

CLINICAL GUIDELINE FOR THE CARE OF THE DECEASED PATIENT

POLICY/PROCEDURE NUMBER:	CG84
VERSION NUMBER:	4
REPLACES SEPT DOCUMENT	Procedural Guideline for the Care of the Deceased Patient
REPLACES NEP DOCUMENT	Not applicable
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IMPLEMENTATION DATE:	October 2017
AMENDMENT DATE(S):	February 2019
LAST REVIEW DATE:	February 2019
NEXT REVIEW DATE:	February 2022
APPROVAL BY CLINICAL GOVERNANCE & QUALITY SUB COMMITTEE DATE:	20 th February 2019

CLINICAL GUIDELINE SUMMARY

These clinical guidelines set out a consistent approach for dealing sensitively with a patient who is verified or medically certified as having died. This includes guidelines to be followed in all in-patient areas and includes domiciliary community health services. Additional guidance has been added to reflect changes to DoLS legislation. The guidelines reflect overall standards across the Trust.

The Trust monitors the implementation of and compliance with this clinical guideline in the following ways:

A component of supervision may include discussions relating to care following death.

All complaints and compliments relating to care at the end of life are monitored by the End of Life Subcommittee. Incidents or near misses, related to care of deceased patients, should be reported via the Trust Risk Management reporting systems i.e. Datix. Monitoring of this policy will include data collected from any clinical incident reporting.

The Director responsible for monitoring and reviewing this Clinical Guideline is the Executive Nurse

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

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Appendices**Appendix 1 – Religious & Cultural Considerations**

CLINICAL GUIDELINE FOR THE CARE OF DECEASED PATIENTS/SERVICE USERS

1.0 INTRODUCTION

- 1.1 The UK is a multicultural and multi-faith society and as such, in accordance with the Trust's core values and philosophy, deceased patients will be treated at all times with respect and dignity, taking into account different cultural and religious rituals that accompany the death of a patient (Appendix 1).
- 1.2 This guideline sets the standard for sensitive, compassionate communication with family members/significant others. Providing sensitive care after death and supporting bereaved family/significant others can be some of the most difficult and challenging aspects for nurses but, equally, they can also be the most rewarding.
- 1.3 The aim of this guideline is to ensure that there is timely confirmation and Notification of Death by medical staff and that there is correct preparation of the deceased person's body for viewing by family members/significant others and dignified removal to the appropriate mortuary.
- 1.4 The guideline will provide staff with the appropriate and relevant procedural guidelines in the event of the death of a patient in both in-patient services and those patients nursed in their usual care setting by Trust staff.

2.0 SCOPE

- 2.1 All staff within the Trust have an obligation to ensure that the death of a patient is managed sensitively to cause minimal distress to bereaved families/significant others.
- 2.2 This guideline contains the general principle that will be applied consistently throughout Trust in-patient areas and for those staff nursing patients within their normal care setting. It will be implemented in conjunction with any local procedures or clinical guidelines that are in place within individual services along with the following policies, associated procedural guidelines and the End of Life Framework:
 - CPR Policy and Procedural Guideline (CLP14)
 - DNACPR Procedural Guideline (CLPG14B)
 - Records Management (CP9)
 - Sickness Noticing (CG33)
 - Administration of Mental Health Act 1983 Policy (MHA1)
 - Safeguarding Adults Procedural Guidelines (CLP39)
 - Safeguarding Children Procedural Guidelines (CLP37)
 - Appendix 11 Safeguarding Children Procedural Guidelines - Procedure for Unexpected Child Death Review Process (CLP37)
 - MCP2 Deprivation of Liberty Guidelines (MCP2)
 - Adverse Incidents including Serious Incidents (CP3)
 - Infection Control (ICP1)

- Advanced Decisions and Statements Clinical Guideline (CG6)
- Data Protection & Confidentiality Policy (CP59)
- Being Open and Duty of Candour (CP36)
- The Royal Marsden Manual for Clinical Nursing Procedures (CLP79)
- End of Life Care Guidelines (CG84)

3.0 RESPONSIBILITIES

3.1 The Trust Board is responsible for:

- Ensuring that the principles of this clinical guideline and other associated policies and guidelines are implemented across the organisation;
- Considering use of financial resources to support implementation of this clinical guideline.

3.2 The Executive Nurse has lead responsibility to ensure:

- That guidelines are embedded into clinical practice and updated regularly;
- Overseeing that clinical risk issues are addressed with relevant managers;
- The implementation of relevant national guidance.

3.3 Directors and Senior Managers are responsible for:

- Providing evidence that EPUT guidelines have been followed;
- Ensuring that any actions arising as a result of clinical audit and patient feedback are implemented across the Trust.

3.4 Managers and Other Persons in Charge are responsible for:

- Advising and instructing staff on the requirements set out in this clinical guideline via local induction arrangements and ongoing communication mechanisms, such as staff meetings, supervision etc.;
- Ensuring this clinical guideline is implemented and necessary local procedures are developed;
- Ensuring staff are supported in the event of the death of a patient.

Individuals will ensure:

- Any difficulties relating to carrying out the care of deceased patients are reported to their line manager;
- That all deaths are incident reported within in-patient services
- All deaths within the community are reported to the patients GP;
- That they adhere to all EPUT policies and guidelines;
- That they are familiar with these guidelines and associated documents and know where to locate them, i.e. on the Trust intranet (InPut).

4.0 PROCEDURE FOR ALL PATIENT / SERVICE USERS' AREAS WITHIN EPUT AND COMMUNITY STAFF PRESENT IN PATIENTS CARE SETTING AT TIME OF DEATH

- 4.1 Nurses with the required competence to verify a death may do so when the death is expected. However, all deaths must be certified by a member of the medical team or doctor.
- 4.2 Staff will be mindful of other people present in the vicinity and the area will be screened off, thus respecting dignity. When death has occurred in patient's own home, dignity and respect for the body should be discussed with family members/significant others present and any known Advanced Statement wishes after death respected.
- 4.3 Staff involved in any resuscitation attempts must provide a clear and accurate record of every intervention performed.
- 4.4 In the community setting when the death is expected, Last Offices can be offered and performed.
- 4.6 In the community, staff should offer to change bed linen and cover patient as agreed with family members/significant others present.
- 4.7 Every attempt should be made not to disturb the area around the deceased and they should not be moved. If this is an unexpected death, all evidence must be retained and left where found.
- 4.8 The deceased will be covered with a clean sheet.
- 4.9 Police will be notified immediately in the event of unexpected death or where there is a potential safeguarding concern. In these circumstances, i.e. there is a safeguarding concern, the Trust's Safeguarding Team must also be contacted in hours. Out of hours they should follow the on-call procedure. If the death is going to be referred to the Coroner, advice must be sought before interfering with anything that might be relevant to establishing the cause of death. In the community, in the event of an unexpected death, the body should not be moved and the GP or 111 should be called who will then take responsibility for notifying the Police.
- 4.10 On in-patient areas, the senior nurse on duty must be informed.
- 4.11 On in-patient areas, in the event of an unexpected death occurring out of hours, the on-call manager must be notified.
- 4.12 The next of kin must be notified.
- 4.13 The date and time of death must be recorded in nursing notes once determined by doctor in attendance.
- 4.14 The CQC must be informed if the patient dies whilst under section of the Mental Health Act.

- 4.15 Last offices are carried out in accordance with religious and cultural beliefs (Appendix 1). Where necessary, staff should await Police clearance to do so.
- 4.16 The Notification of Death Certificate must be obtained in accordance with local procedures. In the community setting, the family/significant others are responsible for arranging to collect the Notification of Death Certificate from GP.
- 4.17 The nurse in charge must arrange removal of the deceased to either the hospital mortuary or contract the Funeral Director to remove the body to the Chapel of Rest. In the Community setting, the family/significant others are responsible for arranging removal of the body by the Funeral Director.
- 4.18 Staff will ensure an incident form is completed in a timely manner for all deaths that are unexpected and for all deaths in the in-patient services.
- 4.19 Where there is a death of a child or adolescent; these guidelines should be read in conjunction with EPUT Safeguarding Children Procedural Guidelines (CLPG37) Appendix 11 Procedure of Unexpected Child Death.
- 4.19.1 The child or adolescent should be transferred immediately to A&E where a designated paediatrician declaring the death will be responsible for initiating a rapid response child death review process.
- 4.19.2 A Rapid Response Team will be identified (within 24 hours of the death being notified) and will decide on action, for example a visit to the ward and collecting information
- 4.19.3 Staff on child and adolescent units will be expected to notify the Trust Safeguarding Team.
- 4.19.4 Staff on child and adolescent units must co-operate with the Child Death Review Team (CDRT) and may be required to submit a report within 10 working days using Form B that will be sent to them from the CDRT.
- 4.20 For community staff caring for patients who die in their own care setting, they will only be involved if present at the time of death or contacted to visit at time of death by family/carers or significant others.
- 4.21 In last days of life for expected deaths patients, relatives/significant others will be given information regarding what to do in the event of death.

5.0 PROCEDURE TO BE FOLLOWED IN ALL CASES REGARDING THE CORONER
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- 5.1 The following deaths will be referred to the Coroner:
- When a doctor has not treated the deceased during his or her last illness;
 - When the doctor attending the patient had not seen them within fourteen days before death;
 - When the death occurred during the operation or before recovery from the effect of an anaesthetic;

- When the death was sudden and unexplained or attended by suspicious circumstances;
- When the death might be due to an industrial injury or disease, or to accident, violence, neglect or abortion, or to any kind of poisoning;
- If the patient dies whilst under section of the Mental Health Act.

5.2 Deprivation of Liberty

There are 2 different requirements depending on whether the DoLS has been authorised or not.

Standard Authorisation: With a death occurring on or after 3rd April 2017 any person subject to a DoL (i.e. a deprivation of liberty formally authorised under the MCA 2005) is no longer ‘in state detention’ for the purposes of the 2009 Act. When that person dies the death should be treated as with any other death outside the context of state detention: it need only be reported to the coroner where one or more of the other requisite conditions are met.

Urgent Authorisation: A person who dies while subject to restrictions amounting to “state detention” in a hospital or care home, but without there having been a deprivation of liberty authorised under the MCA 2005, will still have to be the subject of an investigation and inquest on “state detention” grounds.

Where there is a concern about the death, such as a concern about care or treatment before death, or where the medical cause of death is uncertain, the coroner will investigate thoroughly in the usual way. There will always be a public interest in the careful scrutiny of any death in circumstances akin to state detention. As in all cases there must be sufficiency of coroner inquiry.

- 5.3 If the death is not due to a natural cause, the Coroner is obliged by law to hold an inquest. The Coroner can be contacted out of hours through the Police.

6.0 NEXT OF KIN – IN-PATIENT

- 6.1 If the next of kin is not present, the nurse in charge should make necessary arrangements to ensure that they are informed as soon as possible, or as agreed within the care plan. (An example being when a patient dies at night, some relatives want to be informed immediately, whereas others would prefer to be informed in the morning).
- 6.2 The next of kin will be contacted via telephone and sensitivity and compassion will be paramount. The telephone call will be made from a quiet private room, free from distraction, with no background noise or conversation occurring. The person making the telephone call will ensure that all other staff are aware of the nature of the telephone call being made.
- 6.3 In the event of someone having died who had been ‘sick noticed’ and if the next of kin cannot be contacted, the nurse in charge will request the Police to trace the next of kin and arrange for them to contact the service.

- 6.4 In accordance with Duty of Candour principles, honest information should be sensitively provided at all times. It is crucial that communication is sensitive, empathetic and open. It is important to consider the emotional state of bereaved relatives or significant others and to involve them in deciding when it is appropriate to discuss what has happened.
- 6.5 It is desirable for staff who know the family member, or the most senior member of staff available, to make initial contact to offer condolences and identify any immediate support needs. This person must keep a record of any discussions and actions taken during contact and will be responsible for handing over any relevant information to the Family Liaison Officer (FLO) if required.
- 6.6 Families/carers should be offered bereavement support in accordance with their needs and circumstances.

7.0 CULTURAL, RELIGIOUS AND SPIRITUAL INFLUENCES

- 7.1 Performing Last Offices is the final demonstration of respect and care that nurses offer the patient. These requirements vary amongst individuals within any specific group. Do not presume you know the patients and families wishes; refer to Appendix 1 for further guidance.
- 7.2 Following the death of a patient, staff will ensure communication with the next of kin is maintained to provide best practice in performing Last Offices. At all times the deceased will be cared for with dignity and respect and in accordance with the families' wishes.

8.0 LAST OFFICES

- 8.1 This procedure should be undertaken by at least one qualified nurse and it is considered best practice if this is carried out by two people, in accordance with safe manual handling guidance and where possible within 2–4 hours of death. In the community this may be carried out by one person from any grade who may be assisted by family, carers or significant others. Alternatively staff can contact their senior colleague to arrange support.
- 8.2 If no specific religious or cultural beliefs are known to staff, the standard Last Offices procedure should be followed for laying out the body. Ensure dignity and respect is maintained at all times. Cleanse the skin and ensure that the patient is clean and free from any loss of body fluids. Remove all indwelling catheters or syringe drivers in line with procedural guidance.
- 8.3 In-patients services staff are required to ensure the patient has a wrist band on their wrist and one around their ankle. The deceased patient should be put into a shroud and wrapped in a sheet.
- 8.4 The family should have the opportunity to view the deceased patient prior to the Funeral Director taking them to the mortuary if they wish.

- 8.5 If a patient has a cardio defibrillator magnet attached to their chest this should remain in place and should go to the mortuary still intact and taped to the patient. The Funeral Director would need to know about cardio defibrillator magnet as soon as possible.
- 8.6 Appendix 1 details the arrangements for dealing with the death of patients with specific religious or cultural beliefs. All staff will ensure that these arrangements are upheld and respected at all times.
- 8.7 Standard precautions are to be followed as outlined in Policy **ICPG1, Section 2 Standard Precautions of Infection Prevention and Control**.
- 8.8 If a patient has died from a known infection, staff must be aware of Policy **ICPG1, Section 3 - Infection Prevention and Control in Clinical Practice Point 8.0**, before Last Offices commence.

9.0 ARRANGING FOR COLLECTION OF THE BODY

- 9.1 The contracted Funeral Directors provide a mortuary service for these sites, until the deceased's next of kin decides which Funeral Directors they wish to use. The deceased's family should be informed of these arrangements; they will have a clear understanding **that they are under no obligation to use the contracted Funeral Director** and that no cost will be incurred to the family for the use of the Chapel of Rest. Within the community, the family should contact a Funeral Director of their choice to remove the deceased patient once it has been certified by the doctor.
- 9.2 Before the deceased is removed the contracted Funeral Director should be informed of:
- The deceased's religion and any special spiritual or cultural observations that need to be followed (Refer to Appendix 1);
 - If the deceased has been identified to have a 'Low Risk Infection', i.e. wound infection, urinary tract infection or a chest infection, etc., or a 'High Risk Infection', such as HIV, Hepatitis, TB, Meningitis etc. Refer to Infection Control Policy & ICPG1 – Section 3, Appendix 1 – Risk on Admission – Transfer Form.
 - Whether the deceased is fitted with a pacemaker and if this has been deactivated and the magnet is still attached or not;
 - Whether there are any organ donor requests.

10.0 NOTIFICATION OF DEATH

- 10.1 The **Notification of Death** can only be completed by a doctor who has attended the patient within the previous 14 days. This may or may not be the doctor who has confirmed the death.
- 10.2 **Notification of Death Certificate** is given to the relatives by the doctor (when available) and the ward staff, with instructions of 'what to do next', and 'how to register the death'. Within the community this is completed by the General Practitioner and the family will be required to contact them.

- 10.3 If a patient dies whilst in hospital under a section of the Mental Health Act (1983) notification to the CQC must be made. This process is managed by the Mental Health Act Administration Manager; however the form will need to be completed and signed by ward manager/nurse in charge in consultation with the doctor who has certified the death. The completed form **MUST** be returned to the Mental Health Act Administrator no later than **ONE WORKING DAY** of the death. To access the form follow the link: <http://www.cqc.org.uk/content/mental-health-notifications>.

11.0 CREMATION

- 11.1 If the body is to be cremated, the doctor signing the Notification of Death Certificate and who has personally seen the body after death should complete one part of the Cremation Certificate.
- 11.2 It is important to check for the presence or absence of cardiac pacemakers and radioactive implants and declare it on this form. This is inclusive of pacemakers that have been deactivated previously or have a magnet still attached to the patient.
- 11.3 A second doctor, (qualified for 5 years or more) and with no professional connection with the certifying doctor or the associated practice concerned, will be contacted to view the body and complete the second part of the Cremation Certificate.
- 11.4 It is the duty of the second doctor to contact the first doctor to discuss the cause and circumstances of death.

12.0 POST MORTEM EXAMINATIONS

- 12.1 By law, there are certain circumstances when the Coroner following the death of a patient will order a post mortem examination. These include:
- Death due to unnatural causes
 - Unexpected deaths
 - Cases where the cause of death is unknown
 - Suspected cases of industrial disease
 - Murder
- 12.2 Staff must ensure that relatives are assisted to understand fully the requirements for a post mortem, as appropriate to each case. Within the community this is coordinated by the General Practitioner.
- 12.3 In addition, an Autopsy Request Form should be completed by the doctor and sent to the mortuary with the body. This is completed by the General Practitioner.

13.0 SUPPORT TO RELATIVES

- 13.1 Relatives should be allowed to stay with the deceased according to their wishes.
- 13.2 Professionals who have been working with the family should be prepared to offer their support during the bereavement process to the families/significant others of the deceased. Staff should provide relatives with a Trust Bereavement Information Sheet identifying bereavement services.
- 13.3 Opportunities to discuss the circumstances of the death with an appropriate professional will be offered to the family/significant others.
- 13.4 Sensitivity and compassion will remain a priority, and staff will be open and honest with all answers to questions.
- 13.5 If the death was sudden, unexpected or suspicious, great care will be taken in the amount and detail of information given as an internal or external investigation will follow in accordance with Trust Policy CP3.

14.0 PATIENT SUPPORT

- 14.1 In the event of a death, staff will remain calm and professional in delivering care to all other patients.
- 14.2 Staff will ensure that patients / service users are informed, when applicable, and every effort is made to provide support (which may involve counselling, spiritual or religious support) to patients in the event of a sudden death.
- 14.3 It is important that staff respect the deceased patient and their family/significant others privacy and confidentiality at all times.

15.0 STAFF CARE

- 15.1 The Trust recognises that staff members may need support and they should be encouraged to identify appropriate mechanisms.
- 15.2 If staff members are particularly distressed, one to one support from a senior manager or an independent counsellor should be made available.
- 15.3 Good practice will ensure that nursing staff, who have experienced deaths within their working environment, will offer and provide, training, procedural guidance, offering support and understanding to members of staff who have not encountered similar situations previously.
- 15.4 Staff should have the opportunity to reflect on their experience and this should form part of the supervision and appraisal process.

16.0 HOSPITAL PATIENTS WITHOUT A NEXT OF KIN

- 16.1 In hospital, if there is no next of kin, staff will seek advice from their line manager. A member of the ward/ department may be requested to register the death at the nearest Registry Office.
- 16.2 If a patient dies in hospital and there is no traceable next of kin, the Trust will assume responsibility for making and funding the funeral arrangements. In such circumstances, staff must inform the Welfare Services Manager. In the community, the General Practitioner should be informed when they certify the patient as deceased.

17.0 OTHER ACTIONS REQUIRED

- 17.1 If the deceased has prior hospital or health related appointments booked with other health services, ensure that these are cancelled accordingly. In the Community, the cancellation of appointments is family/significant others responsibility.
- 17.2 Seal and secure patient notes and arrange collection/delivery to The Serious Risk Team for patients who are Serious Incident reportable (see policy CPG3 for guidance). There may be some paper records in the community which should be returned to the appropriate team.

18.0 MEDIA

- 18.1 In the event that the media contact the ward/unit or community teams where a death has occurred, staff will not, under any circumstances, divulge information relating to the incident. All calls will be forwarded to the Communication Department. Refer to CPG59b Confidentiality Procedure & CP51 Media Policy.

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