University Hospitals of Leicester NHS
NHS Trust

Last Offices and Care of the Deceased Patient Policy

Approved By:	**Policy and Guideline Committee**
Date of Original Approval:	**13 August 2010**
Trust Reference:	**B28/2010**
Version:	V5
Supersedes:	V4 – June 2016
Trust Lead:	Rebecca Broughton, Head of Learning from Deaths. Kim Sanger, Bereavement Support Service Nurse
Board Director Lead:	**Chief Nurse**
Date of Latest Approval	**17 November 2023 – Policy and Guideline Committee**
Next Review Date:	**March 2027**

CONTENTS

REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

V5 – This is a significant rewrite of V4 representing current and introduces new practices. Using the latest Trust format, it chronologically lists Appendices 1-9 and makes reference to new guidelines and policies within the Childrens Hospital and Paediatric Emergency Department, Infection prevention, Medical Examiner and Bereavement Support Services. Updates and amendments have been made in sections 2.3 to 2.9, 3, 4.1 to 4.15, 6.1, 7.1, 8.1, to 8.3. Appendix 1: 1.1 to 1.5, 2, 3, 4. Appendix 2: 1d, 2b, 2d, 2f, 2g. Appendix 3: 1.1, 1.2, 2.3, 2.6 to 2.8, 3.3.12, 4.2, 4.5 to 4.10, 5.2, 5.3, 5.5, 5.6, 6.1, 6.2. Appendix 4: updated. Appendix 5: Introduction, 1 to 4, 6, 7,10 to 12, 15, 18, 20, 22, 26, 27. Appendix 6: Introduction, 1 to 9, 11 to 13, 16 to 19, 21, 22, 25 to 28. Appendix 7: 3.6. Appendix 8: 1.2, 2, 3.1.1, 3.1.2, 3.2.9, 3.4.2, 3.5.1, 5.4, 5.5, 6.1, 6.5. Appendix 9: 2, 3. Appendix 10: Jainism and Rastafarian.

V4 - review of V3 in May 2016, reformatted into latest Trust template. Complete Re- write of policy monitoring table, Appendix 2, Appendix 3 section 5.3,5.4,5.5, Appendix 4 update of clinical names in Responsibility Section 1.2, section all reference to Interserve and Directorates removed.

V3 – review of Version 2 December 2013, reformatted into latest Trust template, appendix 5 added in and no longer a standalone document (Taking Samples after Death/Removal of ET Tubes Trust reference (B51/2009).

V2 – review of V1 in August 2010, complete re-write and reformatted into latest Trust template. Approved by the Policy and Guideline Committee on 13 August 2010 and issued new Trust reference number (B28/2010).
V1 approved by the Policy and Guideline Committee on 7 August 2006 as Last Offices Policy – Trust reference B36/2006.

KEY WORDS

Last Offices, End of Life, Deceased.

1 INTRODUCTION AND OVERVIEW

1.1 This document sets out the University Hospitals of Leicester (UHL) NHS Trusts Policy and Procedures for care of the patient who has died (deceased patient) from the point of death until arrival in the Mortuary.

1.2 The policy also outlines the procedures that enable respectful and dignified care compliant with regulatory guidance and statutory legislation.

The aim of this policy is to guide staff through the processes relevant to care of the deceased patient and their relatives to be used in conjunction with the attached appendices.

2 POLICY SCOPE –WHO THE POLICY APPLIES TO AND ANY SPECIFIC EXCLUSIONS

2.1 The policy covers all three hospital sites within University Hospitals of Leicester NHS Trust (UHL), applies to all staff groups and applies to all deceased patients (adult and child).

2.2 For maternal deaths within UHL, please refer to Maternal Death UHL Obstetric Guideline C2/2007".

2.3 This policy does not cover the care of the non-viable foetus or stillborn baby. Please see following documents for further information and advice: Fetal Remains Up To 16 Weeks Gestation -

Sensitive Disposal UHL Policy (B3/2007), Certification of Stillbirth and Neonatal Death on Labour Ward UHL Obstetric Guideline (C33/2010); Stillbirth and Late Fetal Loss - Bereavement Care UHL Obstetric Guideline (C27/2016. For all Neonatal deaths within Maternity and Neonatal services, refer to the End of Life Checklist and ensure sections A,B and C are completed.

2.4 In the event of suspicious or unexpected death within Maternity or Neonatal services, please refer to the Child Death and CDOP Process (0-18 years) UHL Childrens Hospital Guideline (D3/2021).

2.5 This policy does not apply where consent has been given for organ donation. Please refer to Organ and Tissue Donation UHL Policy (B4/2012).

2.6 This policy does not cover the death certification process of the deceased – Please refer to the Medical Examiners UHL Policy (B49/2017).

2.7 Where urgent release of deceased is requested, please also refer to the Deceased Urgent Certification and Release Outside Normal Hours UHL Policy (B12/2013).

2.8 Where the transfer of a deceased child or young person to Rainbows Hospice is requested, please also refer to Rainbows Referral UHL Childrens Hospital Guideline (C50/2021).

3 DEFINITIONS AND ABBREVIATIONS

Last Offices: The term last offices relates to the care given to a patient after death.

Expected Death: Patient has a completed Individualised Care Plan or it has been documented in the patient's records by a senior clinician that death is expected for Last Days of Life and has been recorded on NerveCentre as being in the Last Days of Life, and there were no suspicious circumstances at the time of death

Suspicious Death: Where a patient has died and it is immediately apparent that something untoward has or may have occurred to bring about the patient's death, whether accidental, self-inflicted, inflicted by others, or medically unaccountable (even if an expected death) - See Appendix 2 for more information.

4 ROLES – WHO DOES WHAT

4.1 BEREAVEMENT SERVICES

Open Monday to Friday 09:00 – 16:00hrs excluding bank holidays.

LRI – 15194/6 GH – 13417 /13401 LGH - 14235

Responsible for:

- Being the first point of contact for bereaved families in respect of the Death Certification process.
- Receiving deceased patients' property, where it has not been possible or appropriate for the family to receive it from the ward, as per the Patient Property Management UHL Policy (B24/2007).
- Liaising with families, the Bereavement Support Service and the Mortuary in office hours regarding regarding any viewing of the deceased requests.
- The revision and printing of Notification of Death/ Bereavement Notification forms and the "Helpful Information Following a Death" and ''Following the death of your child'' booklet.
- Make direct referrals to Bereavement Support Service where early contact with the bereaved is required.

4.2 Bereavement Support Service

Responsible for:

- Providing a key point of contact for the bereaved, from the time of death onwards.
- Offering a confidential listening ear, information and an opportunity to provide feedback and raise questions or concerns about the experience of care (as part of the Trust's Learning from Deaths Process).
- Providing signposting to appropriate support organizations (such as bereavement counselling) as required.
- Assisting with mortuary visits.
- Revision of the 'Following the death of your child'' booklet.

Adult deaths – see Bereavement Support Service guideline (B4/2016). Contact Nurses by calling 0116 258 6776/7742/4380 or email bereavementsupportservice@uhl-tr.nhs.uk
Child deaths – see Child Bereavement Support Service guideline (C57/2021). Call 0116 258 6776/7742 or email childbereavement@uhl-tr.nhs.uk
For Neonatal and Maternity Unit deaths – Contact Bereavement Support Midwife. Call 07747 475441 / 07977371284 / 07921545588 or email wnbereavementlink@uhl-tr.nhs.uk,

4.3 Health Care Support Workers

Under the supervision/instruction of a registered nurse or midwife, responsible for

- preparing the deceased patient for transfer to the Mortuary
- managing the deceased's property in accordance with the "Management of Patient Property Policy and Procedures" (B24/2007) in collaboration with the Ward Clerk

4.4 Chief Nurse – Executive Lead for this policy

Responsible for informing the Trust Board of changes in practice and relevant information.

4.5 Duty Managers

Responsible for:

- Managing the scene and in liaison with the Silver Nurse, informing the Police and family where a suspicious death has occurred (Appendix 2).
- Coordinating the transfer of the deceased patient to an appropriate ward where Last Offices can be carried out, where a patient dies whilst attending out patient investigations or treatment.
- Supporting the process of urgent certification and release as required, in collaboration with the Medical Examiner Office team, when the Bereavement Services is closed / out of hours – (B12/2013).
- Providing a key point of contact where families wish to take their child home or transfer to a Hospice

4.6 MEDICAL EXAMINERS (ME)

Responsible for the provision of advice on whether or not a death should be referrered to H.M. Coroner. See policy B49/2017. Contact Monday- Friday (excluding bank holidays) 09:00 – 16:00 via Bereavement Services, or out of hours 09:00 – 21:00 via switchboard.

4.7 MEDICAL EXAMINER OFFICER (MEO)

Responsible for providing a key point of contact for ward staff when Bereavement Services are closed in respect of urgent certification and release of the deceased outside of normal office hours (replacing the previous role of the Duty Manager – see policy B12/2013).
Contact via Bereavement Services or via switchboard out of hours.

4.8 MORTUARY DEPARTMENT STAFF

Responsible for the provision of personal protective equipment in the Mortuary, disinfectant and spill kits for their use and arranging Mortuary visits.
Assisting with removal of lines /drains / Endotracheal (ET) tubes prior to release from the Mortuary where requested by the Funeral Director or family (Appendix 4);

4.9 PORTERING STAFF

Responsible for:

- The transfer and booking the deceased patient into the Mortuary
- Maintaining the safety, dignity and care of the deceased whilst in transit, as well as cleaning and disinfecting equipment after use.
- Safe storage of the Childrens Hospital Bereavement Pram.
- Timely delivery of Notification of Death/Infant Bereavement Notification form to Bereavement Services and one copy delivered to Mortuary when transferring deceased patient.
- Informing the Mortuary team where notified that a deceased patient weighs more 200kg

4.10 REGISTERED MEDICAL STAFF

Responsible for:

- Examining the deceased patient, declairing and documenting that life is extinct and assessing whether death is suspicious.
- Working with the Registered Nurse to ensure all relevant child death documentation is completed.

    - Childrens Hospital & Paedicatric Emergency Department - UHL Child Death Paperwork & CDOP Process (0-18 years) (D3/2021).
    - Maternity and Neonatal Unit – End of Life Care checklist.

Notifying the Child Death Overview Panel (CDOP) using the online eCDOP form.
www.ecdop.co.uk/LLR/live/login

4.11 Registered Nurse or Midwife in Charge

Responsible for:

- Confirming if death (adult) is suspicious or meets the SUDIC guidance for a child, (Sudden Unexpected Death in Children- see Child Death paperwork *D3/2021*) in collaboration with Registered Medical Staff and escalating accordingly. (see Appendix 2)
- Ensuring appropriate and sensitive communication with the bereaved occurs (Appendix 3)
- Overseeing the preparation of the deceased patient (Appendix 5 & 6).
- Accurate completion of the Notification of Death form.
- Informing and supporting the Bereavement Services or on call Medical Examiner Officer where urgent release of the deceased has been requested out of hours. (see Deceased Certification and release Outside of Normal Hours - B12/2013) and the Duty Manager where a child is to be transferred home (see Taking a Deceased Child Home (where registerable birth) policy B17/2022)
- Appropriate delegation of Ward Clerk duties (see 4.15 below) where a Ward Clerk is not available.
- Documentation fully completed after a child death: Childrens Hospital and Paediatric Emergency Department – Final checklist within UHL Child Death Paperwork & CDOP Process (0-18 years) (D3/2021). Neonatal and Maternity Units – End of Life care checklist.

4.12 Registered Nursing and Midwifery staff (ALL)

Responsible for:

- Documenting the **identified time of death** - Verification of Death Form available for use (Appendix 1, section 3).
- Preparation of the deceased patient.
- Completion of Notification of Death Form / Bereavement Notification Form (all).
- Documentation after child death - Nursing section of UHL Child Death Paperwork (D3/2021) within Paediatric Emergency Department and Childrens Hospital**,** or local Maternity or Neonatal End of Life Care checklists.
- Ensuring availability of personal protective clothing on the ward,
- Initiating transfer to the mortuary, recording the date and time of release of the deceased from the ward, informing portering and mortuary staff of manual handling/infection/other known risk.
- Providing support for the bereaved (Appendices 3, 5 and 6)
- Offering the bereaved the opportunity to discuss the possible option of tissue donation with the Tissue Donation Services and make referral where appropriate (details on Notification of Death Form) – refer to the Organ and Tissue Donation UHL Policy in Adults and Children – B4/2012
- Offering the opportunity and encouraging families (where appropriate) to take the deceased patient's personal belongings home (in accordance with the Management of Patient Property Policy - B24/2007) to prevent unnecessary return to the hospital.
- Referring families to the Bereavement Support Service Nurses where early contact may be required (see section 4.2 above)
- Ensuring that all families receive appropriate verbal information about what happens next and are given (or are sent in the post) the relevant bereavement booklet.

4.13 Registered Verifying Nurse

Responsible for examining the deceased adult patient where death is expected and not suspicious, and declaring and documenting that life is extinct *(see Appendix 1.2)*.

4.14 SILVER NURSE (NURSING TACTICAL COMMAND)

Responsible for assisting the Duty Manager out of hours and contacting the family where required, when a patient has died in suspicious circumstances (Appendix 2)

4.15 WARD CLERKS

Responsible for:

- *Recording the death on the Trust's electronic system.*
- *Transferring the deceased patient's case notes to Bereavement Services office; management of the deceased's property in accordance with the Management of Patient Property Policy and Procedures (B24/2007).*

4.16 UHL FACILITIES MANAGER

Responsible for the provision of manual handling training for portering staff, provision and maintenance of portering equipment.

5. POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS –WHAT TO DO AND HOW TO DO IT

This policy is supported by the procedures detailed in the attached appendices within this policy and all staff must follow these when caring for the deceased patient.

6 EDUCATION AND TRAINING REQUIREMENTS

6.1 All staff should receive policy updates from their Senior Managers. Any education and training requirements regarding this policy should be identified by the Line Manager through the appraisal process and addressed in the individual's personal development plan.

6.2 How to perform last offices is included in the Health Care Support Worker and Registered Nurses, induction program.

7 PROCESS FOR MONITORING COMPLIANCE

7.1 Key Performance Indicators/Audit Standards

Element monitored	Lead	Tool	Frequency	Reporting arrangements
Mortuary reception identification checks	Mortuary Manager	Database DATIX/Serious Incidents/Complaints	Upon reception to mortuary (or next working day)	Non compliance escalated through Cellular Pathology and CSI Quality & SafetyCommittee Non compliance

Compliance with turnaround times of Porter request to collect deceased to transfer to the mortuary and deliver the Notification of Death forms to Bereavement Services	Porters/Director of Estates and Facilities	Notification of Death forms/DATIX	Daily monitoring	Reports to be generated though PLANIT system as required or requested through the End of Life Steering Group
Covers on mortuary trolleys / concealment trolley in good repair	Mortuary/ Portering Services	Observation	Daily monitoring	To be escalated to Head of Portering Services
Compliance to policy guidance in meeting the individual needs of the deceased and their family in relation to Equality, Diversity and Incusion	Head of Learning from Deaths (LFD)	Family feedback received by: • Bereavement Services • Medical Examiners • Bereavement Support Nurses • Complaints	Daily monitoring Quarterly reporting Yearly LFD reporting	Concerns escalated to the Head of Learning from Deaths Bereavement Support Service and Complaints reporting to EoL Steering group Head of LFD reporting to Mortality Review Committee and EoL Steering group

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

9.1 Related Policies Guidelines

Bereavement Support Service – Adult (B4/2016)
Child Bereavement Support Service (C57/2021)
Certification of Stillbirth and Neonatal Deaths on Labour Ward (C33/2010)
Consent to Hospital Post Mortem Examination Policy (B9/2010)
Infection Prevention Policy (B4/2005)
Maternal Death: Guidelines for the Management of Maternal Death (C2/2007)

Management of Patient Property (B24/2007)
Medical Examiner Policy (B49/2017)
National infection prevention and control manual for England. NHS England 2023. National-infection-prevention-and-control-manual-v2-4-250123.pdf (england.nhs.uk)
Organ and Tissue Donation Policy (B4/2012)
Procedures for the Urgent Certification and Release of the Deceased Outside Normal Hours Policy (B12/2013)
Policy for the Sensitive Disposal of Foetal Remains up to 16 weeks Gestation(B3/2007)
Rainbows Referral guideline (C50/2021)
Reception, Accommodation and Release of Patients and Specimens in the Mortuary (PR3837)
Sands Bereavement Support Book – Stillbirth & Neonatal Death Charity www.sands.org.uk
Stillbirth and Late Fetal Loss – Bereavement Care UHL Obstetric Guidelines (C275/2016)
Sudden Unexpected Death in Infancy/Childhood ED Protocol (C94/2006)
Support for Women and Families Where Outcome for the New-born Baby is Poor or Suspected to be Poor (C23/2011)
Taking a Deceased Child Home (where Registerable Birth) (B17/2022)
UHL Child Death Paperwork & CDOP - (0-18 years) (D3/2021)
Academy of Medical Royal Colleges : A Code of Practice for the Diagnosis and Confirmation of Death 2008

9.2 Useful Links

Undertakers of Leicestershire

http://www.uk-funerals.co.uk/funeral-directors/leicestershire.html

Link for tissue donation
www.nhsbt.nhs.uk/tissuedonation

Public Health England can be contacted to notify them of an infection or for advice on 0344 225 4525 Option 1 and ask for the Leicester team.

List of Notifiable diseases and legislation:
http://www.legislation.gov.uk/uksi/2010/659/schedule/1/made

9.3 Contact Telephone Numbers

H.M. Coroner for Leicester and South Leicestershire 0116 4541031
H.M. Coroner for North Leicestershire and Rutland 0116 3057732

(Please refer to Medical Examiner Policy)

Orthodox Jewish Community
Local Rabbi Shmuli Pink Via UHL Switchboard

Muslim Burial Council of Leicester (MBCoL)
MBCOL Office: 0116 273 0141 or 07803 240 493 (call mobile first)

Trustee and volunteer coordinator Ahmed Kasu 07973 344341

Patron Suleman Nagdi 07759 446555
Office Manager Adam Sabat 07801 101786

A full list of the MBCOL Board can be found on the organisation's website,
http://www.mbcol.org.uk/

10. Process for Version Control, Document Archiving and Review

This document will be uploaded onto the Policy and Guidelines Library and will be available for access by Staff through INsite. It will be stored and archived through this system.

The policy was first approved in 2006 and has been reviewed by a multi-professional group consisting of representatives from UHL Nursing and Midwifery, Head of Chaplaincy, Bereavement Services, Mortuary, Pathology and Portering.

The "Last Offices" review group will be responsible for reviewing the policy at regular intervals, six months after approval initially and then no more than three years apart (or earlier in response to changes in National guidelines). Progress will be reported through the UHL End of Life Steering Group.

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

10.1 Contributors to the Last Offices Policy Review V5 (alphabetically listed):

Bell Sarah – Consultant in Palliative Medicine; Binks Robin – Depuity Chief Nurse; Bishop Samantha - Lead Bereavement Services officer; Bring Kartar – Head of Chaplaincy; Broughton Rebecca – Head of Leadring from Deaths; Burton Susan Deputy Chief Nurse; Choudhury Saiful – Head of Privacy; Collins Elizabeth - Lead Nurse Infection Prevention; Crook Rebecca – Bereavement Midwife; Fossey Samantha – Deputy Sister NNU; Gill Jane – Consultant Neonatologist; Jawaid Saad – ED Consultant - Jeggo Natalie – Logistics Coordinator; Johal Mandeep – Head Of Service, ED (Adults);Kelly Michelle – Matron Children's Safeguarding; Malcomson Roger DG - Consultant Paediatric and Perinatal Pathologist; - Mason Catherine E - Professor. H.M Senior Coroner; Meadows Sarah – Matron Adult Safeguarding; Meldrum Eleanor – Deputy Chief Nurse; Miralles Robin – Consultant Neonatologist; Murrey Steve – Assistant Director (Head of Legal Services);Preece Joanne- Consultant Neonatologist; Rowlands Rachel – Consultant Paediatric Emergency Medicine; Rogers Mathew – Mortuary Manager; Sanger Kim - Bereavement Support Service Nurse; Statham Sarah - Matron Imaging; Steers Shaheen – Modern Matron GPAU, Blue Majors, DVT; Swindells Jayne – Modern Matron; White Julie – Deputy Head of Nursing (W&C); Whiteley Caroline – Deputy Laboratory manager; Wilson Joanne – Matron Children PICU CICU; Zavery Sandy – Head of Equality Diversity and Inclusion.

Declaring Life Extinct	University Hospitals of Leicester NHS NHS Trust **Last Offices and Care of the Deceased Patient Policy** **Appendix One**

1. DECLARING LIFE EXTINCT:

1.1 Verification of death must take place prior to the transfer of the deceased patient to the Mortuary.

1.2 Declaring Life Extinct is a clinical process sometimes known as 'verifying death' rather than a legal one.

1.3 Any member of medical staff may assess a patient for signs of life and declare that the patient has died.

1.4 A Registered Nurse (not including Nursing Associates) or Advanced Care Practitioner (ANP) hereafter referred to as 'Verifying Nurse', who is deemed competent and has completed the relevant Nurse Verification of Expected Death training may assess an adult patient for signs of life and declare that the patient has died if the following criteria are met:

a) Death occurs in a UHL hospital.

b) Death is expected and not suspicious (see definitions and Appendix 3). This includes when the person has died expectedly from mesothelioma or COVID.

c) Patient has a valid and signed Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form with a clear "Do not attempt cardio-pulmonary resuscitation" (DNACPR) decision in line with current guidance.

d) Patient has a completed Individualised care plan for Last Days of Life including a doctor's signature to confirm nurse verification can occur.

e) Next of Kin have raised no concerns over any circumstances

The Verifying Nurse carrying out this procedure must inform the responsible doctor covering the ward of the death (ST1 or equivalent) during this working shift (day or night), and document the date and time this was carried out in the clinical records.

The Verifying Nurse must instigate the process for deactivation of an implantable cardiac defibrillator (ICD), where applicable and not previously actioned.

It is the right of the Verifying Nurse to refuse to verify a death and to request the attendance of the Duty Manger and senior responsible doctor on duty /police if there are any unusual or concerning circumstances.

2. Verification of Death Procedure:

Following a death, the verifying doctor or nurse must:

- Confirm the patient's identity against the healthcare records using their identity wrist bands
- A Verifying Nurse must determine if the patient's death and the circumstances of the death are compatible with nurse verification parameters
- Check medical history details (drugs, cataracts, false eyes, pacemaker)
- Inform family / carers if present that you are about to commence the physical examination of the patient to ascertain that death has occurred.

- The individual should be observed by the person responsible for confirming death for a minimum of five minutes to establish that irreversible cardiorespiratory arrest has occurred.

- The absence of mechanical cardiac function is normally confirmed using a combination of the following:
  - absence of a central pulse on palpation
  - absence of heart sounds on auscultation

- In a hospital setting they can be supplemented by one or more of the following:
  - asystole on a continuous ECG display
  - absence of pulsatile flow using direct intra-arterial pressure monitoring
  - absence of contractile activity using echocardiography

- Any spontaneous return of cardiac or respiratory activity during this period of observation should prompt a further five minutes observation from the next point of cardiorespiratory arrest

- After five minutes of continued cardiorespiratory arrest, the absence of the pupillary responses to light, of the corneal reflexes, and of any motor response to supra-orbital pressure should be confirmed
  (Note – it is not possible to perform corneal reflexes on a baby <24 weeks gestation)

- The time of death is recorded as the time at which these criteria are fulfilled

- Document the results of the assessment above in the patient's healthcare records, along with date, time and name of Verifying Nurse or Doctor. The Verification of Death record sheet is currently available in paper format for use (Appendix 1, section 3 below) and will be available on Nerve Centre in the future.
- Child death (Childrens' Hospital and Paediatric Emergency Department) – follow and complete the UHL Child death paperwork (D3/2021) which also offers supplimentary verification criteria.

3. Assessing whether a death is suspicious: (definition in section 3)

3.1 Suspicious deaths always need to be referred to the H.M Coroner for investigation. Advice should be sought from the duty Medical Examiner who will advise whether the referral to the H.M Coroner is recommended or not. Contact details in section 4.6.

3.2 In these cases, the scene must be managed carefully to preserve evidence and senior Trust staff informed immediately (Line Manager, duty 'Silver nurse' (up to 21:00hrs) and Duty Manager). See Appendix 2

Last Offices and Care of the Deceased Patient Policy Appendix 1, Section 3.

University Hospitals of Leicester NHS Trust

Verification of Death Record Sheet

Patient's Name …… ***Hospital Number***……

Date of Birth…… ***Consultant***……

IDENTIFIER: I saw this patient on ……/……/ 20… *at : hours and* ***identified*** *that death had occurred.*

Print Name …… *Role*…… *Signature*……

Response confirmed;

1. Absence of cardiac function – no central pulse on palpation or heart sounds on ausculatation for a minimum of five minutes
2. Absence of pupillary responses to light
3. Absence of the corneal reflex
4. No motor response to supra-orbital pressure

Place of Death : Hospital…… Ward ……..

VERIFIER: Print Name …… ***Signature***……

Time of Death Verified …… ***Date of Death Verified*** ……

Contact Tel Number…… ***Position***……..

Work Base……

University Hospitals of Leicester NHS Trust

(Adult Deaths) Competency Based Assessment Tool for Verification of Expected Death by a Registered Nurse

	Training and Specific Knowledge	Date Confirmed/Observed	Print and Signature
1	The Registered Nurse (RN) has undertaken relevant training in verifying death		
2	The RN can demonstrate knowledge and skills in verification of death:		
a	Compassion and Sensitivity to relatives/carers		
b	Who can verify a death		
c	Who can certify a death		
d	What is an expected death		
e	How to position the patient for examination and verification of fact of death		
f	What to do with tubes, lines, drains, patches and pumps		
g	The patient should be observed for a minimum of five minutes to establish that irreversible cardiorespiratory arrest has occurred.		
h	Listen to the chest and observe to ensure no respiratory effort. The absence of mechanical cardiac function is confirmed using a combination of the following: ○ absence of a central pulse on palpation ○ absence of heart sounds on auscultation		
i	Any spontaneous return of cardiac or respiratory activity during this period of observation should prompt a further five minutes observation from the next point of cardiorespiratory arrest		
j	After five minutes of continued cardiorespiratory arrest the absence of the		

	pupillary responses to light, of the corneal reflexes, and of any motor response to supra-orbital pressure should be confirmed		
m	Recording time of death		
n	Recording time of verification of death		
o	Completing relevant verification of death paperwork		
p	Recording death on patient's record		
q	Advising next of kin on next steps		
3	Three assessments are required. To be assessed by a doctor - first by Registrar or above.		

Signature of Verifier: …… Print: …….

Role: …… Date: …….

Signature of Assessor: …… Print: ……..

Role: …… Date: …….

(UHL would like to thank LOROS for sharing and permitting us to adapt this assessment tool)

Actions To Be Taken For Suspicious Death	University Hospitals of Leicester NHS NHS Trust Last Offices and Care of the Deceased Patient Policy Appendix Two

1. What should be done

a) Immediately call the Cardiac Arrest Team by calling 2222 and commence resuscitation. If resuscitation is not successful:

b) **DO NOT TOUCH ANYTHING**. Do not touch anything on the body, the surrounding area or personal effects. If there is any evidence of drug abuse, do not touch or move the evidence. If the Crash Trolley is not implicated in the incident, it may be removed and restocked.

c) Screen off the area, wherever possible, to maintain the dignity of the deceased patient.

d) Inform Line Manager/Duty Manager immediately and follow their instructions. Duty Manager can be contacted via Switchboard. Duty Manger will inform the Police

e) ALL equipment must be kept in situ. This includes intravenous lines, central lines, arterial lines, catheters, chest drains, defibrillator pads and any disposable equipment. A list of all equipment present at the time of death must be completed and filed in the case notes.

f) **DO NOT PERFORM LAST OFFICES**; do not wash the deceased, change their clothes or bed linen.

g) The deceased patient may be collected by H.M. Coroner's removal service. If this does not happen the Line Manager/Duty Manager will authorise transfer to the Mortuary; place the deceased patient in a body bag and document clearly on the Notification of Death Form that this was a suspicious death.

h) Preserve the scene of death until authorised to clear it by the Line Manager/Duty Manager or Police even after the deceased patient has been transferred to the Mortuary.

2. WHO SHOULD BE INFORMED?

a) It is not the remit of frontline staff to report such incidents to external agencies (including, but not limited to the police); this responsibility shall be reserved to senior management dependent on the nature of the incident.

b) Inform patient's Consultant immediately. If out of hours via Consultant on-call, if deceased was an in-patient or attending as an outpatient.

c) Appropriate manager(s) within the department.

d) Next of Kin/Relatives should be informed and supported (see "Communication with the Family"). Communication with the next of Kin/relatives should be (in hours) via the Clinical Management Group Head of Nursing and the Clinical Director, or out of hours via the 'Duty Silver Nurse' (up until 21:00 shift end) or Duty Manager. It is important to be clear about the procedures and further investigations that are conducted in suspicious circumstances.

e) Immediate reporting to the Corporate Safety Team and Duty Manager within normal working hours. Outside of normal working hours, the Duty Manager will cascade this information as appropriate to the on-call Managers and Director on-call, who will ensure that H.M. Coroner is informed by the Clinicians at the appropriate time.

f) The Corporate Safety Team will ensure that other interested parties external to the Trust are informed, as appropriate. Suspicious deaths will normally need to be referred to H.M. Coroner for investigation and should be discussed with the duty or on call Medical Examiner (see section 4.6) .

g) If the deceased patient is below the age of 18 years, the Safeguarding children Team must be informed via phone x15770 or email child.protectionteam@uhl-tr.nhs.uk

Communication with the family	University Hospitals of Leicester NHS NHS Trust **Last Offices and Care of the Deceased Patient Policy** **Appendix Three**

1. INTRODUCTION

1.1 Relatives often remember the way in which the news of the death of a loved one was broken to them. The way that the news was given and subsequent actions may influence their bereavement experience and grieving process and should be undertaken with compassion and sensitivity.

1.2 For those patients who were recognised to be dying and were supported by an Individualised Plan of Care for the Last Days of Life, it should already be established how the next of kin wish to be contacted during the day and night. Therefore, breaking bad news should be expected.

2. BREAKING BAD NEWS

2.1 Prior to informing the next of kin that a patient has died, it is essential to confirm the correct information e.g. that the correct patient and their relatives are identified.

2.2 For those patients receiving palliative/end of life care, it should already be established how the next of kin wish to be contacted during the day and night. Therefore, breaking bad news should be expected.

2.3 In circumstances of sudden death, informing the next of kin that an accident or sudden illness has occurred and requesting their presence at the hospital can be justified (eg where the next of kin was not previously aware of the patient's admission, incident or accident, or where it is understood by those caring for the patient that breaking bad news over the telephone may have a severe detrimental outcome for the next of kin). The intention is to prevent harm and maximise benefit by imparting news in a supportive environment. The rationale for this should be clearly documented in the patient's medical records and explained to the next of kin when the news of the death is given. It may be more appropriate to involve the Police, if not already involved, and ask them to visit the next of kin. For all other circumstances, please refer to 3.2.2 below.

2.4 Where the death of an inpatient takes place outside of the ward area the breaking of bad news should be undertaken by the in-patient ward clinical team.

2.5 Information should never be left on an answer machine notifying the family of a death, unless previously arranged with the family. A message should be left asking the family to call the ward.

2.6. An individual's right to confidentiality continues after death. Where the deceased has given instruction to the clinical team preventing them from informing the family of their admission, diagnosis or prognosis, sensitive communication with the family (NoK) should take place after death to inform them of the death and the deceased patient's wishes.

2.7 A summary of communication with the family (with names and relationship to the deceased patient), should be clearly documented in the clinical records.

3. Breaking Bad News Over the Telephone

3.1 Consider the following before making the decision to break bad news over the telephone:

- Whether it is appropriate to break bad news over the telephone.
- Whether you are the most appropriate person to deliver this news.
- What knowledge the next of kin/bereaved may have about the patient's condition prior to death.
- When that person last saw the patient.
- The age and health of the person.
- How far the next of kin may have to travel to reach the hospital.
- Communication barriers; speech, hearing or language.
- Whether they wanted to be contacted over the telephone or during the night/have any previous discussions taken place?

3.2 Once the decision has been made to break the bad news over the telephone:

It is essential to confirm the correct information, e.g. that the correct patient and their relatives are identified.

Do not imply or state that the patient is alive at the time of the call if they are not, as omitting truth or facts may later appear suspicious.

- Make sure you will not be disturbed or interrupted when making the call.
- Check their location and whether they are alone. If they are alone, staff must take this into account when breaking bad news.
- State who you are when calling and whether you have met or spoken to them previously.
- Acknowledge the difficulty of having this conversation over the phone as this will reduce the negative impact and serve as a warning shot.
- Be honest if they ask if the patient has died and give a brief description of what happened.
- Be direct and clear with the information you give. Confirm that death has occurred – use the words 'is dead' or 'has died'.

- Make sure you have time to listen, empathise and answer any questions that the next of kin may have.
- Offer that they can phone back later with any questions or queries and provide them with the appropriate telephone number.
- Do they want to see the deceased patient? Not all people do.
- Are other relatives/friend/important others likely to want to visit pre - mortuary.
- Where the family will not be visiting the hospital after death, provide the information in section 4.6 below and ensure that they receive a copy of the relevant bereavement booklet (4.6 below).

4.CARE OF THE DECEASED PATIENT'S FAMILY

The experiences of those grieving can very much affect the grieving process in the short and long term. The response of relatives and important others are not always going to be the same and may vary significantly. It is important that staff respect and are sensitive to the grief response of relatives and important others.

4.1 It is essential that a lead is taken from the family with regards to their needs. They may have religious or cultural needs that they wish to demonstrate, even if the patient does not have a religion recorded. Refer to Appendix 10 for more information They may ask to see a member of the chaplaincy or ask to contact a specific person. It is appropriate to ask if they wish anyone else to be contacted.

4.2 Family may wish to speak to a Doctor / Nurse or ask questions regarding the time before the patient's death e.g. 'who was with them' and 'were they in pain'. If this is not possible, family members should be advised that they will have the opportunity to speak to either the Medical Examiner or Bereavement Support Nurses who will help to facilitate this.

4.3 Do not use medical language. At such times a lot of information is not absorbed by relatives and it may be necessary to reiterate the information or give them written information.

4.4 Family and important others may not wish to see the deceased but where they do, they should not be rushed to leave the ward and refreshments should be offered and privacy provided where possible.

4.5 The relevant UHL Bereavement Booklet, should be given to the family, copies are available from Bereavement Services or the Neonatal Unit. 'Helpful Information Following a Death' (adult death) or 'Following the death of your child' (Childrens Hospital and Paediatric Emergency Department), or the 'Sands Bereavement Support Booklet' (Maternity Hospital / Neonatal Unit NNU)

4.6 The family should be advised to telephone Bereavement Services using the numbers in the bereavement booklet on the next working day. The Bereavement Services staff will take their details and advise them on the next steps for the death certification procedure. Timescales should **not** be given to the family for how long it may take for the Medical Certificate of the Cause of Death (MCCD) to be completed. Where families express a need for urgent release, inform the Bereavement Services Office or refer to the out of hours 'Urgent Certification and Release' policy (B12/2013).

4.7 Where the family is aware of the patient's death (Adult ward / Children's hospital or Emergency Department), a UHL 'blue butterfly' condolence card should be written and posted to the NoK by the patient's named nurse (on behalf of the team) at the time of performing Last Offices. This also provides the Bereavement Support Service Nurses contact details on the back, should the family have any questions or bereavement needs.

4.8 See Appendix 5 & 6 regarding property

4.9 Refer to Appendix 5 and 6 for supportive memory making for the family.

4.10 Offer the next of kin the opportunity to discuss the possible option of tissue donation with the Tissue Donation Services. Make referral where appropriate, and referral centre contact family and coordinate the rest (details on Notification of Death Form) – refer to the Organ and Tissue Donation UHL Policy in Adults and Children – B4/2012

5. VISITING THE PATIENT AFTER DEATH

5.1 No visits may take place on the ward or Emergency Department, other than in the following circumstances:

- When the patient has just died and when the family are on-route to the hospital or where death is unexpected . Discretion is permitted to allow sensitivity to the needs of the deceased patient's family, bearing in mind that the deceased patient should ideally be transferred to the Mortuary within four hours of death (see Appendix 5 and 6 on Preparation of the Deceased Adult/Child (Last Offices).For neonatal patients there is the option of using a cold cot on the ward to allow the family a longer period with their baby. This option needs to be balanced depending on the need/ wish for a post mortem when it is preferable for the body to be in the mortuary as soon as possible after death.
- Within the Maternity Units, where the condition of the mother may prevent her from attending the mortuary to transport the baby back to the Maternity Unit (refer to Appendix 8)

5.2 Where mortuary visits have been requested, the family should be made aware that they 'may' be able to visit the deceased, but this may not be possible (e.g. infection prevention restrictions / capacity) and

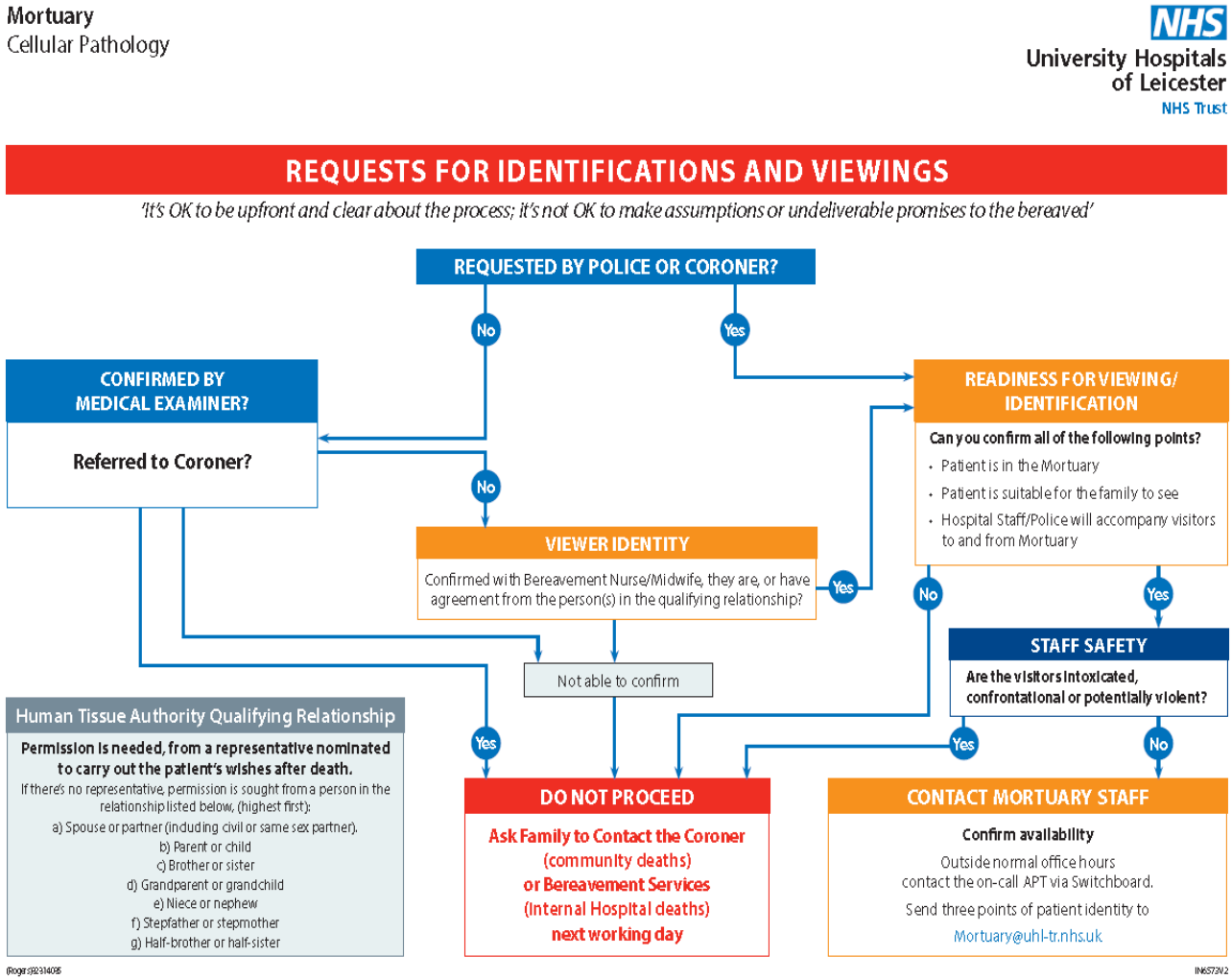
therefore should not be promised. Visiting requests are supported by the Mortuary team wherever possible on a case by case basis. Appointments will need to be made via the Bereavement Services, or Bereavement Support Nurses /Bereavement Midwives, who will support the visit. if out of hours discussed with the on call Duty Managers.

Families should be advised that the Funeral Director usually provide opportunities for visiting and spending time with the patient after death.

5.3 Where Coroner involvement is anticipated, arrangements for families to spend time with the patient in the Mortuary cannot be made without Coronial agreement and will usually require a member of the Bereavement Support or Bereavement Services team or Police to be present .

5.4 Where a visit takes place on the ward, ensure that the environment is tidy, privacy and dignity is maintained for the deceased and other patients on the ward, and the family are 'prepared' and supported by staff.

5.5 See Flow Chart below for requests for identifications and visiting within the mortuaries at UHL



6. Photography after death

6.1 Staff- Using the iPad for Photography - where family unable to visit.

FaceTime or Skype iPads should NOT be used for taking photographs after a patient has died outside of Intensive Care Units (where there has been specific local guidance in place during the COVID-19 pandemic period).
If clinical staff are asked by relatives to take photographs, they should seek assistance from the Matron (or Duty Manager out of hours), who depending upon the circumstances may seek guidance from the Bereavement Support Team, Chaplaincy or Palliative Care team (e.g. a sensitively taken photograph of the patient's hand holding a personal item or keepsake).

The maternity and neonatal services do take photographs with a unit camera and the SD is given to families with all of the photographs on. There are no photographs stored on any hospital device.

6.2 Family- Taking a photograph at the bedside after death.

6.2.1 It is permissible for a Next of Kin to take a photograph of the deceased. The nurse must ensure that appropriate safeguards are observed (e.g. curtains/doors are closed) to maintain the confidentiality, privacy and dignity of all patients on the ward. It should be documented in the patient's medical records that a photograph has been taken and the above guidance has been followed.

6.2.2 Where a photograph has been observed to have been taken which breaches the above guidance, the nurse in charge should sensitively approach the person and request this be deleted. Refusal to comply with this request should be escalated to the Matron or Duty Manager. Further failure to comply should be escalated to the Local Security Manager and Privacy team.

6.2.3 Where a photograph is taken of a child on a 'ward camera' at the request of the parents, the single use memory card should also be given to the parents.

Removal of Endotracheal Tube (ET)	University Hospitals of Leicester NHS NHS Trust **Last Offices and Care of the Deceased Patient Policy** **Appendix 4**

ET tubes may be removed if it is clear when death is verified that referral to H.M. Coroner is not required. If there is any doubt the ET tube must be left in place until referral is clarified.

H.M. Coroner has given University Hospitals of Leicester clear instructions on the management of Endotracheal tubes following the death of a patient in sudden or suspicious circumstances.

***ADULTS** - ET tubes **MUST NOT** be removed where death is sudden, suspicious or may be referred to H.M. Coroner.*

***CHILDREN** and NEONATES– ET Tubes **MUST NOT** be removed **where death is suspicious (**refer to definition in section 3), and **should not be cut down after death**. Where an ETT is left in situe and has been previously cut down as part of routine care, this should be noted in the baby's notes. In all other circumstances (including where referral to H.M Coroner is required but death is not suspicious), the ET tube may be removed where assessments and documentation within the Child Death Paperwork (D3/2021) or Neonatal Medical Records have been completed by two doctors confirming correct ET tube placement prior to removal. If any inadvertent dislodgement occurs during this checking procedure this must be documented clearly in the baby's notes. Use of the video laryngoscope may assist this check and may be more acceptable to the family than direct layngoscopy.*

Document presence of ET tube on the Notification of Death form/Infant Bereavement Notification Form, to inform Mortuary Staff.

Where applicable, ensure family are aware that an ET has been left in situ, and reassure them they will likely be able to view the deceased without the ET tube when H.M. Coroner's investigations have been completed, either in the Mortuary viewing room or at the Funeral Directors.

On collection and prior to release, the Funeral Director or family members will be asked by the attending Mortuary team if they are comfortable to receive the patient's body in it's present condition. Lines /drains / ET tubes will be removed where requested. Where removal has not been requested, it is the responsibility of the Funeral Directors or family members to remove these.

Preparation of the deceased Adult	University Hospitals of Leicester NHS NHS Trust **Last Offices and Care of the Deceased Patient Policy** **Appendix Five**

Action	Rationale
DO NOT follow this procedure if the death is considered suspicious. The deceased patient may be collected from the place of death by H.M. Coroner's removal service. If this is not required authority for removal must be given by the Line Manager or Duty Manager and the deceased patient placed directly into a body bag and transferred to the Mortuary. The only other action that should be taken is to ensure correct identification bands are on the deceased patient and document any equipment in use (including batch numbers if available). Consider cultural requirements – refer to Appendix 10.	Evidence must be preserved for a forensic investigation into the cause of death for the Policy and/or H.M. Coroner.
If the deceased was an inpatient and they die outside of the ward that they are an inpatient on for example Imaging or Therapies, the patient should be returned to the ward in a concealment trolley or concealment cover over their bed (request from Porters). Last Offices will be performed by the ward staff who cared for the patient. The deceased should then be transferred to the mortuary as per Appendix Eight. Communication with the next of kin should be carried out by the clinical ward staff (Appendix Three).	Ward staff are trained in this procedure and provides continuity of care.

1	**<u>Equipment list:</u>** A laminated butterfly '**Do Not Enter- Please speak with Nurse in Charge'** sign should be displayed outside the bed area immediately after death. (Obtained from Bereavement Support Service Insite page or Print Room) - Disposable plastic aprons and gloves (and follow Trust infection prevention guidance for additional personal protective equipment required). - Mouth care equipment (including denture cleaning) - Identification bands (x2) - Disposable gown or patient's own clothes/ nightwear or clothing requested and comply with patient / family / cultural wishes - Bowl of warm water, soap, towel and disposable cloths, comb, nail care equipment - Micropore tape - Clinical waste bag - Property bags, book and tags - Clean sheets - Sharps box - Notification of Death form - Laundry skip and soiled linen bags Extra equipment may include: - Dressings, bandages, gauze - Cannula bungs, catheter /nasogastric tube spigots - Body bag - Stoma bag - Incontinence pad	Privacy and prevents staff and family entering the area unprepared Not applicable
2	Put on gloves and apron. Where additional UHL infection prevention guidance / procedure in place during life, continue to follow these after patient has died.	Standard (universal) precautions must be followed for any contact with bodily fluids. Reduces risk of contamination and cross-infection. Maintains staff and patient safety.

3	Lay the patient on his/her back with assistance of other member/s of staff (adhering to UHL Manual Handling Procedures and Safer Handling Policy). Ensure a pillow is placed underneath the head Support the jaw by placing a pillow or rolled up towel on the deceased's chest underneath the jaw. • Do not tie the jaw unless otherwise guided by family members Remove only mechanical aids such as syringe drives etc. and secure the sites with gauze and tape to syringe driver sites and document actions in nursing documentation. All lines must be left in situ and capped off with a blind end cannula bung. **Document all lines left in situ on the Notification of Death form.** • Unless removal is requested by the Funeral Directors or family on collection of the deceased from the Mortuary, these lines will be removed at the Funeral Directors or by the family. Straighten the lower limbs as far as possible and place arms and hands by their side.	To maintain the patient's dignity and for future management of the body, as rigor mortis occurs 2-6 hours after death, with full intensity within 48 hours and then disappearing within another 48 hours. To assist with drainage from the head and promote jaw closure. Lines removed after death leak profusely. To maintain dignity. Flexed limbs can cause difficulties with moving and handling into the concealment trolley or mortuary fridge.
4	ET tubes must not be removed where death is sudden, suspicious or where referred to H.M. Coroner. ET tubes may be removed if it is clear when death is verified that referral to H.M. Coroner is not required. If there is any doubt the ET tube must be left in place until referral is clarified. Ensure family are aware ET tube has been left in situ, and reassure them they will be able to visit deceased without ET tube when H.M. Coroner's investigations have been completed, either in the Mortuary viewing room or at the Funeral Directors. Removal may be requested by the Funeral Directors or family at the time of collection from the Mortuary.	Instruction received from H.M. Coroner regarding the removal of lines and tubes.

5	Close the patient's eyes by applying light pressure to the eyelids for 30 seconds	To maintain the patient's dignity and for aesthetic reasons. Closure of eyes will also provide tissue protection in case of corneal donation.
6.	If a catheter is in-situ, gently drain the bladder by pressing on the lower abdomen. Spigot or leave catheter bag insitu. (document on death notification form)	Because the body can continue to excrete fluids after death.
7.	Do not pack orifices. An incontinence pad can be applied where vaginal or faecal leakage is present. If excessive leaking from the oral cavity or tracheostomy site, consider suctioning. Suction and spigot nasogastric tubes. Clamp drains (remove bottles). Cover stoma's with clean bag. Use body bag where leakage present.	Leaking orifices may pose a health hazard to staff coming into contact with the body. Packing can cause damage
8	Exuding wounds should be covered with a clean absorbent dressing and secured with an occlusive dressing. If a post mortem is required, existing dressings should be left in situ and covered with an additional dressing.	Open wounds post a health hazard to staff coming into contact with the body.
9	Open drainage sites may need to be sealed with an occlusive dressing.	Open drainage sites pose a health hazard to staff coming into contact with the body. If a post mortem is required drainage tubes, etc. should be left in situ.
10	Wash the patient, and provide nail care, unless requested not to do so for religious/cultural reasons (please refer to sections on individual faiths Appendix 10). Family members must not perform Last Offices without a member of staff being present. It may be important to family and carers to assist with washing, thereby continuing to provide the care given in the period before death. Do not shave the deceased. If shaving is necessary / requested by family, it should be performed prior to death using an electric razor if possible, or a normal razor can be used, applying massage cream / moisturiser immediately afterwards. Explain to family that shaving can cause skin disfigurement /grazes/burn marks.	For hygienic and aesthetic reasons. As a mark of respect and a point of closure in the relationship between nurse/midwife and patient. Post death shaving causes razor burn as the skin is no longer self-lubricating. Funeral Directors are best placed to perform this procedure as they would apply a massage cream to the face some time prior to preparation of the deceased. Any razor burn marks caused by shaving cannot be disguised by the Funeral Director, causing disfigurement and upset to the families.

11.	Clean the patient's mouth using a foam stick to remove any debris and secretions. Clean dentures and replace them in the mouth if possible. If not, ensure they accompany the body. Document on Notification of death Form. Suction may be necessary to clear fluids from the patient's mouth.	For hygienic and aesthetics reasons. To maintain the integrity of the face shape.
12.	If family are not present, jewellery should remain on the deceased and will be removed at the Funeral Directors. Ensure that rings and other loose items such as knitted hearts/keepsakes that remain with the patient are secured by micropore tape to avoid loss. Items such as flowers, soft toys and blankets should have a patient identity label with Name, DOB and S number, securely attached so they can be easily identified as the patient's. Details and a description (e.g. yellow metal – do not write gold) of the items remaining on or with the patient should be documented on the Death Notification Form. **Sikh patients may wear a bangle (Kara) on their wrist, which should not be removed. Alongside this baptised Sikhs may also have a small wooden comb (Kanga) and a small ceremonial dagger (Kirpan) these are all religious articles of faith which should not be removed.** See chapter 10 to support the families of other faiths Two members of staff should be present where jewellery or other items are removed and given directly to the family. Where appropriate, offer and encourage families to take any property home with them. Details of any items taken by the family and their names along with the staff names should be clearly documented in the patient's medical records. Any other property that is not taken by the family must be bagged and documented in accordance with the Management of Patient Property Policy and Procedures (B24/2007). If it is not clear that appropriate relatives are present (e.g. where there is a family dispute), jewellery should remain on the deceased and property should be taken into hospital custody.	To meet with legal, requirements and relatives wishes. Loss prevention. To meet cultural needs Families are no longer required to return to the Bereavement Services Office as Medical Certificates are electronically sent to the Registrar Office. Offering the property to the family can prevent unnecessary return to the hospital.
13.	Ensure the patient is clothed during transfer to the mortuary e.g. night clothes, hospital gown or shroud. Patients should NOT be sent to the mortuary without being appropriately and decently attired.	To maintain dignity.
14.	Ensure two identification bracelets with the following information are present: - Patient's S number - Date of Birth - Name Place one label on the deceased's right wrist, and one label on their right ankle. It is acceptable for this to be their current identification bracelet, and one other. If the right limbs are missing, place identification label on the left limbs.	To ensure the legal, correct and easy identification of the body in the mortuary.
15.	Complete Notification of Death form / Bereavement Care Check list (including addressograph label and patient's weight). Give one copy of Notification form to Porter when collecting the deceased patient, which they will hand deliver to Bereavement Services, and one copy is transferred by the Porter with the patient to the mortuary. White copy filed in notes.	To ensure legal, correct and easy identification of the body in the mortuary. Bereavement Services are notified of of death

16.	Sensitivity should be used when preparing the transgender deceased patient to maintain strict confidentiality of previous gender including discussion with the family.	To comply with the Gender Recognition Act 2004.
17.	Non-infectious/non-leaking bodies should be wrapped in a clean white sheet.	To maintain the deceased patient's dignity
18	Body bags should be used for the following cases: a) Forensic and suspicious death including death in custody (place deceased patient in body bag with minimal intervention from nursing staff). b) Recently administered active unsealed source radioactive material for cancer treatment. c) Where leakage and discharge of body fluids or faeces is likely (this include patients from Intensive Therapy Unit, High Dependency Unit, Renal Wards, immediate post-operative patients, patients with large pressure sores, trauma, burns, gangrenous limbs and infected amputation sites). Patients identified in table 3.6 within Appendix 7	Minimise the risk of transmission of infectious diseases.
19	Dispose of equipment according to infection control principles. Remove gloves and apron and wash hands with soap and water.	To minimise risk of cross-infection and contamination
20.	Request transfer of deceased patient to mortuary by contacting porters. Inform Porters of any relevant factors: a) Deceased patient weighing more than 200kg* (may need to contact Manual Handling Team or Duty Manager out of hours for advice) *Porters will need to contact Mortuary to arrange appropriate refrigeration arrangements. b) If body bag has been used, including reason why (leaking fluids, risk of infection, radiopharmaceuticals, other c) Other ward factors such as ward rounds, catering rounds, drug rounds and visiting times. d) Potential threat of any aggression or conflict (transfer may be delayed until area secure).	Decomposition occurs rapidly, particularly in hot weather and overheated rooms and safe transfer to the mortuary should take place within a reasonable time. Transfer to mortuary should be within 4 hours of death although sensitivity to family needs must be exercised.
21	Prepare ward area for arrival or porters with concealment trolley by drawing curtains and remove unnecessary equipment to allow concealment trolley to be placed next to the bed.	To ensure the safe, legal and dignified transfer of the deceased patient to the mortuary.
22.	Greet porters on their arrival, confirm identity of deceased patient (S number on ID bands) and assist with transfer by ensuring bed brakes are locked, bed and trolley are at the same height and pat slide used for lateral tranfer.	To ensure the safe, legal and dignified transfer of the deceased patient to the mortuary.
24.	Provide appropriate support and reassurance to other patients and visitors to the ward	Other patients and visitors may be aware that a death has occurred.

25.	Record all details and actions within the nursing Documentation	To record the identified and verified date and time of death, names of those present and names of those informed. (The identified and verified date of death may differ e.g. pre and post midnight, and be important to the family.)
26	Discuss with the family if they would like any keepsakes, such as locks of hair (place in small fabric draw string bag provided by Bereavement Services or paper envelope), sensitively taken photographs (Appendix 2.6). Offer hand prints and a memory box, where the deceased has children 0-18years.	These keepsakes will act as a memory of the deceased for the family (continuing bond). Contact Bereavement Support Service or Palliative care team for supply information.
27	Ensure that relatives are fully prepared prior to visiting the deceased's body as to what they will observe in relation to skin colour, eyes, mouth, lines, tubes etc.	To reduce distress of family
28	Take notes and any remaining property to Bereavement Services office within 3 hours of patient's death during office hours (or by 10.00am the following working day if out of hours).	To ensure Bereavement Services Officers are notified of the death and can deal appropriately with relative's enquiries.

Preparation of the deceased Child

University Hospitals of Leicester NHS
NHS Trust

Last Offices and Care of the Deceased Patient Policy
Appendix 6

Action	Rationale
Do not follow this procedure if the death is considered suspicious and may be referred to H.M. Coroner. The deceased patient may be collected from the place of death by H.M. Coroner's removal service. If this is not required authority for removal must be given by the Line Manager or Duty Manager and the deceased patient placed directly into a body bag and transferred to the Mortuary. The only other action that should be taken is to ensure correct identification bands are on the deceased patient and document any equipment in use (including batch numbers if available). …… If the deceased was an inpatient and they die outside of the ward that they are an inpatient on for example Imaging or Therapies, the patient should be returned to the ward using a concealment trolley/ concealment cover / bereavement pram, where no leakage (and with waterproof cover on mattress), requested from Porters. Last Offices will be performed by the ward staff who cared for the patient. The deceased should then be transferred to the mortuary as per Appendix Eight. Communication with the next of kin should be carried out by the clinical ward staff (Appendix Three). A laminated '**Do Not Enter- Please speak with Nurse in Charge'** sign should be displayed outside the bed area immediately after death. (obtained from Bereavement Support Service Insite page or Print Room)	Evidence must be preserved for a forensic investigation into the cause of death for the Policy and/or H.M. Coroner. …… Ward staff are trained to carry out last offices procedures and provides continuity of care. Privacy and prevents staff and family from entering unprepared

1.	**Equipment list:** - Disposable plastic aprons and gloves (and follow Trust infection prevention guidance for additional personal protective equipment requirements). - Mouth care equipment (toothbrush or cotton bud) - Identification bands (x2) - Disposable gown or patient's own clothes or nightwear, or clothing requested and comply with patient / family / cultural wishes - Bowl of warm water, soap, towels and disposable cloths, comb, nail care equipment - Micropore tape - Clinical waste bag Property bag, book and tags - Clean sheets	N/A

	- Sharps box - Death /Infant Bereavement Notification form - Child Death Paperwork (Childrens Hospital & Paediatric Emergency Department) / Local bereavement checklist (Neonatal/ Maternity) - Laundry skip and soiled linen bags Extra equipment may include: - Dressings, bandages, gauze, wicks - Cannula bungs, catheter/ nasogastric tube spigots - Body bag - Nappy / Incontience pad - Neonatal Unit- Cotton wool /Cardboard for supporting head	
2.	Approach child's family to explain the last offices procedure and gain verbal consent to undertake the procedure whilst encouraging participation if appropriate (Not appropriate if H.M. Coroner's case, death under suspicious circumstances or child protection issues are a query). Discuss the option of taking a lock of hair, photograph, hand or footprint with the parents before last offices are performed and document those taken.	Family orientated care and gives the family an opportunity for closure whilst recognising that child is still part of their family. Keepsakes provide a continuing bond for the family.
3.	Some families may request to take the child's body home before last offices are performed. This can be arranged if appropriate, after discussion with the Medical Examiner where a Coroner referral is not required. (Please refer to Urgent Release policy and follow the Taking a deceased child home guideline) Discuss with the family the possible option of transfer to Rainbows Children's Hospice. This should ideally be discussed with the family prior to the child's death whenever possible. Refer to Tranfer to Rainbows guidance.	To ensure that all legal, social and emotional issues have been considered. To provide the family with additional time and support up until the time of burial/cremation.
4.	Put on gloves and apron Follow Trust Infection prevention guidance for additional personal protective requirements.	Standard (universal) precautions must be followed for any contact with bodily fluids. To reduce risk of contamination and cross- infection.
5.	Lay the infant or child on their back with assistance of another member of staff if the patient is an older child (adhering to the manual handling policy). If possible lay limbs out straight, close mouth and shut eyes by applying light pressure to the eyelids for 30 seconds but do not force. Remove excess bedding and pillows leaving a sheet underneath the child and cover the child and a single pillow underneath the head if appropriate. In older children consider supporting the jaw by placing a pillow or rolled up towel on the child's chest underneath the jaw.	To maintain the patient's dignity and for future management of the body, as rigor mortis occurs 2-6 hours after death, with full intensity within 48 hours and then disappearing within another 48 hours. Closure of eyes will also provide tissue protection in case of corneal donation.

	- Do not tie jaw unless otherwise guided by family members, as this can cause disfigurement. Remove only mechanical aids such as syringe drives etc. and secure the sites with gauze and tape and document actions in nursing documentation. Lines must be left in situ and capped off with a blind end cannula bung. **Document all lines left in on the Notification of Death form.** In infants, peripheral lines may only be removed under the instruction of a Senior Doctor on compassionate grounds, where the death is not considered suspicious and requires referral to the H.M Coroner. This must be clearly documented in the childs notes.	Lines removed after death leak profusely.
6	ET tubes may be removed if it is clear when death is verified that the death is not suspicious. Where H.M. Coroner referral is required for non suspicious deaths, the ET tube can be removed after the documentation of correct placement has been completed by 2 appropriately trained doctors in the UHL Child Death Paperwork *(D3/2021)*. If there is any doubt the ET tube must be left in place until referral is clarified. Ensure family are aware when an ET tube has been left in situ, and reassure them they will be able to visit the deceased without the ET tube when H.M. Coroner's investigations have been completed, either in the Mortuary visiting room or at the Funeral Directors. Removal may be requested by the Funeral Directors or family at the time of collection from the Mortuary.	
7.	If a catheter is in-situ gently drain the bladder by pressing on the lower abdomen. Spigot or leave catheter bag in-situ. In infants/younger children use a nappy to retain urinary secretions.	Because the body can continue to excrete fluids after death.
8.	Do not pack orifices. An incontinece pad / nappy can be applied where leakage is present. If excessive leaking from the oral cavity or tracheostomy site, consider suctioning. Suction and spigot nasogastric tubes. Clamp drains (remove bottles). These may only be removed under the instruction of a Senior Doctor on compassionate grounds, if the death is not considered suspicious and requires referral to H.M Coroner.This should be clearly documented in the child's medical records. Cover stoma's with clean bag. Use body bag where leakage present.	Leaking orifices may pose a health hazard to staff coming into contact with the body. Packing can cause damage
9	Exuding wounds should be covered with a clean absorbent dressing and secured with an occlusive dressing. If a post mortem is required, existing dressings should remain intact and secured with an additional dressing	Leaking wounds may pose a health hazard to staff in contact with the body. Preserves wound site and dressing for post mortem investigation.
10.	Open drainage sites may need to be sealed with an occlusive dressing.	Open drainage sites pose a health hazard to staff coming into contact with the body. If a post mortem is required drainage tubes, etc. should be left in-situ.

11.	Wash the infant or child and provide nail care, (allowing family to participate as appropriate) unless requested not to do so for religious/cultural reasons (please refer to sections on individual faiths Appendix 11). Family members must not perform last offices without a member of staff being present (continued overleaf). It may be important to family and carers to assist with washing, thereby continuing to provide the care given in the period before death.	For hygienic and aesthetic reasons. As a mark of respect and a point of closure in the relationship between nurse/midwife and patient.
12.	If necessary clean the infant/child's mouth using a foam stick or cotton bud to remove any debris and secretions. Otherwise clean the child's teeth using their own toothbrush and toothpaste.	For hygienic and aesthetic reasons.
13.	Any jewellery should remain on the child unless family want it to be removed, then do so and give to the family (in the presence of another nurse) and record these items along with the names of the nurses and family member receiving the items in the medical records. **Sikh patients may wear a bangle (Kara) on their wrist, which should not be removed. Alongside this baptised Sikhs may also have a small wooden comb (Kanga) and a small ceremonial dagger (Kirpan) these are all religious articles of faith which should not be removed.** See Appendix 10 for other faiths Ensure that loose jewellery/rings and other items that remain with the child are secured by micropore tape to avoid loss. Items such as flowers, soft toys and blankets should have a patient identity label with Name, DOB and S number securely attached so they can be easily identified as the patients'. Where appropriate, offer and encourage parent/next of kin to take any property home with them Any other property that is not taken by the family must be bagged and documented in accordance with the Management of Patient Property Policy and Procedures (B24/2007).	To meet with legal requirements and relatives wishes. Loss prevention To meet cultural needs Families are no longer required to return to the Bereavement Services Office as Medical Certificates are electronically sent to the Registrar Office. Offering the property to the family can prevent unnecessary return to the hospital.
14.	Dress the child in parent's choice of clothing or nightclothes as appropriate.	To maintain dignity and include family in the procedure.
15.	Ensure two identification bracelets with the following information are present: - Patient's S number - Date of Birth - Name Place one label on the infant or child's right wrist, and one label on their right ankle. It is acceptable for this to be their current identification bracelet, and one other. If the right limbs are missing, place identification label on the left limbs.	To ensure correct and easy identification of the body in the mortuary.

16.	Complete Notification of Death form / Bereavement Care Check List (including addressograph label and child's weight). Give one copy of Death / Infant Bereavement Notification form to Porter when collecting the deceased child, which they will hand deliver to Bereavement Services, and one remains with the child for the Porters to transfer with the child to the Mortuary. White copy filed in notes.	To ensure correct and easy identification of the body in the mortuary. Informing Bereavement Services of the death
17.	Support family to say goodbye to infant or child **on the ward** before transfer to the mortuary. Ensure they are aware of visiting arrangements in the mortuary and with the Funeral Director. A 'Cuddle Cot' is available from PICU, CICU, Neonatal Unit and Maternity Units (with directions for use) to allow parents to spend more time with their child prior to transfer to the mortuary. Although it should be disouraged, there may be parents who wish to accompany their child to the mortuary doors. The medical and nursing team should risk assess whether this is safe and appropriate and document their discussion with the family. In this situation a discussion with the Portering and Mortuary staff must take place first and nursing staff must accompany the parents and porter.	Family Orientated Care and to ensure that the family has an opportunity for closure whilst recognising that the child is still part of their family. Separation should ideally occur on the ward, where appropriate support and privacy can be maintained
18.	Wrapping – The Neonatal Unit apply head hugging protection (cotton wool and coardboard) around the child's head as part of the wrapping process.This practice may be applied in the Maternity Unit. Local guidance available. All non-infectious/non-leaking bodies should be wrapped in a clean white sheet.	Protects the head Actual or potential leakage of fluid, whether infection is present or not, poses a health hazard to all those who come into contact with the deceased patient. The sheet will absorb excess fluid.
19.	Body bags should be used for the following cases a) Forensic and suspicious death including death in custody (place deceased patient in body bag with minimal intervention from nursing staff). b) Recently administered active unsealed source radioactive material for cancer treatment. c) Where leakage and discharge of body fluids or faeces is likely (this include patients from Intensive Therapy Unit, High Dependency Unit, Renal Wards, immediate post-operative patients, patients with large pressure sores, trauma, burns, gangrenous limbs and infected amputation sites). d) Patients identified in table 3.6 within Appendix 7	Minimise the risk of transmission of infectious diseases.
20.	Dispose of equipment according to infection control principles. Remove gloves and apron and wash hands with soap and water.	To minimise risk of cross- infection and contamination

21.	Request transfer of deceased patient to mortuary by contacting porters. Inform porters of any relevant factors: - Deceased patients weighing more than 200kg* (May need to contact Manual Handling Team or Duty manager out of hours for advice) - Porters will need to contact Mortuary to arrange appropriate refrigeration arrangements. - If body bag has been used, including reason why (leaking fluids, risk of infection, radiopharmaceuticals, other). - Other ward factors such as ward rounds, catering rounds, drug rounds and visiting times. - Potential threat of any aggression or conflict - (transfer may be delayed until area secure). Concealment container or trolley to be used for all transfers to the mortuary. Give porters estimate as to the length/size of child, so the appropriate concealment trolley or cover is brought to ward: - Neonatal transport container - Half-size "child" concealment trolley or cot/bed concealment cover - Full size "adult" concealment trolley or bed concealment cover. For infant deaths (where no leakage or infection present), a covered 'bereavement pram' may be offered as a transportation option to the parents. The matress should have a sheet or blanket placed over a wipable mattress covering and a nurse must escort the deceased child and return the pram into storage. (see Appendix 8) Document time porter requested and note the job reference number.	Decomposition occurs rapidly, particularly in hot weather and in overheated rooms. Transfer to the mortuary must occur in a respectful and dignified manner, ensuring that members of the public are not exposed to the sight of a deceased child during transfer and that staff are not placed under unnecessary risk.

22.	Prepare ward area for arrival or porters with concealment trolley / pram by drawing curtains and remove unnecessary equipment to allow concealment trolley/pram to be placed next to the bed.	To ensure the safe, legal and dignified transfer of the deceased patient to the mortuary.
23.	Greet porters on their arrival, confirm identity of deceased patient (S number on ID bands) and assist with transfer by ensuring bed brakes are locked, bed and trolley are at the same height and pat slide used for lateral transfer.	Safe transfer
24.	Provide appropriate support and reassurance to other children and visitors to the ward.	Other patients and visitors may be aware that a death has occurred.

25.	Record all details and actions within the nursing sections of the Child Death documentation / child's medical / nursing records.	To record the identified and verified date and time of death, names of those present, and names of those informed. (The identified and verified date of death may differ e.g. pre and post midnight and be important to the family.)
26.	Appropriate verbal and written information (bereavement booklet) should be given to the family (or posted, where unable to attend) explaining how to contact Bereavement Services the next working day, what happens next, support available from their 'Key worker'/Bereavement Support Nurses/ Support Organisations, and how to raise questions. (see Appendix 3, sections 4.4 - 4.6) Where urgent release of the child has been arranged, and property is received by family, future contact with the Bereavement Services Office is not required.	To ensure the family receive on-going support.
27.	You must ensure that there is a system in place for other professionals involved in the child's care to be informed (such as GP, community nurses, Health Visitor, Rainbows Children's Hospice, or Service Co-ordination Scheme). Follow guidance and complete checklist within the UHL Child Death Paperwork D3/2021 or local bereavement checklists on the Neonatal or Maternity Units	To provide on-going support. To ensure that the family do not receive any appointments or letters regarding the child and allow those staff who have been involved with the child to visit the family.

28.	Take all medical and nursing notes and any remaining property to Bereavement Services office within 3 hours of patient's death during office hours (or by 10.00am the following working day if out of hours). For babies on the neonatal unit, ward clerk to ensure a full copy of all clinical notes are made. Copy of the notes - send to bereavement services on the next working day Original file together with any other volumes eg ICU charts – send to the neonatal secretaries to be available for the Perinatal Mortality Review team. A copy of the Notification of death / Child Bereavement Notification form should accompany the child to the Mortuary (ALL areas). Copy of UHL Child Death Paperwork should accompany a child to the Mortuary from the Paediatric Emergency Department or Childrens Hospital. Maternity child death: Post Mortem Form, Clinical information, Euroking 3 (labour/birth summary) and the Infant Bereavement Notification form are scanned to the Mortuary mailbox in addition to paper copies accompanying the child to the Mortuary.	To ensure Bereavement Services Officers can deal appropriately with relative's enquiries. Documentation/case notes etc. needed to commence the death certification process. Mortuary team have relevant information to identify and provide appropriate care for patient.

	Paediatric Emergency Department - Notes will be scanned and put onto CITO.	

Risk of Infection and use of Body Bag

University Hospitals of Leicester NHS
NHS Trust

Last Offices and Care of the Deceased Patient
Appendix 7

1. SPREAD OF INFECTION

1.1 The risks of infection from a patient rarely increases after death and can be prevented by the use of standard precautions including the use of appropriate Personal Protective Equipment (PPE).

2. PERFORMING LAST OFFICES

2.1 Because it is not possible to rule out an underlying infection in every case, it is advisable that nursing staff perform last offices with the same protective precautions as when the patient was alive; this includes disposable gloves and apron (minimum) and additional PPE where required as per UHL guidance when handling the deceased.

2.2 Overt use of protective measures can cause distress. Gloves and apron should be removed after handling the deceased and hands washed thoroughly before meeting the family.

3. COMMUNICATION

Registered Medical Practitioners have a legal obligation to notify the Health Protection Agency of suspected disease, infection or contamination in a dead body (see Public Health England contact details in useful links).

3.1 If a patient has died with a known or suspected infection, it is the legal responsibility of those performing last offices to ensure those who care for the deceased after death are informed of the potential risk of infection.

3.2 The persons who need to know include next of kin, portering staff, mortuary staff and funeral director.

3.3 Ward staff should use the Notification of Death form to communicate the nature of infection and the precautions required. This will ensure the specific diagnosis remains confidential, even after death.

3.4 Relatives may be unaware of the true nature of the infection and an individual's right to confidentiality continues after death, but the bereaved relatives must be advised on how to avoid risk of infection to themselves.

3.5 Specific questions about the nature of the infection from the next of kin should be referred to the doctor who confirmed that the patient had died.

3.6 Table showing transmission based precautions for the deceased patient with infections table (National infection prevention and control manual for England. NHS England 2023)

Infection	Causative agent	Hazard Group	Is a body bag needed[1] ?	Can the body be viewed?	Can post mortem be carried out?[2]	Can hygienic treatment be carried out?[3]	Can embalming be carried out?[2]
Airborne: small particles that can remain airborne with potential for transmission by inhalation							
Plague (Pneumonic and bubonic)	*Yersinia pestis*	3	Yes	Yes	If an appropriate facility is found	Consult specialist advice	Consult specialist advice
Tuberculosis	*Mycobacterium tuberculosis*	3	Yes	Yes	Yes	Yes	Yes
Middle Eastern Respiratory Syndrome (MERS)	MERS coronavirus	3	Yes	Yes	Yes	Yes	Yes
Severe acute respiratory syndromes	eg SARS coronavirus see HSE Handling the deceased with suspected or confirmed COVID-19 - HSE	3	Yes	Yes	Yes	Yes	Yes
Droplet: large particles that do not remain airborne for very long and do not travel far from source with potential for transmission via mucocutaneous routes (ie mouth, nose, or eyes)							
Meningococcal septicaemia (Meningitis)	*Neisseria meningitidis*	2	No	Yes	Yes	Yes	Yes
Non-meningococcal meningitis	Various bacteria including *Haemophilus influenzae* and also viruses	-	No	Yes	Yes	Yes	Yes
Influenza (animal origin)	eg H5 and H7 influenza viruses	3	No	Yes	Yes	Yes	Yes
Diphtheria	*Corynebacterium diphtheriae*	2	No	Yes	Yes	Yes	Yes

Infection	Causative agent	Hazard Group	Is a body bag needed[1] ?	Can the body be viewed?	Can post mortem be carried out?[2]	Can hygienic treatment be carried out?[3]	Can embalming be carried out?[2]
Contact: either direct via hands of employees, or indirect via equipment and other contaminated articles where transmission is primarily via an ingestion route							
Invasive streptococcal infection	*Streptococcus pyogenes* (Group A)	2	Yes	Yes	Yes	No	No
Dysentery (shigellosis)	*Shigella dysenteriae (type 1)*	3	Advised	Yes	Yes	Yes	Yes
Methicillin-resistant *Staphylococcus aureus* (MRSA)	Methicillin-resistant *Staphylococcus aureus*	2	No	Yes	Yes	Yes	Yes
Hepatitis A	Hepatitis A virus	2	No	Yes	Yes	Yes	Yes
Hepatitis E	Hepatitis E virus	3	No	Yes	Yes	Yes	Yes
Enteric fever (typhoid/para typhoid)	*Salmonella typhi/paratyphi*	3	Advised	Yes	Yes	Yes	Yes
Brucellosis	*Brucella melitensis, B. arbortus, B. suis*	3	No	Yes	Yes	Yes	Yes
Haemolytic uraemic syndrome	Verocytotoxin/ shiga toxin producing *E.coli* (eg O157:H7)	3	No	Yes	Yes	Yes	Yes
Contact: either direct or indirect contact with blood/other blood containing body fluids via a skin-penetrating injury or via broken skin and through splashes of blood/other blood containing body fluids to eyes, nose and mouth							
Acquired Immune Deficiency Syndrome related illness	Human immune-deficiency virus	3	No	Yes	Yes	Yes	Yes
Anthrax	*Bacillus anthracis*	3	Yes	No	Yes[4]	No	No
Hepatitis B, D and C	Hepatitis B, D and C viruses	3	No	Yes	Yes	Yes	Yes
Rabies	Lyssaviruses	3	No	Yes	No	No	No
Viral haemorrhagic fevers	See appendix 11b	4	Yes[5]	No	No	No	No
Contact: either direct or indirect contact with body fluids (eg brain and other neurological tissue) via a skin-penetrating injury or via broken skin							
Transmissible spongiform encephalopathies (eg vCJD)	Various prions	3	Yes	Yes	Yes	Yes	No

Notes

[1] It is advised that a body bag is used for the deceased in all cases where there is (or is likely to be) leakage of bodily fluids.

[2] When carrying out higher risk procedures such as post-mortem or embalming, consideration should be given to the need for additional measures to prevent contamination of equipment

Infection	Causative agent	Hazard Group	Is a body bag needed[1] ?	Can the body be viewed?	Can post mortem be carried out?[2]	Can hygienic treatment be carried out?[3]	Can embalming be carried out?[2]
and the environment and to prevent staff exposure to infectious material eg through additional PPE and use of safer sharps devices. [3] Hygienic treatment refers to washing and/or dressing of the deceased. [4] Where anthrax infection is suspected, before undertaking a post mortem the rationale for the procedure should be carefully considered; particularly where examination may increase the potential for aerosol generation. [5] A double body bag must be used. NB Hazard group 4 and HCID will be transported by HART teams (see section 2.6)							

TRANSFER TO THE MORTUARY

University Hospitals of Leicester NHS
NHS Trust

Last Offices and Care of the Deceased Patient Policy
Appendix Eight

1 Introduction

1.1 The Portering Department is responsible for undertaking the transfer of deceased patient from the Ward/Department/Emergency Department/place of death to the Mortuary.

1.2 All transfers will be undertaken in a safe and dignified manner.

1.3 Body to be collected within 1 hour of the request for transfer to the Mortuary being made.

1.4 Family and friends are not able to accompany the porters whilst they collect or transfer the deceased patient to the Mortuary.

1.5 However, if a parent wishes to walk alongside the transporter to the mortuary doors, or transport an infant by other means (which would be risk assessed by clinical team and discussed with the Portering and Mortuary team first) a nurse will accompany the Porter. (Refer to Appendix 6, section 16)

2 EQUIPMENT

In order to maintain the privacy and dignity of the deceased patient, visitors and staff in any surrounding area, an appropriate concealment trolley should be used for transfers:

- Neonatal transport container (held on Delivery Suite)
- Half-size “child” concealment trolley or cot/bed concealment cover
- Full-size “adult” concealment trolley or bed concealment cover
- Bariatric concealment trolley or bariatric trolley cover

Concealment trolleys will be stored out of public view when not in use, and will be used in a dignified and professional manner at all times (even when empty).

The concealment trolley and its cover should be checked to make sure it is in good working order

prior to use, and cleaned and disinfected with Clinell wipes (available in the Mortuary) after every transfer. Appropriate Personal Protective clothing must be worn when disinfecting and cleaning the trolley.

A covered 'bereavement pram' may also be used for small infants (where no infection or leakage risk). This is stored in the Porters Lodge. The responsibility for cleaning, returning to the lodge and covering with a sheet is the responsibility of the accompanying nurse. The responsibility for safe storage lies with the Porters.

3. Procedure for Transfer to the Mortuary

3.1 Request for transfer:

3.1.1 Ward staff to request transfer of deceased patient to the mortuary by contacting porters on extension 17888 or via the electronic referral system .

3.1.2 Ward staff to inform porters of any relevant factors, including which concealment trolley / bereavement pram to be used, whether patient is more than 200kg and as well as whether a body bag has been used and if so, reason why:

3.1.2.1 The use of a body bag and Personal Protective Equipment is sufficient to protect those handling the deceased patient from leaking fluids, infections or radiopharmaceuticals.

3.1.3 Ward staff to inform porter of any other factors that may affect transfer, including ward rounds, catering rounds, drug rounds, visiting times or potential issues with family members.

3.1.4 If there are any potential threat of aggression or conflict. portering staff will decide whether to delay transfer until an escort from security is available.

3.2 Collection of deceased patient from ward:

3.2.1 Ward staff are responsible for ensure the deceased patient is prepared and Notification of Death form completed prior to portering staff arriving to collect the patient.

3.2.2 Ward staff are responsible for preparing the ward area prior to the arrival of portering staff, ensuring that curtains are drawn to maintain privacy (unless deceased patient is in a single room) and any unnecessary equipment has been removed to allow placement of the concealment trolley next to the deceased patient's bed.

3.2.3 A minimum of two porters are required for the transfer of all deceased patients, including child death where a pram is used, and more for bariatric patients.

3.2.4 Porters will collect (and assemble) the correct concealment trolley or concealment cover, ensure it is in good working order and proceed to the ward in a professional and dignified manner, reporting to the Nurses' Station on arrival to the ward.

3.2.5 Ward staff must be available to assist the porters, and confirm the identification of the deceased patient.

3.2.6 Nursing staff and porters will us appropriate Personal Protective Equipment during the transfer of the deceased patient from their bed to the concealment trolley.

3.2.7 Once privacy has been ensured (closing single room door or curtains around the bed space) the frame and cover of the concealment trolley can be removed and the trolley positioned laterally to the bed. It is essential that the castors of the bed and trolley are locked and both are at the same height.

3.2.8 A pat slide should be used to transfer the deceased patient from the bed to the trolley.

3.2.9 Once the deceased patient is on the concealment trolley the framework and cover should be replaced, maintaining the privacy and dignity during transfer to the mortuary.

3.2.10 Where a pram is used, a cover should be placed across the hood, ensuring privacy, secured with clips.

3.3 Notification of Death form:

3.3.1 Ward staff are responsible for ensuring the correct identification labels are on the deceased patient, and that the Notification of Death form has been completed.

3.3.2 Portering staff will take one copy of the Notification of Death form with the deceased patient to the mortuary.

3.3.3 Portering staff will also deliver an additional copy of the Notification of Death form to Bereavement Services.

3.4 Transfer of Deceased Patient to the Mortuary:

3.4.1 Apron and gloves should not be used during transfer to the mortuary.

3.4.2 The route from wards to all three mortuaries at University Hospitals of Leicester is through public areas. Maintaining privacy and dignity of the deceased patient and minimising distress to visitors/contractors/staff members will be by the use of the concealment trolley with frame and cover in situ at all times, as well as ensuring family members do not accompany the deceased patient during transfer to the mortuary. Transfer must be in a professional and dignified manner. (Any exceptions to this must be risk assessed on the ward prior to transfer).

3.5 Reception of Deceased Adult/Paediatric Patient into the Mortuary:

3.5.1 On arrival into the mortuary, porters adopt appropriate PPE and place the deceased into the fridge. Porters must ensure the mortuary is secure when leaving the department. It is not common practice, but in some rare cases, ward staff may be requested to accompany the deceased patient to the Mortuary. In such situations the following should be borne in mind:

- Ward staff are not permitted to enter the fridge room without prior discussion and consent from the Mortuary Manager and only when no other mortuary activity is ongoing.
- On arrival to the Mortuary, Mortuary staff or Porters (outside of mortuary working hours) will determine when the fridge room can be accessed.
- Only Mortuary or Portering staff are permitted to operate mortuary equipment, including body fridges.
- All persons present when a patient is placed into a fridge must complete the Mortuary Patient Reception Register.

3.5.2 The hydraulic hoist must be used to remove an empty tray from the temperature controlled accommodation, and the frame and cover removed from the concealment trolley. The height of the hoist and concealment trolley must be the same and the castors locked for safe transfer.

3.5.3 A pat slide must be used to transfer the deceased patient from the trolley to the tray.

3.5.4 The deceased patient must remain securely wrapped at all times, to protect their privacy and dignity.

3.5.5 The tray must be returned to its original position and the door secured. Portering staff must document the first initial of the forename and the name of the deceased patient on the name plate on the exterior of the door, and the Mortuary Register must be completed.

3.5.6 The concealment trolley and cover must then be disinfected and cleaned, the framework and cover replaced and Personal Protective Equipment removed and disposed of.

3.5.7 On leaving the mortuary portering staff must ensure the department is secure.

4 TRANSFER OF PATIENTS FROM NON-WARD AREAS

Transfer of patients who have died in non-ward areas, such as theatres, catheter labs etc. should follow the above procedures for transferring patients within the hospital. Transporting patients on open beds/trolleys, without the use of a concealment cover, is **NOT** acceptable practice, as it compromises the dignity of both patients and their relatives.

5 TRANSFER OF INFANTS/CHILD

5.1 The transfer of the deceased baby from the Maternity or Neonatal Unit will follow the procedure as outlined above.

5.2 A Nurse/Midwife may accompany portering staff during the transfer, but must not transfer the deceased baby on their own. See section 3.5.1 above for child death transfer

5.3 The Notification of Death Form is not completed in these cases. Instead an **Infant Bereavement Notification Form** will be completed by ward staff, and a clinical summary and post-mortem request form (if necessary). Ward staff are responsible for the accuracy and completion of this paperwork and portering staff will deliver the forms as outlined in section 3 above. Pregnancy loss form is completed for pre-sixteen week non-viable foetus and an Infant Bereavement Notification Form is completed for post-sixteen week gestation to the 28 day after birth.

5.4 Ward staff may occasionally request that the deceased baby is brought back to the Maternity or Neonatal Unit for visiting, if the condition of the mother is such that she is unable to attend the mortuary. This is the only time that it is acceptable for any deceased patient to return to the ward area and must be carefully managed:

- Ward staff should accompany portering staff to the mortuary to confirm the identity of the deceased baby and complete the Temporary Release and Return Register in the mortuary. If the ward staff are not available to accompany the portering staff to the mortuary visiting on the ward will not be possible.

Ward staff are responsible for:

- Attending the mortuary with portering staff
- Confirming the identity and ensuring the deceased baby is presentable before viewing takes place
- Maintaining the privacy, dignity and security of the deceased baby on the ward
- Ensuring there is minimal impact on any other patients, visitors or staff
- Supporting the mother and any visitors during the visiting
- Preparing the deceased baby for transfer back to the mortuary.

The release of the deceased patient from UHL must go through the Mortuary, including those mentioned in 5.5 below, (with the exception of direct releases from the Neonatal and Maternity areas- ref B17/2022)

A deceased child under the age of 1 year may, where requested, be released and directly transferred and transported to Rainbows Hospice or to the family home by the family (Refer to Rainbows Transfer and Taking a Deceased Child Home where Registerable Death guidelines). For all others, Funeral Director transportation is required.

6 BARIATRIC PATIENTS

6.1 Ward staff must inform portering staff if the transfer of the deceased patient is likely to post a manual handling risk and/or weighs more than 200kg*. The patients weight must be clearly documented on the Notification of Death form

*Porters should contact the Mortuary (or on call Anatomical Pathology Technologist (ATP) as required out of hours via switchboard) to arrange appropriate refrigeration arrangements.

6.2 Portering staff may decide to visit the ward to visually assess the deceased patient in order to use the most appropriate and respectful method of transport.

6.3 In certain circumstances, transfer to the mortuary may be delayed whilst additional staff and/or equipment is located. The method of transport will be adapted to suit each of the three hospital sites dependent on availability of equipment.

6.4 In circumstances where such equipment is not adequate, it may be necessary for the deceased patient to be transferred direct from the ward to the funeral home by University Hospitals of Leicester contract Funeral Directors. Transfer is authorised and arranged by either the Mortuary Manager or on-call mortuary staff.

6.5 Once appropriate staff and equipment are available, transfer should follow the procedure outlined in section 3 above.

For accomodation of the deceased, Please refer to: Reception, Accommodation and Release of Patients and Specimens in the Mortuary
Reference Number: PR3837

POST MORTEM EXAMINATIONS/ TAKING TISSUE SAMPLES AFTER DEATH

University Hospitals of Leicester NHS
NHS Trust

Last Offices and Care of the Deceased Patient Policy
Appendix Nine

1. Taking Samples After Death When Not Part of a Post Mortem Examination

1.1 The Human Tissue Act (2004 – HT Act) governs post mortem activity, including any tissue samples that are taken after death.

1.2 The HT Act defines this as any sample which may contain cells (including urine), and therefore includes every possible sample which may be taken. Locks of hair are not covered by the HT Act.

1.3 The HT Act is enforced by the Human Tissue Authority (HTA) and failure to comply can result in withdrawal of HTA license, a fine and up to three years imprisonment.

For further guidance, refer to Consent to Hospital Post Mortem Examination Policy B9/2006

2. SUDDEN UNEXPECTED DEATH IN INFANCY/CHILDHOOD (SUDIC)

2.1 For child deaths, the Paediatric Emergency Department is the only area where Post Mortem samples can routinely be taken without consent from the Coroner (Neonatal and Maternity Units arrangements pending): See detailed procedures for taking samples in UHL Child Death Paperwork & CDOP Process (0-18 years) Ref D3/2021

2.2 The HT Act requires that named individuals have responsibility to ensure that this process complies with the HT Act

2.3 The Designated Individual (HTADI) for University Hospitals of Leicester, with legal responsibility for compliance with the HT Act, is Caroline Whiteley, Deputy Service Manager, Department of Cellular Pathology.

Clinical leads who manage services in line with requirement of the HT Act, are:

Dr M Johal, Head of Service, Adult Emergency Department
Dr S Robinson - Children's Hospital Governance Lead and Head of Service for Paediatric Specialities (excludes PICU, ED and neonates)
Dr J Tong – Clinical Lead PICU's and ECMO
Dr J Behrsin - Consultant Neonatologist and Head of Service
HTA Persons Designate, who assist the HTADI in particular cases are :
Children's Emergency Department - Dr Rachel Rowlands, Lead for Child Deaths in the ED.
Maternity – Dr Penny Mc Parland
ANY member of staff seeking consent or taking a sample is personally responsible for ensuring compliance with this policy and traceability log.

Cultural and Religious Requirements

University Hospitals of Leicester NHS
NHS Trust

Last Offices and Care of the Deceased Patient Policy
Appendix Ten

The following are only suggestions and can be used in conjunction with the Green "Diversity in Healthcare" folder produced by the University Hospitals of Leicester (April 2003). Folders are available within the clinical area.

- Primarily it is essential that any religious beliefs held by the patient or family of a child or infant are identified on admission, or prior to death, so that nursing staff can adhere to the needs of the patient, relatives and important others.

- Individual requirements will vary even among members of the same religion. Varying degrees of adherence and orthodoxy exist within all the world's religions. The identified religion may occasionally be offered to indicate an association with particular cultural and national roots, rather than to indicate a significant degree of adherence to a particular religion.

- It is essential where a specific need is identified, a lead should be taken from the family.

- When requesting a member of the Chaplaincy to visit a patient, contact switchboard and ensure you clearly state the patient's religion.

REQUIREMENTS FOR PEOPLE OF DIFFERENT RELIGIOUS FAITHS

Many requirements and preferences for religious and cultural reasons are already covered by the normal infection prevention measures in this policy. For example where gloves are being worn for infection prevention reasons, this also prevents physical contact between the healthcare worker and the deceased, which in some religions would not be acceptable if the worker were not the same gender as the deceased.

The following table gives indications of additional measures that may be appropriate for various religions.

Bahai	Bahai relatives may wish to say prayers for the deceased person, but normal last offices performed by nursing staff are quite acceptable. If a special ring is placed on the finger of the patient it should not be removed.

Buddhism 	A request may be made for a Buddhist monk or nun to be present. As there are a number of different schools of Buddhism, relatives should be contacted for advice on how the body should be treated. The relatives may request, for the body to be left for a period of time, while prayers are said.
Christianity 	Relatives may request a hospital chaplain or priest from their own church to offer prayers. Roman Catholic families may request the presence of a Roman Catholic priest.
Hinduism 	A Hindu patient or relative may request the services of a priest during the last stages of life.The Hindu Hospital Chaplain may be requested to perform last rites Where possible the body should not be handled before consulting the relatives. Hindu's often prefer nursing staff of the same sex as the patient to handle the body. The deceased should always be covered by a plain white sheet. Where possible preparation for this eventually should be made by moving the dying person to a single room, so that other patients or visitors are not disturbed by these expressions of grief at the time of death. Support the jaw. Do not remove threads or jewellery. Cremation frequently occurs soon after death, and speedy completion of the death certificate will aid this process.
Muslim 	The Muslim Hospital Chaplain may be requested to say prayers at end of life. Many Muslims would prefer to be touched by someone of the same faith and of the same sex. The body should not be washed.The family may request that the body is turned to face towards Mecca (head first). Mecca is South East of Leicester. Muslim patients are usually buried as soon as possible after death.

Jainism	The family may wish to provide a plain white gown or shroud for the deceased. Prayers are offered for soul of dying patient- presence of a Jain Spiritual Caregiver is preferred. Family may wish to assist with Last Offices. Prefer no post-mortem unless required Cremation frequently occurs soon after death, and speedy completion of the death certificate will aid this process.
Judaism 	Many Jews would prefer someone from the Jewish faith to touch the body. **Traditionally the body is left for about 8 minutes before being moved while a white feather is placed across the lips and nose to detect any signs of breathing.** The body should be handled as little as possible. The patient should not be washed and should remain in the clothes in which they died. **The family may request the jaw is tied up.** It is often seen as a religious duty for Jewish people to stay with the body until burial.
Mormon (Church of Jesus Christ of the Latter Day Saints) 	Relatives may advise staff if the patient wears a one or two piece sacred undergarment. If this is the case, relatives may dress the patient in these items.
Rastafarian 	Family members may pray at the bedside of the dying person, but there are no rites or rituals before or after death. At death, routine last offices are appropriate. Few would agree to a post-mortem unless it is ordered by the Coroner

Sikhism 	The Sikh Chaplain may be requested to say prayers and offer last rites. The eldest son may wish to take the lead for the Last Offices. Do not remove the'5Ks'which are personal sacred objects: Kesh: Do not remove head covering-turban (men)/duppata(women) Kanga: Do not remove semi-circular comb, which fixes hair Kara: Do not remove any bracelets Kachh: Do not remove special shorts worn as underwear. **Seek advice from family if soiled.** Kirpan: Do not remove miniature sword if worn.
Zoroastrian (Parsee)	The family may wish to be present during, or participate in, the preparation of the body. Orthodox Parsees are likely to require a priest to be present. The family may provide specific clothing to be worn, called the Sadra.

Equality Analysis – Crib Sheet Guidance

1. Introduction

The Equality Analysis Crib Sheet is a useful tool to help collect equality data/information. This crib sheet will assist you in identifying the key equality issues and provides you with the opportunity to ensure we meet the requirements of the Equality Delivery System 3 (EDS3), Public Sector Equality Duty (PSED) and the Equality Act 2010.

The CQC will be requesting evidence of good equality practice and how we plan to use information to improve the service we provide to patients (their families/carers), staff and our diverse communities.

2. Step-by-Step Guide:

- Capture the information relating to the event/meeting, including the date and the venue.
- Explain why the event is taking place and its objectives.
- Capture the attendees/audience for example patient groups, strategic partners, community groups and staff.
- Consider the attendees/audience in relation to their protected characteristic. For example, if you're working with a specific community group. Please be aware that for the vast majority of people have more than one protected characteristic. For example if you are working with school children age would be a consideration, gender, disability, religion or belief and race may apply and would be captured on this sheet.
- EDS3 Goals, think about which of the goals you are meeting during this event and tick accordingly. For example, if the meeting is around patient experience, you would tick Goal 1, if it's a staff event you would tick Goals 2 and 3.

  Goal 1: Commissioned or provided services: The NHS should achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results.

  Goal 2: Workforce developments and well-being: The NHS should improve accessibility and information and deliver the right services that are targeted, useful, useable and used in order to improve patient experience.

  Goal 3: Inclusive leadership: the NHS should increase the diversity of their staff. Take into account and evidence their commitment to the Public Sector Equality Duty, EDS3, Equality Act 2010 and NHS Constitution.

- Equality outcomes and actions: this is your opportunity to consider and document what outcomes have been achieved and the subsequent actions you intend to take in relation to Equality, Diversity and Inclusion.

3. EDS3 CRIB SHEET and Applying "Due Regard"

Prior to completing the Equality Analysis it is useful to understand and apply what is known as the – Browne Principles. This is vital to ensure we meet our legal responsibilities and **Clearly Demonstrate – "Due Regard".**

(1) Decision makers must be aware of their equality duties.
(2) The due regard duty must be fulfilled before and at the time of decisions.
(3) Equality Analysis must be rigorous.
(4) The duty to have due regard cannot be delegated.
(5) The duty is a continuous one.
(6) It is essential that organisations keep a record of their activities.

EDS3 has 10 outcomes based around 3 key Domains:

a. Domain 1- Commissioned or Provided Services.
b. Domain 2 – Workforce Development and wellbeing.
c. Domain 3 – Inclusive Leadership.

- Commissioned or provided services will focus on issues such as good access to services, needs being met and patients being free from harm, abuse and having positive experiences of health care whilst at UHL.
- Workforce development and well-being will focus on staff being free from bullying, harassment and other harms. Equality and Equity, career development, data from the Staff Survey aligned with WRES. Internal staff networks and TU Representatives.
- Inclusive leadership – Focus – Leaders must demonstrate their commitment to EDI. Board and committee papers should have a good and appropriate EDI Content. Critical engagement with Patients, service users, local communities, Voluntary organisations and staff networks to demonstrate how they play their part in the EDI process / plans / actions.

Public Sector Equality Duty (General Duty)

- Eliminate Discrimination (in all its forms);
- Foster Good Relations (between all protected characteristics);
- Advance Equality of Opportunity (between all protected Characteristics).

These 3 elements need to be evidenced in your response. Please consider how you demonstrate the way in which you challenge discrimination (in all its forms) i.e. racism, sexism, homophobia. This can be via national and local campaigns; it includes Trust initiatives in tackling bullying or harassment. Supporting staff networks. Developing your own / teams understanding of how discrimination occurs. Fostering healthy relationships and encouraging a sense of respect and dignity for all. Providing the opportunities for professional development for all staff regardless of their status.

4. Equality Mapping – EDS3

Date:14/4/23

Purpose of the policy:

Last Offices Policy B28/2010 : This document sets out the University Hospitals of Leicester (UHL) NHS Trusts Policy and Procedures for care of the patient who has died (deceased patient) from the point of death until arrival in the Mortuary.

The policy also outlines the procedures that enable respectful and dignified care compliant with regulatory guidance and statutory legislation.

The aim of this policy is to guide staff through the processes relevant to care of the deceased patient and their relatives to be used in conjunction with the attached appendices

Who are you working with?
(For example: working with local strategic partners / /community engagement / team meetings / patient groups).

See policy for details

Equality Questions:

These questions are to assist your thinking and processes. We have a legal responsibility to ensure we are compliant with legislation but also to bring fairness and consideration in our decisions and actions for both patients and staff.

Please consider the 8 questions and how you are able to evidence how these have been met.

Q 1- What is the aim of the function / policy / practice / procedure.
See above

Q 2 - What outcomes do you want?
To ensure safe, consistent and effective practice

Q 3 – Would you receive a different outcome if you were from a particular group (Protected Characteristic?)
No
Q 4 – Would that outcome be adverse?
Policy applied to all groups irrespective of protected characteristics and beyond. Where potential concerns are identified, these will be addressed on an individual basis to the best of our ability.

Q 5 – If you have answered yes, can you mitigate or explain why it has to be delivered or done in a particular way?
N/A
Q 6 – Can you justify and provide the evidence to support the decisions you have made In line with the Public Sector Equality Duty (PSED)

Yes – it is in line with our infection and prevention and health and safety requirements. However any identified cultural differences or specific needs for groups or individuals will be discussed with the individuals. (eg. individual variances on cultural rituals)

Q 7 – How have you obtained the evidence (patient groups / local, regional and national data)?
Consultation with working group as in policy.

Q 8 – Have you carried out equality monitoring on the protected characteristics?

Medical Examiner and Bereavement Support Service feedback received from the bereaved family members provides individual accounts of standards of EoL care in UHL according to CMG, ward base and ethnic background which will provide monitoring. There is also monitoring of this policy and associated policies in both adult, children's and maternity services via the CDOP (Child death overview process), the LeDeR (Learning from death reviews -disabilities), Perinatal Mortality review Group, Mortality review Committee. The diversity of individuals and their considerations will be applied where possible.

Tick the protected characteristics that apply to those attending:

Age	**y**	Disability	**y**
Gender Reassignment	-	Race /ethnicity	y
Pregnancy & Maternity	y	Religion & Belief	y
Sexual Orientation	-	Marriage & Civil Partnerships	-
Sex	y		

EDS3 – The 3 Key Goals - tick the box/es that apply:	
Commissioned or provided services	**y**
Workforce development and wellbeing	**y**
Inclusive leadership	**y**

CQC Key Lines of Enquiry - tick the box/es that apply:

Are they safe? ☐ yes -applies

Evidence to support: as above and see policy

Are they effective? ☐ yes

Evidence to support: see policy

Are they caring? ☐ yes

Evidence to support: see policy

Are they responsive? ☐ yes

Evidence to support: see policy

Are they well-led? ☐ yes

Evidence to support: see policy
Health Inequality Considerations. What are the Health Inequalities Identified in your assessment? N/A Please view the link for guidance https://forequity.uk/
Job Title/Department/Division: Bereavement Support Nurse UHL Contact details: 14380
Equality Outcomes and Actions: No actions- just to check with Lead chaplain re any Jainism and Rastafarian needs
Monitoring Dates – Review progress 2/5/23 – Guidance provided and included in policy re Jainism and Rastafarian needs.
Please return to: Equality, Diversity & Inclusion Team: Returned 2/5/23 equality@uhl-tr.nhs.uk