East London NHS
NHS Foundation Trust

Dignity in Care at the End of Life

Practice Guidance

Version:	2.0
Ratified by:	The Clinical Effectiveness Committee
Date ratified:	19th January 2016
Name of originator/author:	Peter Sheils/Eirlys Evans
Name of responsible committee/individual:	The Quality Committee
Circulated to:	All Clinical Staff
Date issued:	5th March 2014
Review date:	March 2017
Target audience:	Clinical staff working in adult and older adult in-patient services. Staff caring for young people should refer to separate guidance.

Version Control Summary

Version	Date	Author	Status	Comment
1.0	05/03/14	Peter Sheils/ Eirlys Evans	Final	
2.0	07/12/15	Eirlys Evans	Final DRAFT	Revision of title in Appendix 2: Arrangements for the deceased to Care After Death, and guidance concerning persons who

				die at a time when they are deprived of their liberty under the Mental Capacity Act (2005). Revision of title :Appendix 3: Change from Last Offices Guidance and Procedure to Personal Care After Death . Procedure 24 expansion of section maintaining privacy and dignity.

Contents

1 Introduction

1.1 East London NHS Foundation Trust (The Trust) recognises the need to support standards and a programme of education for all staff to deliver high quality, compassionate care to service users that have an advanced life limiting illness in the community or in hospital and provide support to their carers**.**

1.2 This guidance is underpinned by the national End of Life Care Strategy (2008), Improving Supportive and Palliative Care for Adults with Cancer (NICE Guidance), https://www.gov.uk/government/uploads/system/uploads/attach/One_chance_to_get_it_right.pdf (2014), care-of-dying-adults-in-the-last-days-of-life-1837387324357.pdf (NICE 2015) and Hospice UK (2015) Care After Death: Guidance for staff responsible for care after death .

1.3 The tools to support this policy include:

1.3.1 The Gold Standards Framework (GSF) which:

- Identifies patients in the last year of life
- Assesses their care needs and preferences
- Develops a proactive plan of care

Further information about the GSF can be found on the Gold Standards Framework website.

1.3.2 The five priorities of care for the dying person set out in: One Chance to Get it Right:

- Recognise
- Communicate
- Involve
- Support
- Plan & Do

2 Purpose of the Guidance

2.1 To enable multidisciplinary teams to develop a person centred holistic plan of care ensuring symptoms are as controlled as possible, that the physical, psychological, spiritual social and cultural end of life care needs of the patient are met and that work across agencies is supported to ensure the patient has choice of care and good symptom control.

2.2 To improve staff confidence, communication and partnership working through provision of standards of practice and education.

2.3 To ensure that high quality of care is provided in that the patients privacy, dignity, respect are adhered to for all patients at the end of life.

2.4 To enable them to choose their preferred place to die as far as is reasonably possible.

2.5 To ensure that carers are supported, appropriately informed, enabled and empowered throughout the end of life of their relative or friend.

3 Consent

3.1 Patients have a fundamental legal and ethical right to determine what happens to them. The practice of seeking consent is further endorsed by the requirements of the Human Rights Act 1998.

3.2 The Trust's Consent to Treatment Policy sets out standards and procedures that define consent as a patient's agreement for a health professional to provide care.

3.3 Consent may be indicated non-verbally, orally or in writing for consent to be valid. It is essential that all healthcare professionals clearly document patient wishes to interventions and the decisions.

4 Capacity

4.1 The Trust has a duty to support people with impaired mental capacity so that they can make their own decisions about health and social care that they receive. People needing such support might include people with severe and enduring mental illness, dementia, people with learning disabilities and people at the end of a terminal condition.

4.2 Where an adult patient lacks the mental capacity (temporarily or permanently) to give or withhold consent for him/ her, no one else can give consent on their behalf unless there is an identified 'Lasting Power of Attorney' in relation to health matters as well as financial matters. However, treatment may be given if it is in the patients' best interests as long as it has not been refused in a valid and applicable Advance Decision to Refuse Treatment (ADRT), as stipulated in the Mental Capacity Act (2005) Code of Practice. In determining best interests, any Advance Statements the patient has made (verbal or written) should be taken into account during the decision making process. This must be clearly documented in the patient's notes.

5 Patients Making a Will

5.1 Patients wishing to make a will whilst in hospital should be enabled to do so. If the patient expresses a wish to make or alter a will whilst in hospital the team must seek advice from the Trust's Mental Health Act Department.

5.2 The Responsible Clinician (RC) in charge of the patients medical care should sign and date in the patients records that the patient is capable of making a will (capacity assessment) and comment about the patient's mental sate and where there are any doubts about the patient ability to make a valid will. The law requires that the patient has the ability to understand the nature of the will, the nature of the estate to be disposed of and the claim of the patient to assets given. Doctors and nurses involved with a patient cannot act as witnesses for the signing of the will. Staff should be aware of the vulnerability to patients to pressure from those who might have an interest in the will.

6 Advance Care Planning

6.1 Advance Care Planning is the process of discussing and planning ahead in anticipation of some deterioration in a patient's condition and is important for ensuring patient-focused care is central to end of life care. There are two elements to advance care planning: Advance Statement and Advance Decision.

6.2 Advance Statement involves discussion of people's preferences, wishes and likely plans about what they wish might happen to them. Whilst it is not legally binding, it formalises what the patient and their family wish to happen to them and is invaluable in determining planned provision of care. The process of discussing this can be seen as part of the solution in that it enables emotional 'catch up' and adaptation to the new reality and

normalisation of life. Sensitive discussion of advance care planning can strengthen coping mechanisms and enable realistic planning. There is some evidence that it increases rather than decreases realistic hope.

6.3 Advance Decision involves clarifying any refusal of treatment or what the patient wishes to happen as well as assessment of mental competency to make that decision at the time. It formalises what patients do not wish to happen to them and when accurately formulated, the advance decision is legally binding. It also strengthens the role of the Lasting Power of Attorney to enable a nominated proxy person to make decisions about medical as well as social welfare.

7 Resuscitation

7.1 Following a multidisciplinary team assessment and review and/or diagnosis that a patient has an advanced life limiting illness, a discussion with the patient and/or their carer should be offered as early as possible regarding end of life care. This will be carried out with the utmost sensitivity and should include all aspects of care, treatment and resuscitation status where the patient is willing to engage with the discussion. A decision on whether or not to attempt resuscitation should then be made and documented as per the Trust's *Do Not Attempt Resuscitation (DNAR CPR) Practice Guideline* within the Resuscitation Policy. Please note that some patients are not willing to engage with discussions around their care or future care.

7.2 Patients have the right to refuse cardio pulmonary resuscitation (CPR). Unless a family has a lasting power of attorney, family members have no legal right to make the decision. The decision has to be made in the best interests of the patient; however, it is good practice to listen to family views.

7.3 The Trust will expect staff to attempt resuscitation for all patients unless discussions regarding the above have taken place and a decision is made that the patient is 'not for resuscitation' and this has been recorded on the Trust's Do Not Attempt Cardiopulmonary Resuscitation form.

7.4 Decisions about resuscitation should be reviewed at all regular, clinical reviews or whenever changes occur in the patient's condition or in the patient's expressed wishes. The patient's ability to participate in decision-making may change with changes in their clinical condition. Where a patient has previously been informed of a decision and it subsequently changes, they should be informed of the change of decision and the reason for it.

8 Involvement with Patients and Carers

8.1 It is essential that the patients are involved in all aspects of their care and should be given the choice to be involved in decisions regarding their preferred place of care. .

8.2 The patient's next of kin and/or carers who will be involved in care decisions must be identified as soon as possible. In the event that the patient is unable to make their needs and wishes known carers will be given the opportunity to be involved in all stages of the process as appropriate

8.3 In the event of the patients physical health deteriorating nursing staff should identify the main carer's contact details and the agreed times to be contacted. This should be documented in the nursing notes.

8.4 Carers will be offered the opportunity to support their relatives/friends at all times if appropriate to patients wishes. This will be supported by professional staff and over night facilities will be provided in patient areas when at all possible.

8.5 It should be recognised the family may include children and young people who may wish to visit their relative. In these circumstance staff should ensure that the principles of good practice are followed as set out in the Trust's Policy on Children and Young People Visiting Service Users in Hospital. Staff must also recognise that in some instances there may be a need for signposting family members and/or liaising with primary care services e.g. children's services, bereavement services etc.

8.6 It is particularly important that nurses are aware of deaths that require referral to the coroner as this will facilitate the correct personal care and enable nurses to prepare the family for both a potential delay in the processing of the MDCD and also the possibility of a post mortem examination.

8.7 Any items on the patient at the time of death such as jewellery should be documented. Valuables and personal effects should only be handed over to the person entitled to such as the spouse, parent or designated next of kin and a disclaimer form should be signed and recorded to the effect. Valuables should be sent for safe keeping in accordance with the local site procedures.

9 Transfers to another Facility

9.1 There may be instances when a patient's needs are best met in another facility, for example in an acute hospital, care home or hospice. Decisions such as these should be made at the earliest opportunity involving the patient and carers wherever possible. Trust staff will support continuity of care throughout the transfer process by providing a comprehensive handover of care and treatment to the receiving care team

10 Patients Detained Under the Mental Health Act , Mental Capacity Act (DoLs) and Patients under the Care of the Forensic Directorate

10.1 If a patient is detained under the Mental Health Act (1983) at the time of death or subject to a Community Treatment Order, the Care Quality Commission (CQC) must be informed within 72 hours, as well as the relevant Trust Mental Health Act Administration Team. Details of how to report the death to the CQC are on page 10 of the Incident Policy. Notify the Trust's local Mental Health Law office as they keep records which are periodically presented to the quality committee.

10.1 The death of a patient at the time that they are deprived of their liberty under the Mental Capacity Act 2005, is also the subject of a coroner's investigation. 'this means that the person is considered to be 'in state detention' at the time of death if subject to a deprivation authorisation. In these circumstances, the coroner must be informed of the death as soon as possible. Therefore all staff caring for the deceased need to ensure they are familiar with deaths that require such a referral as this will facilitate the correct personal care and enable staff to prepare the family both of the potential delay of the MCCD and the possibility of a post-mortem examination. Forms are usually completed by the team responsible for the deceased's care. The Deprivation of Liberty Policy provides more detail as to the forms which are to be used.

10.2 If a patient's death is referred to the Coroner, this will affect how their body is prepared. Advice must be sought before interfering with anything that might be relevant to establishing the cause of death.

11 Verification and Procedure for Expected Death

11.1 An expected death is recognised as a death that was anticipated as imminent by the patient, carer and by the multidisciplinary team.

11.2 Where a prior decision has been made and documented in the patient's health records that resuscitation will not be attempted in the event of cardiac or respiratory arrest which is the result of their terminal illness, such a death will be considered as expected. Where cardiac or respiratory arrest is part of a reversible condition the DNAR CPR instruction will not be applicable. Please note, a patient may have an advance directive containing DNAR instructions regarding their end of life care but may not be at the end of their life.

11.3 A registered medical practitioner who has attended a deceased person within the last 14 days prior to death of illness is required to issue a medical certificate stating the cause of death "to the best of his/her knowledge and belief". The certificate requires the doctor to state the date on which he saw the deceased person alive and whether or not he has seen the body after death. He is not obliged to view the body, but good practice requires that if he has any doubt about the fact of death, he should satisfy himself in this way. NB patients identified as nearing end of life i.e. a prognosis of weeks, should receive regular review by GP to ensure the above arrangements are met(completion of death cert can be difficult if the patient has not been see in the 2 weeks prior to death) to avoid any unnecessary delay to complete of certificate

11.4 A doctor must issue the medical certificate (MDCD) this should be available on the ward. A registered nurse may however expand their role into verification of expected death within the context of the Nursing and Midwifery Council guidelines. If the patient is for cremation, request that the doctor completes a form Cremation 4 at the same time. This will warrant the doctor viewing the patient's body before completing the form.

11.5 The doctor must confirm and certify the death in all cases and document the time of the death in the patient's records. The death must be confirmed by the doctor prior to the body being moved to the mortuary by the undertaker. Where the verification of expected death has been carried out by a nurse who has been trained in this procedure, the doctor will certify the death at the undertakers. The death must also be reported using the Trust incident reporting system (DATIX).

11.6 For the care and management of the deceased person please refer to the Appendix 2 – Care After Death.

Any items on the patient at the time of death such as jewellery should be documented. Valuables and personal effects should only be handed over to the person entitled to such as the spouse, parent or designated next of kin and a disclaimer form should be signed and recorded to the effect. Valuables should be sent for safe keeping in accordance with the local site procedures.

11.7 If the next of kin or close friends make a request to speak to the relevant team an appointment should be arranged as soon as possible after the event.

12 Registration of Death

12.1 The relatives, where possible, should arrange for the death to be registered. In order to do so, the relatives will need the Medical Certificate of Cause of Death which must be issued the next working day.

12.2 If the next of kin is unable to register the death or is unknown please refer to the local unit policy. In the case where a relative is unable to make the necessary arrangements, any special requests should be adhered to.

13 Informing Relatives

13.1 Where the patient has a terminal illness it is important that staff establish whether the next of kin or carer wishes to be contacted at night if the patient's condition deteriorates and that this information is documented in the patients records as soon as possible.

13.2 In practise it is the most senior nurse on duty who will contact relatives to inform them of any deterioration of the patient. Informing relatives of the patient's death, especially in the event of a sudden and unexpected death, can be difficult and stressful for staff. Staff should receive training in the skills of breaking bad news and on information regarding internal and external agencies available to provide bereavement support to relatives and staff.

13.3 In the event of the patient not having any known family or friends or that the family are unable to be with the dying patient, it is good practice for staff to contact a minister of religion, such as the hospital chaplain or to make arrangements for a staff member to be with the patient. This would depend on the patients' preferences if known.

13.4 The next of kin should be advised when the death certificate will be available and arrangements to collect the patient's property.

13.5 If the named next of kin or carer cannot be contacted after six hours ward staff should inform the police station local to the named relative. Ask the police to call at the home and notify the next of kin/carer in person. Alternatively the police can leave a message asking the relatives to contact the hospital, home or CMHT team.

13.6 If a third party is requested to contact the family, the nurse in charge of the ward must check with the third party (e.g. the police) to ensure that this communication has taken place. This is to avoid the situation occurring in which a relative visits the patient on the ward not knowing that the individual has died.

14 Education, Development and Training

14.1 The Trust will ensure that relevant staff are trained to care for patients nearing the end of life, and that patients will have access to high quality palliative care enabling them to live and die in a place of their choice wherever possible.

14.2 Healthcare professionals caring for patients at their end of life should have a good understanding of the physiological processes and the practical and emotional challenges in the final stages of a patients care.

14.3 Service leads must ensure that staff are appropriately trained, and that team leaders are aware of their responsibility for the implementation of this policy.

14.4 All staff have individual responsibility regarding their competency in the skills required to support patients with advanced life limiting illness and at their end of life phase.

Appendix 1

Related Documents

1. Advanced Decision to Refuse Treatment Policy
2. Health and Safety Policy
3. Health Records Policy
4. Infection Control Manual
5. Management of Dysphagia Policy
6. Manual Handling Policy
7. Mental Capacity Act (2005) Code of Practice
8. Observation Policy
9. Physical Healthcare Policy
10. Pressure Ulcer Prevention And Management - Clinical Practice Guideline
11. Safeguarding Vulnerable Adults at Risk – Policy Guidance for Trust Staff
12. The Best Practice Guide: When Using Interpreters

References

13. Care After Death : Hospice UK 2015
14. The Royal Marsden Manual of Clinical Procedures : Care after Death (2015)
15. Chief Coroner's Guidance (2014) No 16. Deprivation of Liberty Safeguards (DoLs).

Appendix 2

Care After Death

Care after an expected death
1. Doctor or nurse who is suitably trained to verify and record the time of death in the patient's clinical record
2. Contacting the Relevant People
Office Hours Refer to site protocol to inform: ➢ Inform the relatives/carers etc., if not present ➢ Administration Department/Bereavement Officer ➢ Duty Senior Nurse/Bleep 500 ➢ Inform the Consultant/Responsible Clinician ➢ Inform the Modern Matron ➢ Inform the GP ➢ Complete Trust incident form Inform the porters, undertaker and ward RC (as agreed for the site) to arrange for the removal of the body after relatives have viewed it and the final rites and personal care after death have been carried out Out of Hours ➢ Inform the relatives/carers etc., if not present ➢ Inform Duty Senior Nurse/bleep 500 who will inform the On-call Manager ➢ Inform the Consultant/Responsible Clinician ➢ Inform the relevant Administration Department/Bereavement Officer on the next working day ➢ Inform the GP ➢ Contact the GP/RC regarding the signing of the death certificate ➢ Complete a Trust incident form Inform the porters, undertaker and ward RC (as agreed for the site) to arrange for the removal of the body after relatives have viewed it and the final rites and personal care after death have been carried out
3. Care of the Deceased
➢ Religious and Cultural last rights after death to be carried out in accordance with religious and cultural guidelines ➢ Refer to the Royal Marsden Clinical Procedures manual for religious and cultural guidelines and Appendix 3 ➢ Documentation and safe keeping of personal property and valuables ➢ Prepare the body for relative to view + ➢ Replace dentures and pillow support ➢ Comb hair ➢ Tidy bed area Transfer the body to the mortuary or undertaker as arranged
4. Debrief with Staff

Appendix 3

Personal Care After Death

Equipment
Essential Equipment ➢ Disposable plastic apron ➢ Disposable plastic gloves ➢ Bowl of warm water, soap, and the patient's own toilet articles ➢ Disposable wash cloths and two towels ➢ Disposable razor or patient's own electric razor, comb and equipment for nail care ➢ Equipment for mouth care including equipment for cleaning dentures ➢ Identification labels × 2 ➢ Documents required by law and by organisation/institution policy, for example Notification of Death cards ➢ Shroud or patient's personal clothing: night-dress, pyjamas, clothes previously requested by patient, or clothes which comply with deceased patient/family/cultural wishes ➢ Body bag if required (if there is actual or potential leakage of bodily fluids and/or if there is infectious disease). Labels for the patient's body defining the nature of the infection/disease (HSAC 2003) ➢ Gauze, tape, dressings and bandages if wounds, puncture sites or intravenous/arterial devices ➢ Valuables/property book ➢ Plastic bags for clinical and domestic (household) waste ➢ Laundry skip and appropriate bags for soiled linen ➢ Clean bed linen ➢ Record books for property and valuables ➢ Bags for the patient's personal possessions ➢ Disposable or washable receptacle for collecting urine, if appropriate ➢ Sharps bin, if appropriate
Optional Equipment ➢ Caps/spigots for urinary catheters (if catheters are to be left *in situ*) ➢ Goggles ➢ Full gowns ➢ 3M masks (if highly infectious) (HSAC 2003) ➢ Petroleum jelly ➢ Suction equipment and absorbent pads (where there is the potential for leakage) ➢ Card or envelope to offer lock of hair, as appropriate

Personal Care After Death Procedures	
Procedure	**Rationale**
1 Apply gloves and apron, gowns/masks/goggles if the patient is infectious.	Personal protective equipment (PPE) must be worn when performing Last Offices, and is used to protect yourself and all your patients from the risks of cross-infection (Fraise and Bradley 2009, E, HSAC 2003, C; Pratt *et al.* 2007, C, R2b; RCN 2005, C).
2 If the patient is on a pressure-relieving mattress or device, consult the manufacturer's instructions before switching off.	If the mattress deflates too quickly, it may cause a manual handling challenge to the nurses undertaking personal care after death
3 Lay the patient on their back with the assistance of additional nurses and straighten any limbs as far as possible (adhering to your own organization's manual handling policy).	To maintain the patient's privacy and dignity (NMC 2008, C) and for future nursing care of the body. Stiff, flexed limbs can be difficult to fit easily into a mortuary trolley, mortuary fridge or coffin and can cause additional distress to any carers who wish to view the body. However, if the patient's body cannot be straightened, force should not be used as this can be corrected by the funeral director (Green and Green 2006, E).
4 Remove all but one pillow. Close the mouth and support the jaw by placing a pillow or rolled-up towel on the chest or underneath the jaw. Do not bind the patient's jaw with bandages	To avoid leaving pressure marks on the face which can be difficult to remove.
5 Remove any mechanical aids such as syringe drivers, heel pads, and so on. Apply gauze and tape to syringe driver/IV sites and document disposal of medication (adhering to your own organization's disposal of medication policy). Consider leaving prosthetics *in situ* as appropriate (e.g. limb, dental or breast prosthetics).	To prepare the body for burial or cremation. E
6 Close the patient's eyes by applying light pressure to the eyelids for 30 seconds. If this is unsuccessful then a little sticky tape such as Micropore can be used, and leaves no mark. Alternatively, moistened cotton wool may be used to hold the eyelids in place.	To maintain the patient's dignity (NMC 2008, C) and for aesthetic reasons. Closure of the eyelids will also provide tissue protection in case of corneal donation (Green and Green 2006, E).
7 Drain the bladder by applying firm pressure over the lower abdomen. Have a disposable or washable receptacle at the ready to collect urine.	Because the patient's body can continue to excrete fluids after death (Green and Green 2006, E).
8 Leakages from the oral cavity, vagina and bowel can be contained by the use of suctioning, drainage and incontinence pads respectively. Patients who do continue to have leakages from their orifices after death should be placed in a body bag following Last Offices. The packing of orifices can cause damage to the patient's body and should only be done by professionals who have received specialist training. It might be helpful to manage self-limiting leakages with absorbent pads and gently rolling the patient who has died to aid drainage of potential leakages.	Leaking orifices pose a health hazard to staff coming into contact with the patient's body(Green and Green 2006, E; HSAC 2003, C). Ensuring that the patient's body is clean will demonstrate continued respect for the patient's dignity (NMC 2008, C). The packing of orifices is considered unnecessary, as it increases the rate of bacterial growth that can occur when these areas of the patient's body are not allowed to drain naturally (Berry and Griffie 2001, E). However, there are certain situations where it is necessary (in severe leakage or where repatriation is required). A body bag is also necessary in these cases.

Procedure	Rationale
9 Exuding wounds or unhealed surgical scars should be covered with a clean absorbent dressing and secured with an occlusive dressing (e.g. Tegaderm). Stitches and clips should be left intact. Consider leaving intact recent surgical dressings for wounds that could potentially leak, for example large amputation wounds. Reinforcement of the dressing should be sufficient.	The dressing will absorb any leakage from the wound site (Naylor *et al.* 2001, R2b). Open wounds and stomas pose a health hazard to staff coming into contact with the body (RCN 2005, C). Disturbing recent large surgical dressings may encourage seepage and leakage (Travis 2002, E).
10 Stomas should be covered with a clean bag.	
11 Remove drainage tubes, unless otherwise stated. Record the tubes and devices that have been removed and those that have been left *in situ*. Open drainage sites need to be sealed with an occlusive dressing (e.g. Tegaderm).	Open drainage sites pose a health hazard to staff coming into contact with the patient's body (RCN 2005, C). When a death is being referred to the coroner or ME or for post-mortem, all lines, devices and tubes should be left in place (Green and Green 2006, C).
12 Wash the patient, unless requested not to do so for religious/cultural reasons or carer's preference. Male patients should be shaved unless they chose to wear a beard in life. If shaving a man, apply water-based emollient cream to the face.	For hygienic and aesthetic reasons. As a mark of respect and point of closure in the relationship between nurse and patient (Cooke 2000, C). To prevent brown streaks on the skin.
13 It may be important to family and carers to assist with washing, thereby continuing to provide the care given in the period before death.	It is an expression of respect and affection, part of the process of adjusting to loss and expressing grief (Berry and Griffie 2001, E).
14 Mouth and teeth should be cleaned with foam sticks or a toothbrush. Insert clean dentures if the patient normally used them. Apply petroleum jelly to the lips and perioral area.	Teeth and mouth are cleaned for hygienic and aesthetic reasons (Cooke 2000, C) and to remove debris. Petroleum jelly can prevent skin excoriation or corrosion if stomach contents aspirate.
15 Remove all jewellery (in the presence of another nurse) unless requested by the patient's family to do otherwise. Jewellery remaining on the patient should be documented on the 'Notification of Death' form. Record the jewellery and other valuables in the patient's property book and store the items according to local policy. Avoid the use of the names of precious metals or gems when describing jewellery to prevent potential later confusion. Instead, use terms such as 'yellow metal' or 'red stone'. Rings left on the patient's body should be secured with tape, if loose.	To meet with legal requirements, cultural practices and relatives' wishes (Green and Green 2006, C).
16 Dress the patient in personal clothing or white garment, traditionally called a shroud (depending on organizational policy or the family's wishes).	For aesthetic reasons for family and carers viewing the patient's body or religious or cultural reasons and to meet the family's or carers' wishes (Green and Green 2006, C).
17 Ensure the correct hospital or organizational irremovable patient identification label is attached to the patient's wrist and attach a further identification label to one ankle. Complete any documents such as Notification of Death cards. Copies of such cards are usually required (refer to hospital policy for details). Tape one securely to clothing or shroud.	To ensure correct and easy identification of the patient's body in the mortuary (Green and Green 2006, C).

Procedure	Rationale
18 Wrap the patient's body in a sheet, ensuring that the face and feet are covered and that all limbs are held securely in position.	To avoid possible damage to the patient's body during transfer and to prevent distress to colleagues, for example portering staff (Green and Green 2006, E).
19 Secure the sheet with tape.	Pins must not be used as they are a health and safety hazard to staff. E
20 Place the patient's body in a body bag as leakage of body fluids may be anticipated. The patient may also have a known infectious disease.	To avoid actual or potential leakage of fluid, whether infection is present or not, as this poses a health hazard to all those who come into contact with the deceased patient. The sheet will absorb excess fluid (HSAC 2003, C).
21 Tape the second Notification of Death card to the outside of the sheet (or body bag).	For ease of identification of the patient's body in the mortuary (Green and Green 2006, E).
22 Request the funeral directors to remove the patient's body from the ward and transport to the funeral directors.	To avoid decomposition which occurs rapidly, particularly in hot weather and in overheated rooms. Many pathogenic organisms survive for some time after death and so decomposition of the patient's body may pose a health and safety hazard for those handling it (Cooke 2000, E). Autolysis and growth of bacteria are delayed if the patient's body is cooled.
23 Remove gloves and apron. Dispose of equipment according to local policy and wash hands.	To minimize risk of cross-infection and contamination (Fraise and Bradley 2009, E).
24 Screen off the beds/area that will be passed as the patient's body is removed.	To maintain privacy and dignity.
25 Record all details and actions within the nursing documentation.	To record the time of death, names of those present, and names of those informed NMC 2015, C).
26 Transfer property and patient records to the appropriate administrative department.	The administrative department cannot begin to process the formalities such as the death certificate or the collection of property by the next of kin until the required documents are in its possession (Green and Green 2006, C).

Appendix 4

Information for Relatives Following the Death of a Patient

1. In most cases a medical certificate of the cause of death will be available after 11 a.m., the morning following the death (Monday to Friday).

3. The Registrar will require certain information:-

   (a) The deceased's full name

   (b) Date of birth

   (c) Home address

   (d) Place of birth

   (e) Maiden name (if applicable)

   (f) Name and occupation of spouse or civil partner (if applicable)

   (g) Date of birth of spouse or civil partner

   (h) If deceased was in receipt of retirement pension or war pension

4. You will be given the personal property of the deceased when collecting the medical certificate. Any items of clothing etc. can be donated to the hospital or unit

5. Medical certificate of cause of death is to be taken to the Office of the Registrar of Births and Deaths

6. Deaths must be registered as soon as possible and always within five days.

7. You will be issued with a green form. This is required by the undertakers to enable them to arrange the funeral. You will also be issued with a white form which is to be completed on the back and sent to the Pension Service. If the care centre holds the pension the form must be returned to relevant person within the centre.

8. In certain cases of financial hardship, a white form for the Benefits Agency can be issued by the Registrar. A private death certificate may be purchased from the Registrar's office.

9. The undertakers will collect the deceased from the inpatient unit unless alternative arrangements have been made.