known or suspected infection after death with minimal risks to their own health.

1.4 The policy also instructs mortuary staff on what advice they can give to others whilst protecting patient confidentiality.

1.5 Health and Safety law requires risk assessment of Biological Agents likely to be encountered in the workplace.

2 POLICY SCOPE

2.1 This policy applies to all UHL mortuary staff - Assistant Technical Officers and Anatomical Pathology Technologists.

2.2 The UHL mortuary staff will ensure that Pathologists, Medical Students, Police, Scenes of Crime Officers and others involved in the care of the deceased and the bereaved in the Mortuary follow these guidelines.

2.2 Staff employed by the Mortuary (Assistant Technical Officers and Anatomical Pathology Technologists) will be able to demonstrate sufficient competency in their role with their up to date competency record that is freely available within the department.

2.3 This policy is applicable to the patients the mortuary receives from internal wards and departments, other hospitals and the community.

2.4 Patients that have or are thought to have a biological agent that is categorised as a group four pathogen by the Advisory Committee on Dangerous Pathogens (see section 5.4) would not be applicable to this policy, in such unusual circumstances their care would be managed under the direct instruction of Public Health England.

3 DEFINITIONS AND ABBREVIATIONS

3.1 Bacteria, viruses, fungi, protozoa and internal parasites can all be described as **Micro-organisms**.

3.2 A micro-organism that creates a hazard to human health by causing infection or allergic reaction within a host is called a **Pathogen**.

3.3 Health and Safety law often refers to Pathogens as Biological Agents. A Pathogen can also be described as a **Bio-Hazard**.

3.4 When a Pathogen or the toxic substances produced by the Pathogen damage the bodies' tissues it is called **Infection**.

4 ROLES

4.1 The **Executive Lead** for this Policy is the Director of Safety and Risk who has responsibility for notifying appropriate local and national bodies if there is a breach of legislation, confidentiality or safety.

4.2 **Line Managers** are responsible for the following:

a) Annual Review to ensure an appropriate level of training and competence.

b) Ensure Policy is reflected in local standard operating procedures.

4.3 **Mortuary staff** are responsible for the following:

a) Ensuring Policy is reflected in their own work practice.

b) Informing their line manager if they have any difficulties or concerns about their health or work practice or that of others.

c) Maintaining, recording and demonstrating an appropriate level of training and competency.

d) Ensuring the continuity of care, safety and confidentiality of patients, visitors, contractors and others.

4.4 **Occupational Health Department** is responsible for the following:

a) The provision of annual health assessments.

b) Provision of health assessments after self and management referral.

c) Providing advice should a worker be identified as having a health issue that could increase the risk of infection.

5. POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS

5.1 Caring For The Deceased

a) The likelihood of contracting an infection from a patient rarely increases after their death and can be prevented by the application of appropriate precautions.

b) Because it is not possible to identify an underlying infection in every patient, a set of Standard Precautions are used when working in the clinical areas of the Mortuary.

c) It's essential that controls are performed sensitively as the overt use of protective measures can cause distress.

5.2 Standard Precautions

The following Standard Precautions have been formulated to minimise the risk of infection within the Mortuary.

a) Procedures that are identified as having a risk of producing aerosols or droplets will where possible, be performed in the post-mortem room e.g. washing down with high-pressure hoses, cleaning instruments under running water, and squeezing organs that have been removed from the body.

b) Some activities associated with the emission of aerosol will occur outside the Post-mortem room e.g. the manual handling of patients between trollies(s) / tray. Placing a cloth or mask over the mouth of the deceased when moving the patients can help to prevent release of aerosols.

c) Before working in clinical areas, an induction will be given into safe working in the Mortuary.

d) Access is not allowed in to areas where aerosol producing procedures occur, without the direct supervision of the Mortuary staff or a Pathologist.

e) Maintenance staff that require access to areas or equipment that cannot be certified free from infection will be issued with a permit to work.

f) Any cut's, grazes, dermatitis or other forms of open wound, must be covered by a waterproof dressing before entering a clinical area.

g) To prevent the risk of personal clothing becoming soiled and acting as a vector for infection, a complete change of clothing must be made before accessing and regressing areas where aerosol producing procedures are performed.

h) Personal items belonging to staff and visitors must be stored in the lockers in the changing room and not taken into the clinical areas.

i) The Low, Transition and High Risk demarcations will be observed within the Mortuary. Rest and meal breaks must be taken away from the Transition and High Risk areas.

j) Hands must be sanitised upon the completion of tasks and when moving between areas. Wash hands and lower arms when hands are visibly soiled and before eating or drinking.

5.3 Contacts with the Deceased

When patient care requires close contact with the deceased, the following controls must be followed to minimise the risk of exposure to Pathogens:

a) Personal Protective Equipment (PPE) must be used whilst performing patient care: Disposable Apron (whilst bare beneath the elbow) / Laboratory coat and disposable gloves.

b) The addition of a scrub suit with impervious gown / Tyvek suit, water resistant boots, FFP3 mask and visor is essential in areas where splashing bodily fluids or aerosol producing procedures are likely to occur (Post-mortem Room).

c) Upon exiting the clinical area, the use of correct 'doffing' (removal) procedures is essential to avoid exposure and spread of contamination. The user must ensure non-disposable PPE is cleaned and disinfected prior to being returned to storage.

5.4 Categories of Infection

The Advisory Committee on Dangerous Pathogens periodically assess the degree of hazard individual biological agents present and categorizes them into four groups: http://www.hse.gov.uk/pubns/misc208.pdf

Advisory Committee on Dangerous Pathogens Categories of Pathogen	
Catagory	**Description of Hazard**
One	A biological agent unlikely to cause human disease.
Two	A biological agent that can cause human disease and may be a hazard to employees but is unlikely to spread to the community and there is usually effective prophylaxis or effective treatment available.
Three	A biological agent that can cause severe human disease and present a serious hazard to employees; it may also present a risk of spreading to the community, but there is effective prophylaxis or treatment available.
Four	A biological agent that causes severe human disease and is a serious hazard to employees; it is likely to spread to the community and there is usually no effective prophylaxis or treatment available.

5.5 Assessment & Controls

a) Group 1 and 2 Pathogens are frequently encountered within the Mortuary and are easily controlled by the use of Standard Precautions.

b) Even with the use of Standard Precautions, Category 3 Pathogens may still pose a risk of infection, especially at post-mortem. Pathogens in the Group 3 category must be individually assessed so controls in addition to standard precautions can be identified.

c) Group 4 Pathogens are unlikely to be encountered within UHL. The care of a patient with a suspected group four pathogen would require individual risk assessment in conjunction with UHL Infection Prevention Control and the Public Health Laboratory Service (Colindale) or the Centre for Applied Microbiological Research (Porton Down).

5.6 Body Bags

a) Envelope type Body bags can be used for deceased patients that are likely to leak or where there is thought to be a risk of infection to handlers.

b) Zip type body bag are used for suspicious deaths, a hermetically sealed bag, must be used to contain parasites.

c) The deceased's identity bands must be securely attached to the exterior of the bag when contained in a hermetically sealed bag or when a zip type bag is sealed by police.

d) When a body bag is used the reason for use (not the name of the infection) must be recorded into the register to avoid any unnecessary confusion to Funeral Directors.

e) If the exterior of a body bag inadvertently comes into contact with potential sources of infection, the exterior must be disinfected with an appropriate disinfectant solution.

f) To minimise the risk of tearing the bag during transfer, a sheet can be wrapped around the exterior of the bag. This will also minimise the risk of exposure to aerosols.

5.7 Conditions that Require a Body bag

a) To maintain continuity for a forensic death, including death in custody.

b) Where active unsealed source radioactive material for cancer treatment, has recently been administered.

c) To control the risk of infection: https://www.hse.gov.uk/pubns/priced/hsg283.pdf Appendix 1: Application of Transmission-based Precautions to key Infections in the Deceased.

d) Long term accomadation, contain parasites, advanced autolysis.

e) Contain parasites, or where leakage, or discharge of body fluids or faeces is likely:

- Patients from ITU, HDU, Renal ward.
- Immediate Post-operative patients,
- Patients with large pressure sores, trauma, burns, gangrenous limbs and infected amputation sites.

5.8 Communicating the Risk and Nature of Infection

a) An individual's right to confidentiality continues after death.

b) Relatives may be unaware of the true nature of an infection so specific questions about the nature of the infection from the next of kin must be referred to the certifying clinician or the Coroner.

c) If a patient has died with a known or suspected infection, it is the responsibility of those releasing the patient into the care of others to ensure they are informed of the potential risk of infection whilst maintaining patient confidentiality.

d) The Infection section on the Death Notification Form lists precautions for those caring for patients who have died within UHL. Mortuary Staff can contact the ward after reception of the deceased to confirm the specific infection.

e) Those bringing deceased and samples into the Mortuary from the community and other hospitals can record details of known or suspected infection in the comments section of the Patient Reception Register (HM2002 F1) or the Specimen Reception Register (HM2 006 V2).

f) Mortuary staff can record and communicate the nature of infection and the precautions required via the comments section of the Mortuary register and notification of infection.

g) When the completion of certification is facilitated by UHL Bereavement Services, the Funeral Director may be told the specific infection by Bereavement Services, after explicit permission has been granted by the person in the qualifying relationship (Next of kin).

6 EDUCATION AND TRAINING REQUIREMENTS

6.1 Annual Infection Prevention and Control is mandatory to all staff. This training is completed via the Infection Prevention module on HELM, the Trusts Mandatory Training platform.

6.2 The latest copy of this policy will be available on Insite.

7 PROCESS FOR MONITORING COMPLIANCE

These must be set out in the Policy Monitoring table set out below.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements Who or what committee will the completed report go to.
Standard Precautions	Lead Infection Prevention Nurse	Mortuary Standard Precaution tool	Quarterly	CSI IP Meeting

8 EQUALITY IMPACT ASSESSMENT

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

Health and Safety Executive (2003) Safe Working and the prevention of Infection in the Mortuary and Post-mortem Room, Health and Safety Executive Surrey

UHL Preventing Transmission of Infection Policy (Trust Ref B65/2011)

UHL Care of Deceased (Last Offices Policy) (Trust Ref B28/2010)

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

This document will be reviewed by the Mortuary Manager every three years or sooner if there is there is a change in national guidance or a requirement within the Trust.

The updated version of the Policy will then be uploaded and available through InSite Documents and the Trust's externally-accessible Freedom of Information publication scheme. It will be archived through the Trusts PAGL system