Trust-wide Document

NHS Great Western Hospitals NHS Foundation Trust

Care of the Dying and Deceased Policy – Trust-wide

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Target Audience- who does the document apply to and who should be using it. - The target audience has the responsibility to ensure their compliance with this document by: • Ensuring any training required is attended and kept up to date. • Ensuring any competencies required are maintained. • Co-operating with the development and implementation of policies as part of their normal duties and responsibilities.	All employees directly employed by the Trust whether permanent, part-time or temporary (including fixed-term contract). It applies equally to all others working for the Trust, including private-sector, voluntary-sector, bank, agency, locum, and secondees. For simplicity, they are referred to as 'employees' throughout this policy		
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Review period. This document will be fully reviewed every 3 years in accordance with the Trust's agreed process for reviewing Trust -wide documents. Changes in practice, to statutory requirements, revised professional or clinical standards and/or local/national directives are to be made as and when the change is identified.			

Service Teamwork Ambition Respect

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1 Introduction & Purpose

1.1 Introduction & Purpose

This policy guides practice in the care of the dying patient and the care of the deceased patient, until such time as the deceased is released, most usually to a Funeral Director for burial or cremation. The policy also provides direction for the care of family, friends and carers of the patient.

The document will evolve with local and national best practice to provide evidence based care and promote seamless care.

In delivering excellent care for the dying and deceased patient, this policy affirms that such care is 'not an optional extra' but an essential part of excellent patient-centred services. This policy supports the best practice of all employees engaged in the care of dying and bereaved people, including those charged with the care of the deceased.

1.2 Glossary/Definitions

The following terms and acronyms are used within the document:

%	Per cent
ACP	Advanced Care Plan
ACR	Anonymous Call Rejection
ADRT	Advanced Decision to Refuse Treatment
CCG	Clinical Commissioning Group
CCU	Coronary Care Unit
Cdiff	Clostridium difficile
CODE	Care of the Dying Evaluation
CVIS	Integrate Management system
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
Crosscare	Prospect Hospice nursing documentation system
DHSC	Department of Health and Social Care
DNAR/TEP	Do Not Attempt Resuscitation/Treatment Escalation Plan
DNARCPR	Do not attempt cardiorespiratory resuscitation
ED	Emergency Department
EDS	Electronic Discharge Summary
EIA	Equality Impact Assessment
EoL	End of Life
EPaCCS	Electronic Palliative Care Co-ordination System
EPMA	Electronic prescription medicines and Administration system
ESR	Employee Staff Record
GDA	Gender Recognition Act
GP	General Practitioner
GRC	Gender recognition certificate
GSF	Gold Standards Framework
GWH	Great Western Hospital
HTA	Human Tissue Authority
ICD	Implantable Cardiac-Defibrillator
IMCA	Independent Mental Capacity Advocate
IP&C	Infection Prevention and Control

KPI	Key Performance Indicator
MCCD	Medical Certificate for Cause of Death
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NMC	Nursing and Midwifery Council
NMP	Non-Medical Prescriber
PALS	Patient Advice and Liaison Service
Patient	In this document refers to a patient of any age
PDF	Portable Document Format
QPulse	Pathology document tracking system
RNVOEAD	Registered Nurse Verification of Expected Adult Death
SNOD	Specialist Nurse in Organ Donation
SN-TD	Specialist Nurse in Tissue Donation
STAR	Service, Teamwork, Ambition and Respect
TEP	Treatment Escalation Plan
TTA	To Take Away
WHO	World Health Organisation

2 Main Document Requirements

This policy is informed by key publications including: Ambitions for palliative and end of life care, a national framework for local action 2015-20 (Ref 43), National Institute for Health and Clinical Excellence (NICE) guidance and quality standards including NG 31 Care of the dying adult 2016 (42), QS 144, Care of dying adults in the last days of life 2017 (Ref 44) and QS13 End of life care for adults 2017 (Ref 45). It is underpinned by the Trusts End of Life Strategy which sets out the Trusts plans and objective for end of life care for the years 2015-18. (Ref 30).The Trusts strategy is aligned to the Department of Health (DH) National End of Life Strategy (Ref 48).

The principle objective that the NHS Department of Health and Social Care (DHSC) End of Life Strategy sets out and which forms the key objective of the Trusts own End of Life Strategy is:

The patient and their family/carer receive the care and support that meets their identified needs and preferences through the delivery of high quality, timely, effective individualised services, ensuring dignity and respect is preserved both during and after the patient's life.

This policy sets out how the Trust will deliver on this objective by describing the processes in place for implementation.

2.1 Personalised Care Plan

A personalised care planning tool for patients in the last days or hours of life has been developed locally in response to the Leadership Alliance "One Chance to get it Right" (2014) (Ref 12). It is aligned to the NICE Guidance NG142 (Ref 68) End of life care for adults: service delivery (2019) and is the tool to support the care of dying adults within the Acute Trust. Versions are also used by Swindon Community Health and at Prospect Hospice. Copies of the Personalised Care Plan are available at ward/department level with additional stock available from the Specialist Palliative Care and End of Life Team.

The tool is a shared document that contains information for the clinician and nurses. It is accompanied by a booklet of information for the patient and their family, friends and carers. The document is set out in such a way that care for the patient is highly individualised and whereby conversations about individual preferences, nutrition and hydration medical intervention, treatment

conversations and plans, including spiritual/cultural/religious/holistic needs are at the forefront of the patients care.

Additional information is available on the palliative care intranet site (Ref 5).

2.2 Delivery of High Quality Care of the Dying

In the hospital inpatient setting, the clinical team responsible for the patient's care continues to be responsible for their care during the dying phase. In the community setting responsibility will be shared between Trust employees, the General Practitioner (GP), Social Care Teams and Specialist Palliative Care Teams.

The decision that a patient is within the last hours to days of life must be made by a doctor competent to judge whether the patient is likely to die. The decision must be reviewed by a senior doctor at the next available opportunity and the views of the multi professional team taken into account. The dying patient must be reviewed at least daily by a senior clinician and sooner if their condition changes unexpectedly in the acute setting. In the community setting this will be negotiated between the patient, family, GP, community nursing team and Specialist Palliative Care team.

National and local guidance with respect to care of the dying evolves over time. Whilst every effort will be made to update this document when change is made, the most up to date guidance on the principles of provision of care to dying patients, together with tools to support the delivery of this care including care plans currently in use for the Acute and Wiltshire Health and Community Wards settings, are available on the palliative and end of life care page of the Trust intranet – (Ref 5) and SystemOne for Swindon Community Health.

2.3 Preferences with Respect to Delivery of Care during the Dying Phase

Clinicians must have conversations with their patients in order that the patient can make known any preferences that they may have for their care. These conversations must be documented in the personalised care plan/patients notes and the Trust will aim to respond to these wishes wherever it possible to do so.

Priorities vary between patients and may include:

- The location in which they would like their care to be delivered and where they would like to die.
- The people they would wish to have around them.
- Environmental preferences such as music / television etc.
- How they might wish any symptoms to be managed.
- The way in which their personal care and comfort needs are to be met including turning.
- Thoughts about nutrition and hydration.
- Organ and tissue donation.
- Spiritual and holistic support they might wish to receive.
- The ceiling of clinical intervention they wish to be offered.

This information may be available from the patient, family, friends and carers, or from their primary care medical and nursing teams. It may also be pre-recorded in the form of an Advance Care Plan (ACP), Treatment Escalation Plan (TEP) or in an Advance Decision to Refuse Treatment (ADRT) – see below Section 2.10. The existence of ACP/ADRT documents may be recorded on an Electronic Palliative Care Co-ordination System (EPaCCS) where available. Locally, information about patients known to Prospect Hospice's services is recorded on Crosscare. A TEP is patient held. In accordance with current best practice discussion with the patient and/or relative/carers at the time of the forms completion is necessary. Further information on the TEP can be found in the Treatment Escalation Plan and Resuscitation Decisions Policy (Ref 21).

Support in responding to the patient's expressed priorities for care, where this exceeds the skills of the clinical team responsible for the patients care, can be obtained from the Specialist Palliative Care Team (Ref 5). This includes support in rapidly discharging patients home to die that can be supported through the community rapid response team.

Where a patient is moving between settings, it is essential that this information is communicated to all care providers including via the Electronic Discharge Summary (EDS), faxes / letters to community nursing team and supported by telephone communications when needed. The patient or their family, friends and carers may also be asked to present documentation to the care providers. In addition and with the consent of the patient, the information may be recorded on EPaCCS when this service becomes available.

2.4 Palliative Care

Palliative care is the active total care of patients whose disease is no longer amenable to curative management (World Health Organisation (WHO) – Ref 31). Clinical teams in all settings often have the skills to support patients who are dying and to support their family, friends and carers. The clinical teams have responsibility for the provision of this care. The Specialist Palliative Care Team is available to provide additional support where it is needed. This is particularly likely where there is complexity in the physical, psychological, social or spiritual needs of the patient and to support relatives/carers and colleagues.

Palliative Care Teams are available for patients, relatives and employees to contact and have 24 hour advice lines:

- For the Great Western Hospital:
    - Via in-reach Prospect Palliative Care Team, see Trust Intranet Palliative Care (Ref 5)
    - Swindon and North Wiltshire Community Patients (Ref 5)
- For other areas of Wiltshire services by the Community Trust, two other hospices support Trust patients:
    - Salisbury Hospice (Ref 5)
    - Dorothy House Hospice (Ref 5)
- For patients from Berkshire there is support available through Sue Ryder Dukes of Kent Hospice (Ref 5)

All the Hospices can be accessed for telephone advice and support 24 hours a day/ seven days a week by employees and also by patients and their family, friends and carers

2.5 Contingency Medication 'Just in Case Medication'

Dying patients may require rapid access to medication to manage symptoms.

Where a patient is dying in the hospital setting, medication for administration 'as required' should be prescribed by the medical team responsible for their care. Nursing employees should ensure that the medications are always available on the ward. The prescription should be tailored to the individual patients needs and discussed with them and those important to them. Prescribing guidance is available in the personalised care plan document, on the Palliative Care pages of the Trust intranet and from the Palliative Care Team (Ref 7).

A "just in case" medication bundle is available on the electronic prescription management administration (EPMA) system, which must be reviewed and tailored to the individuals needs by the prescribing doctor.

Where a patient is being discharged from an in-patient setting to their home or to a care home to die, ‘just in case medication’ should be sent with the patient as part of their ‘To Take Away (TTA)’ medication (Ref 47). This must include an authorisation signed by the prescriber for nurses to administer the medication. Information that ‘just in case medications’ have been provided must be included on the EDS. Where possible the patient and their carers, family and friends must be informed that the medication has been made available and instructed on how to access support should symptoms arise at home. This support is accessed via the community nursing teams. Ward employees must progress a referral to the community nursing services on discharge (Ref 9).

- Specialist Palliative Care Prescribing information (Ref 7).
- Authorisation form (Ref 8).

Where a patient is dying in the community, ‘Just in Case’ medications are prescribed by their GP or Non-Medical Prescriber (NMP). The GP or NMP also signs the Authorisation Form. The communication with the patient and their family, friends and carers is the responsibility of the prescriber. It is expected that this would be in close collaboration with the community nursing and community Specialist Palliative Care Team. Community pharmacies provide an out of hours service for palliative care drugs.

2.6 Involvement of Patients, Relatives/Carers in Agreeing the Plan of Care and in the Provision of Information and Support in Dying Phase and Post Death

As supported by the Personalised Care Plan, it is important that patients and family, friends and carers are involved in decisions about their care, to the extent that they wish and provided with information and support. These needs will vary between patients. There may be specific information needs or a need for time to explore thoughts, feelings and concerns. This support may be adequately provided by the clinical team responsible for the patients care. Formal opportunities for the patient and those important to them to speak with senior clinicians must be offered, together with informal opportunities, for example whilst nursing employees are delivering other elements of the patient’s care.

As supported by the Personalised Care Plan, opportunity to discuss the following areas should be offered to all patients and to family, friends and carers unless the patient has indicated otherwise:

- The identification of dying.
- Preferences with respect to location of care provision and choice of where to die.
- Spiritual/holistic care needs.
- Plans with respect to further monitoring and investigations and any changes to medications or treatments.
- The provision of food and drink and plans for when the patient is no longer able to eat and drink.
- Plans for the management of symptoms, including medications prescribed ‘as required’ or regularly and the use of a syringe pump.

All conversations must be documented in the Personalised Care Plan or the patients’ medical records if the Personalised Care Plan is not being used.

Clinicians will routinely offer the patient / those important to the patient, written information about practicalities of what to expect when a loved one is dying.

Guidance for clinicians, with respect to these key areas, is available within this policy and on the Palliative and End of Life Care pages of the intranet (Ref 5). Advice is also available from the Specialist Palliative Care Team at all times via the Prospect out of hour’s number

The Specialist Palliative Care Team and the Chaplaincy team are available to support clinical teams in delivering support and to provide direct support to patients and relatives/carers.

On occasions when the patient is experiencing severe psychological distress, clinical psychologist support may also be required and may be accessed through the Palliative Care Team.

The relatives/carers and those important to the patient must be offered the following where applicable:

- Car parking at a reduced rate when visiting. These vouchers are available from Open visiting and the opportunity to stay with the patient including overnight if they so wish. (Ref 49).
- Made as comfortable as possible within the ward environment and given information as to where to access food, drinks etc. including over-night.
- Provided with timely information with respect to changes in the patient's condition and prepared for likely changes in the patient's condition during the dying phase for guidance with respect to information sharing. When they are not wishing to be constantly with the patient or able to be so, it must be established and documented whether they wish to be informed of changes in the patient condition at any time.
- When called to the hospital out of hours, guidance must be given with respect to how to gain access to the ward.

Employees will inform the patients' next of kin, family, friends and carers when the patient's condition has significantly deteriorated or when they have died. In cases of unexpected deterioration or death, the ward employees will telephone the next of kin.

2.7 Provision of Spiritual, Religious and Cultural Support

The patient, family, friends and carers must be directly asked about their religious and spiritual needs. The outcome must be responded to and documented in the clinical record.

On admission to the hospital, Community Caseload, or when "booking-in" maternity patients, religious affiliation should be ascertained by administration employees and recorded on the patient administration system. A record is to be made by nursing employees of any special provision that the Trust or their family could need in order that patients may practice their religion. This should be recorded on the assessment part of the personalised care plan or in the patients' medical notes.

Examples of needs include:

- Special dietary needs.
- Times of prayer.
- Receiving of Holy Communion or other sacraments.
- Visits by religious leaders and/or representatives of the patient's faith community.

The Chaplains are available 24 hours a day to provide spiritual, cultural, pastoral and religious care to patients, their relatives, carers and employees. They can be contacted via the Hospital Switchboard by dialling "0" and asking for the On-Call Chaplain. The chaplaincy team will provide support to patients and relatives/carers/employees irrespective of faith and will also access appropriate Spiritual leaders if required (Ref 50).

The Trust has a one hour response standard by which chaplaincy must be on hand after a request has been made.

Patients cared for in their home must also be asked about their spiritual needs. If there are difficulties finding local support, the On-Call Hospital Chaplain will be able to locate appropriate persons to provide the spiritual/religion assistance.

Guidelines relating to different cultural and religious responses to death and bereavement are on the intranet Chaplaincy section with links to Spiritual Gate. Employees can also refer to the Chaplains, the Mortuary team (Ref 54), Patient Advice and Liaison Service (PALS) (Ref 52), the patient's family or religious leaders in order to help them to understand patient's specific needs. The Trust must then take these needs into account when planning care or treatment or support someone expected to die.

When a request is made for Anointing, Sacrament of the Sick from a Roman Catholic or Anglican priest or for other Occasional Ministry (including Baptism, Naming, and Blessing of Babies/Children); the Great Western Hospital (GWH) On-Call chaplain must be contacted by a member of the clinical team responsible for the patients care.

If the patient's religious/cultural practices appear to go against the patient's best interests, then discussion should take place between the patient's doctor and the patient and their family, friends and carers, involving an interpreter if necessary, to seek to agree a solution. In the matter of religious practices, the Chaplain can also be consulted and participate in the discussion. Such discussion must not seek to over-ride a patient's strongly held views or beliefs, except in a case of public interest or for the protection of a child.

Compliance with the cultural and religious values of one patient may conflict with the well-being of other patients in the environment. In this case, the Trust, the patients involved and their family, friends and carers should seek a mutually agreeable solution in order that all patients' needs can be accommodated as far as possible. If a solution cannot be found, the lead clinicians responsible for care of the patients involved will make, communicate and document a decision in the best interests of the majority.

2.8 Support of Employees

There may be occasions when an employee feels unable to support particular relatives or significant others in a given situation. In such circumstances it is the responsibility of the employee to inform their line manager immediately. The manager will then arrange to provide the patient and family, friends and carers with support from another team member. The line manager will also discuss and agree with the original healthcare professional an appropriate management plan. This is likely to include the provision of additional support such as from Staff Support Services and / or referral Occupational Health.

Employees caring for the dying and bereaved, or employees suffering bereavement themselves, may need additional support at times. The Staff Support Service is available to provide this service. Employees may self-refer in confidence by telephoning 01793 815279 (Ref 53).

Teams are encouraged to develop supportive structures and mechanisms that enable de-brief and reflection.

2.9 When a patient wants to make a WILL

Helping Patients to write a new WILL

It is relatively common for patients approaching death to ask employees to help them to write a new will. Trust employees must not become involved in the personal financial arrangements of patients and therefore assisting patients in will writing is also inappropriate. Employees must recommend that patients seek independent legal advice and signpost them to the "Find a Solicitor" search tool on the Law Society website (Ref 14), (by selecting the relevant town/ postcode and also Wills & Probate under the search box Area of Law) (Ref 14).

Instead of instructing a solicitor to prepare a will a patient may prefer to use a Will writer service. Employees must not make any recommendations regarding any particular law firm or Will writer services. If practically possible, the Trust may assist the patient by arranging a private room for the purposes of the will writing task.

Employees Witnessing a WILL

As background information, the person's solicitor needs to ensure that the will is correctly drafted, signed and witnessed. In some circumstances the solicitor may visit the person in hospital to facilitate this.
It is the responsibility of the person's solicitor to arrange for witnesses to be present in advance of the person signing the will. Where this is done on site, the Trust employees must provide a private room to accommodate the will writing process.
Trust employees must not act as a witness. It is appreciated that in some circumstances there maybe few alternatives to Trust employees. Should situations arise where the person has no one else to act as a witness, please contact the Legal Services Team for advice.

Employees Confirming the Patient has Mental Capacity to make a WILL

It is for the person's solicitor to establish whether the person has "testamentary capacity" to make a will. The solicitor is likely to use a different capacity test to what Trust employees are familiar with. Trust employees should not make verbal statements regarding a person's capacity to make a will. If the person's solicitor requires a report on capacity, this must be made in writing to a relevant senior clinician and if a written report is provided, the clinician is entitled to request a fee.

2.10 Advance Care Planning (ACP), Advance Decision to Refuse Treatment (ADRT)/Living WILLs and Lasting Power of Attorney

A copy of any document expressing advanced wishes in relation to care should be filed in a prominent place within the patients' medical record.

References 3 and 13 provide information to inform care if assessments establish capacity is not present.

- ACP -This is a statement made by a person, while competent to do so, expressing their views as to their future care. It is not legally binding but should be considered as guidance to a patient's wishes in the event that they lose capacity.

- ADRT - This is a legally binding statement made by a competent person to refuse treatment in a particular circumstance. They come into effect in the event that the patient loses capacity. ADRT must be valid (signed and dated) and applicable to the circumstances. Statements which refuse potentially life-sustaining treatment must include 'even if my life is at risk' and as well as being signed, dated and must be witnessed. Advice on whether a document can be considered properly constituted should be sought from the patient's own solicitor or the Trust's solicitor through the Legal Services Team.

- Decisions on behalf of the patient in the event that they lose capacity. Further information including mechanisms to confirm the existence of a Lasting Power of Attorney, are available via the Office of the Public Guardian (Ref 15).

Public information leaflets detailing all of the above are available, as is a Swindon wide Advance Care Planning document. This is available in outpatient areas, in wards, from the palliative care team and in the community at GP practices and community nurses. Guidance on using the document and other

resources and a Portable Document Format (PDF) version of the document are available on Prospect Hospices website (Ref 17).

Guidance for employees is also available See References 17 and 18.

2.11 Organ and Tissue Donation

Exploring a patient's decision about organ and/ or tissue donation should be seen as a usual part of end of life care. The dying patient's decisions should be sought by collaborative working between the clinical team responsible for the patient's care and the Specialist Nurse for Organ Donation (SNOD) or the Specialist Nurse for Tissue Donation (SN-TD).

Please refer to the Trusts document - Identification, Referral and Approach to Families of Potential Organ and Tissue Donors Policy (Ref 19).

If the patient is on the Intensive Care Unit or in the Emergency Department, and there is a plan to withdraw life sustaining treatment or to confirm death using Neurological criteria then consideration of Organ donation should be made. Approach to the family is not recommended by the clinical team on the unit, but referral to the Specialist Nurse in Organ Donation (SNOD) should be made at the earliest opportunity, so they can be present to appropriately support the patient's family at this time, and ensure that the patient's decision regarding Organ Donation is honoured.

The Organ Donation Nurse Specialist can be contacted via the Trust's switchboard or via the Organ Donation Referral line- 03000203040 for all matters concerning organ donation, including checking the organ donor register.

The process of referral for Tissue Donation varies from that of Organ Donation. The family of the deceased person may be approached by the clinical team to gain their consent for referral of their loved one for Tissue Donation. A message can be left with the National Referral Centre, including patient's details and time of death. A Specialist Nurse in Tissue Donation (SN-TD) will then contact the patient's family on the telephone. The family do not need to stay in the hospital for this, as the conversation will happen over the telephone a number of hours later. All other care after death, for those being referred for tissue donation, can be carried out as normal.

The National Referral centre can be contacted by asking switchboard for the 'Tissue Donation Referral number' or on 08004320559.

Please also see the Human Tissue Authority (HTA): Code of Practice Donation of Organs, Tissue and Cells for Transplantation (Ref 10) and the Consent for Medical Treatment for All Patients at the Great Western Hospital Policy (Ref 4).

2.12 Donation to Medical Science

Information about how to explore this matter and guidance is given on the Human Tissue Authority website (Ref 20):

Under the Human Tissue Act 2004 (Ref 32), written and witnessed consent for anatomical examination must be given prior to death; consent cannot be given by anyone else after a persons death. A consent form can be obtained from the nearest medical school and a copy should be kept with the Will. The family, close friends and GP should be aware that a person may wish to donate their body. The mortuary will release the body to a medical school if the signed consent form is in place for this organisation and signed by the deceased.

2.13 Cardiopulmonary Resuscitation/Treatment Escalation Plan (TEP)

It is unusual for a cardiopulmonary resuscitation to be an appropriate intervention for a patient who has been identified as dying. Treatment Escalation Plans help to enable appropriate, considered and agreed ceilings of care to be in place. For further information please refer to Treatment Escalation Plan Policy (Ref 21) and Resuscitation Policy (Ref 66).

A patient information leaflet is available with supporting information available in the Treatment Escalation Plan and Resuscitation Decisions Policy.

Respect for dignity, privacy and personal values are important aspects of the care that is delivered to all patients including in particular those who are dying. The provision of sensitive support for those people in the vicinity of a dying person also needs to be managed well. Please see The Essence of Care Benchmark for Dignity and Respect (Ref 22).

Patients have the right to expect that their privacy and dignity will be respected during their contact with the Trust and that their culture and religion will be accommodated as far as is consistent with their health needs and the facilities which the Trust is able to provide.

2.14 Language Interpretation

Guidance can be found on the PALS Intranet pages. Patients and their family/carers must be supported and assisted where any difficulties or barriers to communication are established. Translated and Easy read versions of the Personalised Care Plan are available and can be accessed on the Palliative Care intranet pages (Ref 5).

2.15 Emergency Marriage/Civil Partnership Ceremonies

The protocol for a Marriage/Civil Partnership Ceremony In Hospital (Ref 23), can only be followed if the physician leading the patient's case can sign off a declaration that to the best of their knowledge it would be fatally detrimental to the patient's condition to be moved and that the patient has no likelihood of recovery strong enough to attend a place licensed to solemnise marriage or Civil Partnership.

The Chaplain is able to support the organisation of Emergency Marriage/Civil Partnership Ceremonies and can be contacted by a member of the team responsible for providing the patients clinical care, by telephoning the hospital switchboard and asking for the On-Call Chaplain.

2.16 Roles and Responsibilities Following the Death of a Patient

Verification of Death – Registered Medical Practitioners, Nurses, Midwives and Advanced Clinical Practitioners

An expected death is defined as any naturally occurring disease or condition which has run its natural course. Death is recognised as imminent by the patient's family, friends and carers, by the healthcare team and by the patient, if in a condition to express a view.

Deaths may be considered 'expected' when a decision has already been made by the health care team, in consultation with the patient's relatives/carers, to discontinue life support measures. Death must be verified as soon as possible after occurrence.

Under the Births and Deaths Registration Act 1953 (Ref 24), a registered medical practitioner who has attended a deceased person during their last illness is required to issue a medical certificate stating the cause of death 'to the best of his knowledge and belief'. The medical practitioner 'is not obliged to view the body but good practice requires that if s/he has any doubt about the fact of death

s/he should satisfy themselves in this way. (Para 5.01 Report of the Committee on Death Certificate and Coroners, English Office, CMMD 4810 November 1971) (Ref 25).

As the doctor is not obliged in law to see the body in order to issue a certificate, nurses and midwives may expand their role into the verification of expected death within the context of the NMC 'Code of Professional Conduct' (April 2018) document (Ref 33).

A doctor, site Nurse Practitioner or Advanced Clinical Practitioner MUST be called to verify death in the case of a sudden or unexpected death in the acute Trust.

In Swindon community the registered practitioner can verify death in the event of an expected death where the patient is known to the Swindon Community Health Service case load and has a completed Do not attempt cardiorespiratory resuscitation (DNACPR) form. In the case of sudden or unexpected deaths this verification must be carried out by the GP.

A registered practitioner may verify that a patient who was expected to die has died provided that:

- They have received appropriate preparation for this role in accordance with the provisions in the Competency Standard: Verification of Expected Death/10th Edition of Royal Marsden Manual) and in the Care after Death Policy and Procedure (Ref 27) and the 2nd Edition of Care After Death: Registered Nurse Verification of Expected Adult Death (RNVoEAD) guidance, 2019. (Ref 55)
- They apply the criteria stated in the Verification on Expected Adult Death – In the Community Setting Competency (Ref 36) to verify the patient's death, and record the verification in the patient's health records in the agreed format.
- There is no note in the patient's health records stating that a doctor should be called to verify the patient's death when they die.
- Any request made by the patient's relatives/carers to see the patient's doctor at the time of death is respected.
- That appropriate death certification forms are completed.

The “Diagnosis of Death” form held on wards needs to be completed by the practitioner verifying the death in the Acute Trust.

2.17 Patients who die whilst under Mental Health Act Detention – Quality Standards Manager/Clinical Governance Officer

When a patient dies whilst under the detention of the Mental Health Act (Regulation 17 Outcome 19) (Ref 13), the death must be reported by the lead clinician or their delegate either, the Safeguarding Administrator, within 24 hours of the death occurring. The Safeguarding Administrator will report the death to the Care Quality Commission (CQC).

2.18 Procedure for Verification of Death

In the Critical Care Unit, death is always verified by a doctor.

Nurses, Midwives and Advanced Clinical Practitioners

The verifying nurse, midwife or Advanced Clinical Practitioner must record their finding in the patient’s health record:

- Stating the date and time of the examination of the body on the diagnosis of death form
- Listing the findings.
- Stating that the patient has been verified as dead.

Entries must be signed by the verifying nurse/midwife and their name and designation must be stated and printed legibly.

If the verifying nurse or midwife has any doubt about their findings, or about the circumstances of the patient's death, they must call a doctor without delay.

If, at the time of death the family, friends and carers of the deceased wish to speak to a doctor, or wish a doctor rather than a nurse or midwife to verify the relative's/friends death, a doctor shall be called without delay.

Where practical, once the nurse or midwife has verified the patient's death, last offices are to be carried out in accordance with Procedure 8.18 "Care after death of The Royal Marsden Manual of Clinical Nursing Procedures- tenth edition (Ref 27) the Trust's Care after Death Policy and Procedure (Ref 28).

The nurse/midwife in charge of the case must inform the patient's hospital doctor of the patient's death at the earliest convenient opportunity and at least within 18 hours of the death. See section 2.19 re training.

Doctors

It is the responsibility of the patient's doctor to issue the death certificate and to inform the deceased's GP (When the death occurs in the hospital, the Mortuary and Bereavement Services Team will notify the GP within 24 hours of the death or on the next working day): "Cases to be reported to the Coroner". An EDS will also be sent to the GP following a patient death in hospital.

If death occurs at a weekend or over a public holiday and/or the patient's hospital doctor is not on duty within 18 hours of the patient's death, the relief doctor will be informed. The relief doctor is then responsible for informing the patient's doctor on their return in order that they may issue the death certificate.

2.19 Hospital Death – Care after Death and Transfer to the Mortuary

Care after Death Procedure

The National End of Life Care Programme (2011) NHS End of Life Care Strategy (Ref 37) refers to the final act of caring for a patient as 'care after death', a term the Trust has adopted as appropriate for a multi-cultural society. This final act provides an opportunity to complete the care given to the patient. Care after death fulfils religious and cultural beliefs as well as health and safety requirements. The Trusts Care after Death Policy and Procedure (Ref 28) and Infection Prevention & Control, Isolation Policy (Ref 46) must be undertaken when a patient has died and within two to four hours of the person dying, to preserve their appearance, condition and dignity and when the **patient has been verified** as **deceased.** The Care after Death Policy and Procedure sets out the procedure by which providing care after death is mindful of dignity and respect, attends to a patients last wishes in terms of organ or tissue donation, religious or cultural needs and indicates the appropriate health and safety procedures for the ward employees and porters to implement.

Before proceeding with these last acts of care the patterns of observance of the patient should be checked for any particular religious or cultural practice in the patients' notes. Most religions have specific rituals for those who have died, which may involve the saying of prayers or the body being washed by someone of that faith. Observing these rituals will be a sensitive matter that will need to be clarified. It is wise to consult with relatives or seek advice from the Chaplain. (Ref 50) Privacy or preference may determine that the Viewing Room in the Mortuary is more appropriate than the ward for rituals or last wishes, the nurse managing the care after death procedure on the ward where the deceased passed away should contact the Anatomical Pathology Technician to discuss specific

requirements. In all instances the preference of what will be required is obtained from the patient and or their relatives/carers.

If this is not possible then a lead can be given through the Chaplaincy intranet page under that department's resources (Ref 50).

The privacy and dignity afforded to a patient in life must, as far as possible, continue to be extended to them after death for as long as they remain in the care of the Trust. This is the Trusts last opportunity to provide care for the patient and it must always be undertaken with pride, care and respect.

Training to familiarise employees with the care after death procedure is available from the Mortuary and Bereavement Services Team.. The Team also provide on ward educational talks which are available to highlight and discuss the sensitive implications should the Care after Death Policy and Procedure not be implemented as described. Training is offered through contacting the Mortuary and Bereavement Services Manager 01793 604809/604392.

Removal and Transfer of Deceased Patients from the Ward

Removal of the deceased from the ward must happen with sensitive regard to grieving family, friends and carers, balanced with the Trust's need to optimise the use of its resources. It has been agreed by the Nursing leads of this Trust that a period, not exceeding four hours from the verification of death by an attendant physician is the maximum time that a deceased body is in the Ward area. Exceptions to this must be agreed by the Site Manager. When a patient has died, ward employees are to reassure other patients in the bay. This may be assisted by employees not directly involved with the deceased patient and family, friends and carers.

The nurse allocated to the deceased patient, will call the Hospital Porter Services to arrange transfer to the mortuary only once the patient has had care after death applied and can be removed from the ward to ensure that when the porters arrive they are not delayed. Following the ward request, two trained porters will be dispatched and arrive with the concealment trolley and when appropriate the deceased will be removed from the ward. Porters will confirm with the nurse delegated to the care of the deceased that the care after death procedure has been completed. The deceased will be taken by the most discreet and direct route to the mortuary and follow procedures to transfer the deceased into a refrigerator and complete details into the mortuary register, whiteboard and fridge door as specified by the Mortuary and Bereavement Services Manager.

It may be necessary for ward employees to contact hospital porters to arrange transfer of the deceased while family, friends and carers are still present. However, care should be taken to ensure that the porters do not arrive and the deceased is not removed from the ward whilst relatives, friends or carers are still present - unless agreed otherwise. Witnessing the movement of a body can be distressing and family, friends and carers who consider being present on the ward should be prepared by the attending nursing employees about what will be seen and what will happen. If family, friends and carers want to be present, then the chaplain or Anatomical Pathology Technician can be deployed to give professional support. This support is geared to help manage expectations and emotions, also to support the porters who might find the presence of distressed relatives significantly difficult. The decision to engage this support should come either from the nursing employees related to the patient's care or the Mortuary and Bereavement Services Team having received the deceased.

Family, friends and carers do not usually accompany the deceased to the mortuary. Occasionally the family, friends and carers may prefer to accompany the deceased patient from the ward. Individual, cultural or religious preferences concerning transportation, handling, storage and presentation of the deceased person need to be carefully documented and accommodated wherever possible. The on-

call Anatomical Pathology Technician will be contacted via Switchboard to manage the care from the porters to the Mortuary.

The deceased will be handled with dignity at all times throughout the transfer.

The use of body bags is only required in certain conditions and not to retain body fluids in preference for protective packing in line with the Care after Death Policy and Procedure. Please check the Isolation policy (Ref 59).

Consult with the Mortuary and Bereavement Services Team if a body bag is to be used, follow the mortuary checklist available from Bereavement services and check the Isolation policy (Ref 59).

Family, friends and carers will need time to adjust to the reality of the death of the patient. Allowing them time to be with the deceased immediately after death may be important to them. They must not be rushed into leaving the ward before they are ready to do so.

Mortuary and Bereavement Services Team hold a number of Standard Operating Procedures and iResponds, including what to do if a patient is dead on arrival, which specify the procedures in place for portering employees and these are agreed, monitored and measured by the Bereavement Services Manager and Serco. iRespond documents are available through the desktop shortcuts on each computer.

Returning a Patient's Property

The correct procedures and communication with the Mortuary and Bereavement Services Team office regarding patient property, the property list and medical notes is most important.

Employees must give any property of the deceased that was on the ward with the patient to their family, friends and carers and ensure that all items are signed for and the record of the transaction is kept in the patients notes.

When a patient dies and the relatives are not present, before the deceased is transferred to the Mortuary, their property must be listed and signed off from the sending department and will be taken to the Mortuary and Bereavement Services within 24 hours of the death by the nursing staff. If patient dies during the weekend or bank holidays, the property should come down the next working day.

All items of value need to be put into the designated care of patient's property after death bags.

In some of the Community localities, in the absence of a designated security department, property is securely kept on the Ward.

See Patients' Property (including valuables) & Lost Property (including valuables) Policy (Ref 40).

The Finance Department only becomes involved in cases where a contract funeral is to be arranged.

Mortuary Viewing – Nurse, Midwife, Mortuary, Chaplaincy

The GWH has a mortuary on the Lower Ground Floor with viewing area where it is possible for family, friends and carers to view their deceased loved one. This "Viewing" is done by arrangement with the Mortuary and Bereavement Services Team and managed through the Trust's Bereavement Service Office (01793 604392 or 01793 604392). Family, friends and carers should be encouraged to view the

deceased once the body has been released to the nominated Funeral Director because of the appropriate caring environment that a Funeral Director's premises afford.

Whilst it is recognised that in special circumstances advanced notice may not be possible; relatives are to make an appointment to view their love one. This avoids embarrassment, inconvenience and unnecessary delay for family, friends and carers at a particularly stressful time. It is necessary that a Mortuary Viewing will take place by prior arrangement with the Trust Mortuary and Bereavement Services Team office and the bereaved family, friends and carers, but the Mortuary will make every effort to be flexible in managing this aspect of care.

Viewings occur normally between 9.00 – 15.00hrs, when the Mortuary and Bereavement Services Team can be contacted directly. In the evenings and at weekends it is necessary to contact the mortuary On-call Anatomical Pathology Technician as required. The Anatomical Pathology Technician will triage and schedule the viewing requests. For viewing babies under 21 weeks gestation Beech Ward, Delivery Suite and Hazel Ward will arrange such requests from bereaved people in their department.

Synonyms such as "Rose Cottage" or the "Chapel of Rest" are not helpful. The Mortuary and Bereavement Services is a clinical environment and as such the environment will be reflective of the duties carried out within it. Some family, friends and carers go to the Chaplaincy rather than the mortuary expecting to view the deceased and the confusion adds to their sense of anxiety or grief. Because of this confusion of terms, it is therefore important that people are told clearly and directly that they will need to contact the Mortuary and Bereavement Services Office to arrange a viewing of their deceased relative at the Mortuary. Employees are encouraged to arrange to see the facilities for viewing at the mortuary so that they can be described with confidence.

See the Mortuary Viewing Policy (Ref 34) for further details regarding viewing of the deceased patient at the GWH Mortuary.

Death in the Community

This is normally managed by the family, friends and carers and their Funeral Director. In exceptional cases in the community the registered practitioner allocated to the care of the deceased patient will need to report the death to the local authority who will take responsibility for the committal and last matters of the deceased. Guidance on this matter can be found through contacting the manager of the local community hospital or through contacting the Mortuary and Bereavement Services Manager, the Deputy General Manager for Clinical Support and Specialist Services Division or the Chaplaincy Team Manager – all at the GWH, for support and guidance in this matter.

2.20 Registration of Death

Family Members

The closer the relationship to the deceased the more accurate the information is likely to be which is passed to the Registrar. Primary Informants: Widow, Widower, Mother, Father, Son, Daughter, Brother, Sister, Cousin, Nephew, Niece.

When a death occurs and family, friends and carers are present, they must be provided with the bereavement information booklet. For further supply of this booklet contact the Mortuary and Bereavement Services Team. In hospital family, friends and carers contact the Mortuary and Bereavement Services office to receive the information regarding the collection of the Medical cause of death certificate (MCCD) in order to register the death. Employees must ensure that family, friends and carers understand that they must telephone the Trust Mortuary and Bereavement Services office and not attend the Trust as the MCCD may not be ready as the process can take up to 72 hours to be

completed and not always available the next working day. The telephone number for the Bereavement Office is 01793 604392. In the community family, friends and carers contact their GP.

Family, friend and carers are provided with a written invitation to participate electronically via the Trust website (Ref 52) or over the telephone in the Care of the Dying Evaluation survey (CODE). The outcome of the survey is reported to the End of Life Committee and to the wards and clinical teams where the patient died. When concerns are raised via the feedback wards and departments address the issues broadly as the CODE is anonymous. The web page does indicate the anonymous nature of the feedback and encourages family and relatives to raise concerns via the patient advice and liaison service if they wish to do so.

Registering a Death when Burial is required within 24 hours – Nurse, Midwife, Mortuary

See: Matching Cultural Needs Guidelines (Ref 51)

Where it is clear that there is to be no Coroner's inquest and the doctor is able to issue a medical cause of death certificate, it is possible for the Registrar of Births, Deaths and Marriages to issue 'An authority for burial before registration' known as the 'Green Form'.

In order to do this they will need:

- Date and place of death.
- Full forename/surname/maiden name.
- Date and place of birth.
- Occupation.
- Married/widowed/civil partner.
- Usual address.
- If the deceased was in receipt of any allowance from public funds.

Documents required:

- A Medical cause of death certificate or "Cert E": Coroner's cause of death.
- Deceased's medical card if possible.
- Assurance that no inquest is required.

Where the body is to be removed overseas the authority of the Coroner is required. The hospital doctor completing the cause of death certificate must sign a freedom from infection letter. These letters are available through Mortuary and Bereavement Services. These arrangements can only be pursued in normal working hours when there can be liaison with the Coroner and Funeral Directors.

In the Community this is managed by the family, friends, carers and their Funeral Director.

Duties of Medical Practitioners in completing the cause of Death Documentation

"If you are a registered medical practitioner and were in attendance during the deceased's last illness", you are required under the Births and Deaths Registration Act 1953 (Ref 35) to "certify the cause of death to the best of your knowledge and belief".

Death certification should be carried out by a consultant or other senior clinician. Delegation of this duty to a junior doctor who was also in attendance should only occur if he/she is closely supervised.

(Text taken from Form 66 – Medical Certificates of Cause of death).

Each weekday morning, the Mortuary and Bereavement Services Team will contact the Consultant, the ward manager and the Matron by email. The death should be discussed at board round and the Doctor must attend the Mortuary to complete the required documentation (MCCD). The Doctor should then discuss and agree the cause of death with their senior and proceed to complete the certificate.

MCCD's should be completed, by the doctor certifying death or a clinician involved with the patients care, within 72 hours of the patient dying. This enables the timely production of the death certificates and release of the body to relatives and/or funeral directors.

The bereavement service team are available to discuss the cause of death and can advise which deceased patients need to be referred to the Coroner's office and how to complete the required paperwork.

Mortuary and Bereavement Services Anatomical Pathology Technician will advise Doctors if they must complete a Cremation Form. All registration books for adults are held in the Mortuary and Bereavement Services Office. The maternity wards hold neonatal Death Certificates and Still-Birth Certificates.

For out of hours access there are registration booklets and cremation forms held in the Trust Offices and at ward level on specific wards, these can be completed and left for the Mortuary and Bereavement Services to collect the next working day.

Reporting Death when the Identity of the Deceased is unknown – Mortuary

In the case of an unidentified body, the death is reported to the local Police by the ward employee.

Reporting Death when the Deceased's Next of Kin is Unknown – Mortuary

Where the death is outside the remit of the Coroner, the search to identify the next of kin is referred to the Mortuary and Bereavement Services Team. The Trust has agreed a contract regarding funeral arrangements for patients with no next of kin.

Employees notifying the death to the Mortuary and Bereavement Services should be prepared to provide any available information which may assist in the investigation.

Cases to be reported to the Coroner

From 1st October 2019 reporting of deaths less than 24 hour is no longer required if a clear cause of death can be provided.

CIRCUMSTANCES IN WHICH THE DUTY TO NOTIFY THE CORONER ARISES:
A registered medical practitioner must report the death as soon as it is reasonably practicable to do so.
The following is taken from section 3 of the Notification of Deaths Regulations 2019 which is to come into force 1st October 2019 (Ref 56).
(1) The circumstances are –
(a) the registered medical practitioner suspects that the person's death was due to -
i) poisoning, including by an otherwise benign substance;
ii) exposure to or contact with a toxic substance;
iii) the use of a medicinal product, controlled drug or psychoactive substance;
iv) violence;
v) trauma or injury;
vi) self-harm;
vii) neglect, including self-neglect;

viii) the person undergoing a treatment or procedure of a medical or similar nature or;
ix) an injury or disease attributable to any employment held by the person during the person's lifetime;

(b) the registered medical practitioner suspects that the person's death was unnatural but does not fall within any of the circumstances listed in sub-paragraph (a);
(c) the registered medical practitioner –
i) is an attending medical practitioner required to sign a certificate of cause of death in relation to the deceased person; but
ii) despite taking reasonable steps to determine the cause of death, considers that the cause of death is unknown;

(d) the registered medical practitioner suspects that the person died while in custody or otherwise in state detention;
(e) the registered medical practitioner reasonably believes that there is no attending medical practitioner required to sign a certificate of cause of death in relation to the deceased person;
(f) the registered medical practitioner reasonably believes that –
i) an attending medical practitioner is required to sign a certificate of cause of death in relation to the deceased person; but
ii) the attending medical practitioner is not available within a reasonable time of the person's death to sign the certificate of cause of death;

(g) the registered medical practitioner, after taking reasonable steps to ascertain the identity of the deceased person, is unable to do so.

If there is any doubt about reporting a death, contact the Mortuary and Bereavement Services on 01793 604392

Sudden Death

Sudden death is defined as:

- Any unexpected death where there is no clinical reason or where a decision has not been reached concerning the patient's condition.
- Where a person is admitted to the hospital unconscious or, for any other reason, the patient is unable to give an account of their condition.

Contact the Coroner

Where death is reported directly to the Coroner's Officer during regular working hours, the administrative matters relating to this situation are managed by the Mortuary and Bereavement Services Team.

Outside of the normal business hours 08.00 – 16.00 and at weekends, a form can be downloaded via the Bereavement support intranet page and emailed to:gwh.mortuary.mailbox@nhs.net

Transgender and Completion of the Death Certificate

The Gender Recognition Act 2004 (GRA) (Ref 57), introduced in April 2005, gives legal recognition to a transsexual person's affirmed gender and recognises a transsexual person as someone who lives permanently in their affirmed gender and intends to do so for the rest of their life. Transgender and trans are umbrella terms that encompass many different identities. This policy applies to Transgender and procedures will be carried out the same as stated within this policy. Problems can arise, in the case of a trans person, when stating the sex of the deceased. If a person is living as a different gender to that they were assigned at birth it is important to identify their legal name prior to death to

ensure the death certificate is correct. If they wish to legally change their gender before their death, it may be helpful to contact the Gender Recognition Panel (Ref 58). Relatives sometimes register the death in their birth gender, no matter how long they lived in their affirmed gender. If the patient has a gender recognition certificate (GRC), your affirmed gender must be used when registering your death. If living permanently in an affirmed gender but you did not have a GRC, it is permissible to register your death in your affirmed gender, as long as your passport and medical card support this (a birth certificate is not a legal requirement to register a death).

2.21 Post Mortems and Storage/Disposal of Tissue

Checklist for Post Mortem

A post-mortem examination is the examination of a body after death and can also be called an autopsy. Post-mortem examinations are carried out for two main reasons: Coroner's Post Mortem, because the cause of a death is unknown, or when a death happens unexpectedly or suddenly. Hospital Post Mortem is to provide information about an illness or cause of death, or to advance medical research

Post-mortem examinations are carried out by Pathologists, and Anatomical pathology technicians. Pathologists are trained doctors who work to standards set by the Royal College of Pathologists and the Human Tissue Authority (HTA). Obtaining consent for a hospital post mortem examination should be a team approach involving the relevant members of the patient's care team and these must include; Mortuary and Bereavement Services Team or Maternity and Paediatric Support Team. The Consent for Medical Treatment for All Patients at the Great Western Hospital Policy (ref 4) gives comprehensive information on this matter.

The Human Tissue Authority regulates the following activities:

- Section 16(2)(E)(i) and (ii)
- Section 16(2)(B)
- Section 16(2)(C) Of the Human Tissue Act 2004
- The Trust is licensed to undertake these activities by the Human Tissue Authority and Human Tissue Act 2004.
- Please referee to the HTA web site for further information.

Retention of Organs and Tissue Samples at Post Mortem

In around 20per cent (%) of adult post-mortem examinations and in most paediatric post-mortem examinations, the cause of death is not immediately obvious. A diagnosis can only be made by retaining small tissue samples of relevant organs for more detailed examination. The Pathologist may need to retain a whole organ for a full assessment to allow an accurate diagnosis of the cause of death to be made. These full assessments often take weeks or even a few months to complete, depending on the extent of the investigations required. Once they are complete, the Pathologist will produce a report for the Coroner or the medical employees responsible for the care of the person before they died.
Tissue samples:

- Small tissue samples which are needed for further examination are usually set into blocks made from paraffin wax. The wax blocks are sliced into very thin layers, which are about ten times thinner than a hair. These slices are placed onto glass slides and stained with a special dye to allow cells to be studied under a microscope.
- Organs.
- If whole organs, part of an organ, or tissue are needed for more detailed examination, they will normally be treated with a chemical that preserves them. Samples of the organ or tissue may then be processed into blocks and slides as described above.

Management of Organs and Tissue after Post-Mortem

- The retention and disposal of Organs and Tissue (anything that contains a cell) removed at Post Mortem examination requires consent.
- Hospital Post Mortem, consents for the management of tissue and organ is stated within the original informed consent.
- Coroners Post Mortem, consent for the management of tissue and organ is obtained by the Coroners officer and only applies once the Coroners interest has ended.
- All Consent needs to be in line with HTA Guidance.
- Where relatives have indicated that they would like the Trust to dispose of any retained organs and tissue (including blocks and slides), this will be normally done by incineration.
- Where relatives have indicated blocks and slides are to be returned either to them or designated persons. The Mortuary and Bereavement Services employees will facilitate this.
- Where relatives have indicated that blocks and slides are to be kept as part of the deceased medical records, these will be retained for a retention period of 30 years for block and 10 years for slides after this time they are disposed of by incineration. This is facilitated by Cellular Pathology employees.
- The Trust operates within the HTA code of practice (5) as scheduled in the HTA governance information.

Hospital Post-Mortem

A Hospital Post Mortem can be extremely useful in determining how, why and when someone has died, or providing information about the effect of treatment given, or the events leading up to death. They can also be useful to better understand how a disease has spread; or whether the person who died had a genetically inherited disease. Finding out more about illnesses may help doctors treat patients in the future.

When a request for a Hospital Post Mortem examination is being made, written informed consent must be sought. Additionally, written consent to the management and disposal of tissue or organs retained at post mortem using the correct consent form must be sought.

Written information about consent is set out in the Trust’s Consent for Medical Treatment for All Patients at the Great Western Hospital Policy (Ref 4) and a standard consent form is available from the Mortuary and Bereavement Services. The written information, and any subsequent verbal explanation of its content, should be provided before relatives are asked to give their consent to the post mortem examination

Requirements need to undertake informed consent:

- Team approach (Consultants and Mortuary and Bereavement Services employees)
- Only employees Trained in HTA consent procedures (Mortuary and Bereavement Services or maternity and paediatric employees).
- Skills and knowledge regarding Post Mortems and tissue retention to deal with questions which may arise from the family.
- Hospital Post Mortem information leaflet.
- Informed consent forms.
- Private environment to talk.
- Time.

What needs to be established?

- Have the relatives been informed about consenting to a hospital Post Mortem and why this have been requested.
- What is the qualifying relationship to the deceased of the person giving consent to the Post Mortem?
- Have the relatives been given a leaflet on post mortem consent (24 hour prior to consent been taken)? Available from the Mortuary and Bereavement Services)
- Explain that the person giving consent may limit the scope of the Post Mortem examination (limited post mortem); however, this may result in the inability to provide further information on the cause of death or disease process causing death.
- Do the circumstances of the patient's death indicate that a Coroner's Post Mortem may be required? If so, employees should be clear that the Coroner's requirements take precedence over the expressed wishes of either the deceased or relatives in relation to organ donation or transplant.
- Provide the persons who are being asked to give consent to the Post Mortem with the relevant information leaflet.
- What are the relative's wishes for the return, storage, use and disposal of tissue at post mortem?
- Allow time for relatives to think about what they have read and agreed too; encourage them to seek clarification prior to Post Mortem date and time agreed.
- Ensure all documentation is in patient's health records and a copy is giving to the relatives.

There needs to be resources and employees with the ability to respond to emotive questions, for example, about the process involved and the reality that the deceased patients' body will have to experience incisions and other procedures, to ensure that family, friends and carers have adequate support in this matter.

Coroner's Post-Mortem (required by law)

It is the policy of the Trust that employees, (the witness), are enabled to make statements for, and attend the Coroner's court, when they are summoned to do so. Full instructions in this scenario are available.

Histological Examination of a Miscarriage of under 24 weeks Gestation

- Histological examinations of miscarried material under 24 weeks are conducted within this Trust or at the John Radcliffe Hospital, Oxford dependent upon the circumstances. Written informed consent is required between 14 and 24 weeks. Written information and a standard consent form are provided for this purpose.
- Histological examinations of foetus' and stillborn babies and neo-natal deaths are conducted at the John Radcliffe Hospital, Oxford. Written informed consent is required. Written information and standard consent forms are provided for this purpose.
- The Trust operates within the "Code of Practice" as directed within the HTA Guidance found on the internet.

Storage and Disposal of Foetal Tissue

This covers the disposal of foetal tissue obtained following surgical procedures for miscarriage and termination, natural miscarriage, medical treatment of miscarriage or termination and any stillborn foetus before 24 weeks gestation. Foetal tissue includes not only the foetal parts themselves but also the placenta.

In accordance with the NHS Management Executive Guidelines - "Disposal of foetal tissue" – Health Service Circulars (91), Booking Funerals for Babies and Foetus (Ref 69), all foetuses and foetal

tissue resulting from termination of pregnancy must be incinerated. However, full account has to be taken of any personal wishes that have been expressed about disposal which require some other method of disposal to be used.

- This should be read in conjunction with the Intrapartum Guidelines (Ref 39) Chapter- Stillbirth and Intrauterine Death. The Gynaecology Ward Manager holds the GWH Women's and Children's Services Checklist for Miscarriage/Stillbirth/Death of a Baby; and the Gynaecological Ward Guideline for Mid-Trimester Termination and their accompanying ward policies and protocols.
- To complete a seamless pathway in communication, information and decisions relating to the disposal must be recorded in patient notes.
- Foetal tissue will be stored and disposed of in such a way that there is no possibility of unauthorised procurement or use.
- Care is taken to check with the mother, in an appropriate and sensitive manner, as to whether she has any special wishes with regards to the disposal of the foetus. Her wishes must be respected.
- After consent has been obtained, the foetus or foetal tissue will be disposed of in a legal and dignified manner on all occasions, whether or not parental involvement has been requested.
- Accurate records must be maintained in accordance with the Health Records Department Operational Policy (Ref 67) to allow subsequent enquiries about disposal, which may occur years later, to be fully answered and an event trail provided where necessary. Information relating to disposal must be entered into patient's notes.
- The minimum requirement is that all foetuses and foetal tissue should be stored separately, unless attached to the umbilical cord, in appropriate containers. Foetal tissue should be transported and loaded separately for disposal. The Trust supports as best practice the disposal of all foetal tissue by cremation rather than incineration.
- Choice of terminology is critically important in the Trusts communication with the family. To refer to 'foetal tissue' and 'disposal' when the mother is thinking of her baby may be deeply distressing and will be remembered. The Trusts whole attitude and language needs to communicate the dignity with which the Trust will treat their baby. The Trust also needs to be truthful. The family can be presented with choices, such as the taking of photographs, but must have the freedom to choose what helps them rather than what helps us or is 'usual' on the ward.

Delivery Suites GWH

- Following a Neonatal death in Delivery Suite or in Special Care Baby Unit, the relevant checklists should be followed and completed.
- Following the delivery of a non-viable foetus or stillborn baby, the procedure detailed in the site specific Intrapartum Guidelines (ref 39), should be followed.
- Checklist for Miscarriage/Stillbirth/Death of a baby should be followed and completed. The foetus/baby is labelled, dressed and/or wrapped in sheets/shroud and transported to the mortuary in a transportation basket/crib with a nurse/midwife and the portering employees. The parent(s) may wish to accompany to the mortuary. If so, this must be arranged prior to arrival with the Mortuary and Bereavement Services Team. The placenta and any appropriate paper work must accompany the foetus/baby. Where the mother has consented to the Trust arranging for the disposal of the foetus/baby, disposal will be by the Trust's contracted Funeral Director by either burial or cremation. Alternatively, parents may choose to make private arrangements. In accordance with national guidelines, the Trust encourages families to engage the services of a Funeral Director to oversee the legal and respectful disposal of the foetus or baby.

When it is decided that a non-viable foetus or stillborn baby post mortem examination is required, the procedure is carried out at Oxford. The foetus/baby is sent to the mortuary (see above) and transport

to Oxford John Radcliffe Hospital and back is arranged through the Trust's contracted Funeral Director. On the return of the foetus/baby to the hospital mortuary, a Funeral Director will dispose of the foetus/baby by burial or cremation in accordance with the family's wishes. Consent for a full or partial post mortem must only be sought following the provision of verbal and written information given by appropriately trained employees.

The Trust offers three options for the disposal of a foetus from 14 weeks to 24 weeks, and two options for a stillborn baby. Option 1 is for the family to make their own arrangements. Option 2 is for burial or cremation at which the family is present. Option 3 is for a disposal at the Crematorium with no family present (non-viable foetuses). The mother's signed consent must be gained, authorising the Trust to dispose of the foetus or stillborn baby. The mother must also indicate whether or not she requires a religious ceremony at the time of disposal and the level of parental involvement required. The Trust is responsible for ensuring that disposal is legal and respectful by the contracted Funeral Director. The dignified service at burial or cremation is usually conducted by a hospital chaplain. Where the mother expresses the wish for disposal in the context of a Faith, the Trust will facilitate this through its contracted Funeral Directors.

Gynaecological Ward

In the instance of a spontaneous miscarriage before 14 weeks' gestation, all expelled tissue will be placed in a specimen pot containing formaldehyde and sent to the Pathology for histological examination together with the histology request form and a Certificate of Foetal Remains for Cremation.

On completion of all examinations, the tissue will remain in the Cellular pathology for disposal. If a request is received for the return of products of conception, the Chaplaincy is informed to facilitate parents' wishes. If no request is received, the products of conception are sent for legal and respectful disposal by cremation.

When a miscarriage occurs at or over 14 weeks' gestation, the foetus will have a name band attached and will be placed in a white coffin. A label is attached to the outside of the coffin with the mother's name and unit number. A Non-Viable Foetus Form is completed (Form A) (Ref 70) and sent to the Mortuary and Bereavement Services. The mother must give her signed consent to the Post Mortem and subsequent disposal of foetus and/or tissue on the appropriate consent form. The foetus will be transferred to the Mortuary and Bereavement Services by portering staff and, following any examination, the foetus will be buried or cremated by a Funeral Director in accordance with the mother's wishes.

Emergency Department

If a woman miscarries while in the Emergency Department, or has miscarried at home and brings the foetus/products of conception in with her, the foetus/products of conception should be placed in a dry, opaque specimen container and discreetly transported with the woman to the gynaecology ward. The foetus/products of conception will then be dealt with as above.

Operating Theatres

When termination of pregnancy or evacuation of retained products of conception, is undertaken by the suction method in theatre, a special liner is inserted into the suction system to collect the foetal tissue. A fresh liner is used for each operation. All suction liners used in any one operating list are individually sealed, put into formalin pots and these are transported to Histology by theatre support workers or portering services out of hours. The foetus/products of conception will then be dealt with as above. A certificate of Foetal Remains for Cremation from Gynaecological Ward must accompany the products to Cellular Pathology.

2.22 Management of Baby Funerals in respect of Transportation from the Mortuary

For babies over 24 weeks gestation, the Trust shall engage the Contracted Funeral Director to undertake the transportation of the deceased from the Hospital Mortuary.

Foetal remains under 24 weeks gestation, can be transported in a suitably packaged container – presently a Bio-degradable casket or, in the case of Products Of Conception – gestational age up to 14 weeks, shall be transported in a numbered batch – up to a maximum of 15 specimens in a Cardboard Container for final committal. This process is completed by the Trust Designated Funeral Director.

The exception to the Product of Conception path scheduled above is when the parent of the miscarriage requests an individual ceremony, in which case the specimen shall be transported and committed in an appropriate bio-degradable casket.

When an Undertaker is not engaged to undertake transportation, the alternative will only be via a Trust Pool Car. Caskets will usually be transported on the back seat or the tail compartment of the Trust Vehicle.

2.23 Patients with Pacemakers/Defibrillators/Syringe Pumps

Defibrillators in the dying patient

The consultant in charge of the patient's care should request for tachycardia therapies (e.g. an Implantable Cardiac-Defibrillator (ICD)) to be deactivated as part of the decision to withdraw active medical therapy. This should be completed on CVIS and the cardiology team aim to deactivate the ICD within 48 hours. If the patient is in the community the department will accept request to disable ICD therapies from the following sources:
Prospect nurse/doctor
Patient's registered GP
Dr looking after the patient

The request must be in a traceable format e.g. email or written and signed on headed paper.

In an emergency/out of working hours (08:00 – 17:30), ICDs can be temporarily deactivated by securing a magnet over the device. This will disable tachy therapies for up to 8 hours. In this instance the ward should document the time of the magnet placement on the white board behind the patient's bed and in their medical notes. After 8 hours, tachy therapies will be re-enabled – if further deactivation is required please remove the magnet from the ICD, wait for 1 minute and reapply. Please change timing documentation on the white board and in patient's notes if an in-patient. In the acute trust magnets are available from Coronary Care Unit (CCU) or Emergency Department (ED). In the community, the magnets are kept in an ICD deactivation bag held in SWICC.

If the deceased patient has been fitted with an ICD, an alert is to be put on the patient notes and Mortuary and Bereavement services notified. The Wiltshire Cardiac Centre should be contacted for advice on bleep 2144 (Monday-Friday 08:00-18:00, Saturday a.m. and Sunday 10:00-14:00) prior to any invasive intervention or cremation. Wiltshire Cardiac Centre will then programme the device off.

Pacemakers

Check the type of pacemaker recorded on the cardiac database or with the Cardiac Physiologist/GP.

If the deceased patient has been fitted with a pacemaker, an alert will be put on the patient notes in case cremation is chosen. This information is included on the cremation form. The correct local procedure should be followed for the removal of the pacemaker. Removal will be undertaken by the Mortuary and Bereavement Services /Funeral Director.

Community Considerations

Syringe pumps will need to be removed, either by the clinician, or the out of hours clinician or the Funeral Director, and be returned to Independent Community Equipment Services. A return envelope will be provided.

2.24 Releasing the Deceased Patient

Releasing the deceased to a Funeral Director from the Hospital

All deceased adults must only be released through the Mortuary once all legal documentation has been completed. Members of several faiths will require burial or cremation within 24 hours. Mortuary and Bereavement Services, Chaplains and Undertakers are aware of these needs and will try to facilitate this whenever possible. Contact the Mortuary On-Call Anatomical Pathology Technician to liaise in these cases.

Coroner's Cases

Appropriate official confirmation is required so that permission for release of the deceased is obtained from the Coroner's Office, once all investigation is completed. Mortuary and Bereavement Services Team will liaise with the Coroner's Office. The authorisation to remove the deceased identifies the Funeral Director involved. The Coroner sends a Coroner's Certificate directly to the Registry Office.
Under no circumstances will a deceased patient be released without the Coroner's permission.

Release of the Deceased Directly to the Care of Family

Consideration and planning must be undertaken before release of a deceased patient from the Trust directly to the family. In the case of GWH this will only be between the hours of 9am and 4pm, Monday to Friday in consultation with the Mortuary and Bereavement Services. For advice outside of these hours contact the mortuary On-Call Anatomical Pathology Technician via the hospital switchboard or for the community, the Healthcare Professional managing the deceased's case.

Babies - In the event that parents take their deceased baby(ies) home, the 'SOP' for taking deceased babies home', must be followed (Ref 71).

For GWH, in the event of the deceased being released directly to relatives, a MCCD must be signed by the Doctors and Cremation forms if needed BEFORE the deceased is released. Mortuary and Bereavement service sends a release form with four unique identifiers to the Funeral Director following consent of the family. The Funeral Director then produce the Green form when attending the Mortuary. All practicalities will be arranged with the Mortuary and Bereavement Services Team.

Growing public awareness of alternative options for funerals will result in an increased demand for a flexible response to which the Trust shall respond with safe practice.

Hazardous Bodies

Hazardous – that is to state; bodies with an infection risk must be secured in a leak proof body bag and labelled as High Risk using an appropriate hazard-warning label fixed to the body bag. Funeral Directors will be informed of the nature of the risk when they collect such the patient.

ONLY TO BE USED in cases of high infectious risk (Please see IP&C isolation guidelines Ref 59). **DO NOT USE** for a deceased patient with MRSA, Clostridium difficile (C.Diff) or leaking, suction must be carried out and line sheet with Inco pads.

The Mortuary must be informed of any infection risk - this can be done either by phone or written on paper and placed into an envelope, to protect patient confidentiality, and attach to exterior of the bag.

Moving On

Each death is unique to the people it affects, and above all they will need time to adjust.

Although there is inevitable pressure on employees to 'move on' to the next patient or task, care should be taken to ensure:

- The appropriate family, friends and carers are informed of the patient's death. Care is taken as to how this is done and may involve asking other relatives or the police to break the news in person.
- If possible, it is helpful to greet those who have been informed of the patient's death by phone and who have been asked to attend urgently.
- Family, friends and carers know that they may take time with the deceased after death
- Appropriate care after death is identified
- Appropriate information is given verbally and reinforced with written material
- The named nurse, or another appropriate employee, continues to be available to relatives until the appropriate conclusion of the care.
- The offer of a return visit to discuss questions relating to treatment could be made, the extension number to have support over the phone may be more realistic and helpful (because of pressure of time for employees and possible difficulties of returning to the place of death).
- In the hospital environment the porters do not remove the body from the Ward until AFTER all family; friends and carers have left the area, unless other arrangements are agreed.
- The dignity extended to the patient in life must, as far as possible, continue to be extended to them in death. Please refer to Care after Death Policy and Procedure (Ref 28).

2.25 Bereavement Support

For family, friends and carers to the deceased patient: Guidance is provided by the Mortuary and Bereavement Services on the following numbers 01793 604392 or 01793 604393.

For employees: See section 2.8 above.

All aspects of handling information must comply with the Trust's Information Governance Strategy and Policy (Ref 2).

Patient information systems must be updated by ward administration employees, particularly with respect to the patient's next of kin and their contact details.

The patient's wishes with respect to information sharing with family, friends and carers must be sought where possible, recorded in the clinical record and followed. Where the patient is unable to participate in decision making, guidance should be followed from the Mental Capacity Act (Ref 3), Mental Capacity Act 2005 Policy and Procedures (Ref 13) and Consent for Medical Treatment for All Patients at the Great Western Hospital Policy (Ref 4).

A Care Plan must be maintained and decisions recorded so that the Trust's Electronic Patient Management Systems and/or paper records can be checked and relied upon for consistency and accuracy.

Current care plans to specifically support the care of the dying patient where available will be located on the palliative care page of the Trust intranet – (Ref 5) for Acute employees and SystmOne for Swindon Community employees.

2.26 Information Management

All aspects of handling information must comply with the Trust's Information Governance Strategy and Policy (Ref 2).

Patient information systems must be confirmed as complete and up to date by ward administration employees, particularly with respect to the patient's next of kin and their contact details.

The patient's wishes with respect to information sharing with family members should be sought where possible, recorded in the clinical record and followed. Where the patient is unable to participate in decision making, guidance should be followed from the Mental Capacity Act Policy (ref 3) and Consent for Medical Treatment for All Patients at the Great Western Hospital Policy (ref 4).

A Care Plan must be maintained and decisions recorded so that the Trust's Electronic Patient Management Systems and/or paper records can be checked and relied upon for consistency and accuracy.

Current care plans to specifically support the care of the dying patient where available will be located on the palliative care page of the Trust intranet – (Ref 5) for Acute employees and SystmOne for Swindon Community employees.

3 Monitoring Compliance and Effectiveness of Implementation

The arrangements for monitoring compliance are outlined in the table below: -

Measurable policy objectives	**Monitoring / audit method**	**Monitoring responsibility** (individual / group /committee)	**Frequency of monitoring**	**Reporting arrangements** (committee / group to which monitoring results are presented)	**What action will be taken if gaps are identified?**
Patient/Carer Satisfaction	PALS Complaint Cards. Ward Team Feedback Communications CODE Prospect feedback via the End of Life meeting	Trust End of Life Committee	Monthly	PALS Department	Management plan will be developed to address any gaps

Measurable policy objectives	**Monitoring / audit method**	**Monitoring responsibility** (individual / group /committee)	**Frequency of monitoring**	**Reporting arrangements** (committee / group to which monitoring results are presented)	**What action will be taken if gaps are identified?**
Monitor Compliance with Training	Training Tracker, and Electronic Staff Record (ESR) Status Reports	Trust End of Life Committee	Monthly for mandatory training, annually for other training	Trust Board	Management plan will be developed to address any gaps
Benchmark local performance against national picture	Biannual National Care of the Dying Audit Compliance with audit associated Key Performance Indicators including annual audit and survey of the bereaved	Trust End of Life Committee	Biannual	Trust Board	Management plan will be developed to address any gaps
Monitor services delivered	Compliance with Trust Quality Markers for End of Life Care	Trust End of Life Committee	Quarterly		Management plan will be developed to address any gaps

4 Duties and Responsibilities of Individuals and Groups

4.1 Chief Executive

The Chief Executive is ultimately responsible for the implementation of this document.

4.2 Ward Managers, Matrons and Managers for Non Clinical Services

All Ward Managers, Matrons and Managers for Non Clinical Services must ensure that employees within their area are aware of this document; able to implement the document and that any superseded documents are destroyed.

4.3 Document Author and Document Implementation Lead

The document Author and the document Implementation Lead are responsible for identifying the need for a change in this document as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and resubmitting the document for approval and republication if changes are required.

4.4 Employee Responsibilities

All registered nurses, midwives and medical employees have the responsibility to:

- Identify patients that are within the last year of life and discuss preferences as appropriate with patient and carers.
- Document preferences and conversations within medical nursing records.
- Identify dying patients and ensure individualised personal care is provided meeting patient preferences utilising the Personalised Care Planning tool to support the planning and delivery of care providing there is consent to do so.
- Inform all members of the health care team who have direct contact with the patient; the said patient is in the dying phase.
- Complete training in accordance with the Trust Training Needs Analysis and Mandatory Training Policy/requirements.
- Adhere to hospital policy particularly the Care of the Dying, Care after Death Procedure and Policy, Mental Capacity Act Policy and Treatment Escalation Plan and Resuscitation Decisions Policy.

For other healthcare professionals this should be communicated via medical records.

4.5 The In-reach Specialist Palliative Care Team/End of Life Team (Acute and Community)

The Palliative Care Team/End of Life Team (Acute and Community) has the responsibility to:

- Act as a specialist resource to increase employee and patient knowledge and awareness of End of Life (EOL) care.
- Maintain Crosscare and SystmOne databases for entering patient referrals and patient preferences at the End of Life.
- Deliver specialist training to Trust clinical employees.
- Provide specialist advice to clinical employees and patients including specialist symptom control.

4.6 Senior Ward manager/Sister (Adult wards only)

Senior Ward Manager/Sisters have the responsibility to:

- Provide advice to employee and patients on palliative care and Care of the Dying care plan documentation in use in their area.
- Attend training to increase their knowledge of palliative and end of life care related topics.
- Provide an overview to their team regarding Trust palliative and end of life information and updates relating to their department.
- Audit their departments' Care of the Dying care planning compliance.

4.7 The End of Life Committee/Group

The End of Life (EOL) Committee have the responsibility to:

- Share Regional and local information of EOL care.
- Oversee implementation and monitor use of Personalised Care Planning tool.
- Oversee quality of care provided to dying patients via CODE survey, Audit outcomes including bi-annual national audit, metrics monitoring, sharing learning from EOL related incidents and complaints, compliance with national guidance including from NICE.
- Monitor educational needs of employees including uptake of mandatory EOL training for all employees and provision of other educational events
- Review new evidence based research relating to EOL care.
- Report quarterly to Patient Quality Committee.

- Provide monthly EOL dashboard for Quality report to Executive Committee.
- Will receive direct feedback from the End of Life governance group.

5 Further Reading, Consultation and Glossary

5.1 References, Further Reading and Links to Other Policies

The following is a list of other policies, procedural documents or guidance documents (internal or external) which employees should refer to for further details:

Ref. No.	Document Title	Document Location
1	Trust STAR Values	Intranet
2	Information Governance Strategy and Policy	Trust-wide documents
3	Mental Capacity Act 2005	www.gov.uk
4	Consent for Medical Treatment for All Patients at the Great Western Hospital Policy	Intranet
5	Hospices websites To add reference for Berkshire?	Swindon and North Wiltshire Community Patients – http://www.prospect-hospice.net For the Great Western Hospital Via in-reach Prospect Palliative Care Team, see Trust Intranet Palliative Care pages link http://gwh-intranet/diagnostics-outpatients/palliative-care.aspx For other areas of Wiltshire served by the Community Trust, two other hospices support Trust patients: Salisbury Hospice http://www.salisburyhospicecharity.org.uk Dorothy House Hospice http://www.dorothyhouse.co.uk
7	Palliative Care Prescription	Intranet – Palliative and End of Life Care
8	Palliative Care Authority to Administer	Intranet – Palliative and End of Life Care
9	Community Just in Case Box Guidance	Intranet – Palliative and End of Life Care
10	HTA -Code of Practice & Standards	www.hta.gov.uk/hta
11	More Care Less Pathway. Report of the independent review into the Liverpool Care Pathway	www.gov.uk

Ref. No.	Document Title	Document Location
12	One Chance To Get It Right. Report of the Leadership Alliance for the Care of Dying People	www.gov.uk
13	Mental Capacity Act 2005 Policy and Procedures	Trust-wide documents
14	The Law Society	www.lawsociety.org.uk
15	Office of the Public Guardian	www.publicguardian.gov.uk
16	Public Information Leaflet – Advance Care Plans (ACP), Advance Decisions to Refuse Treatment (ADRT)/Living Wills and Lasting Power of Attorney	www.nhs.uk/Planners/end-of-life-care
17	Clinician advice – Advance Care Plans (ACP), Advance Decisions to Refuse Treatment (ADRT)/Living Wills and Lasting Power of Attorney	www.prospect-hospice.net
18	Clinician advice – Advance Care Plans (ACP), Advance Decisions to Refuse Treatment (ADRT)/Living Wills and Lasting Power of Attorney	www.hospiceuk.org
19	Identification, Referral and Approach to Families of Potential Organ and Tissue Donors Policy	Trust-wide documents
20	Human Tissue Authority	www.hta.gov.uk
21	Treatment Escalation Plan Policy	Trust-wide documents
22	The Essence of Care Benchmark for Dignity and Respect	www.gov.uk
23	Marriage Ceremony/Civil Partnership in Hospital Protocol	Intranet Link in Chaplaincy pages
24	Births and Deaths Registration Act 1953	www.legislation.gov.uk
25	Report of the Committee on Death Certificate and Coroners, English Office, CMMD 4810 November 1971	webarchive.nationalarchives.gov.uk
26	Trust-wide Oral Care for Adults with Palliative Care Needs Clinical Guideline	Trust-wide documents
27	The Royal Marsden Manual of Clinical Nursing Procedures- tenth edition	www.rmmonline.co.uk
28	Care After Death Policy and Procedure	Trust-wide documents
29	Personalised Care Plan and Information to Support People When They Are Likely To Be In Their Last Days Or Hours In Life And To Support Those Who Are Important To Them	Intranet – Palliative and End of Life Care
30	Great Western Hospital End of Life Strategy	Intranet
31	World Health Organisation	www.who
32	Human Tissue Act 2004	www.legislation.gov.uk
33	The Code - The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates (2018)	www.nmc.org.uk

Ref. No.	Document Title	Document Location
34	Mortuary Viewing Policy	Trust-wide documents
35	Births and Deaths Registration Act 1953	www.legislation.gov.uk
36	Verification on Expected Adult Death – In the Community Setting Competency	Trust-wide documents
37	The National End of Life Care Programme	www.nhsiq.nhs.uk
38	Inquest (Including Guidance for Staff) Policy	Trust-wide documents
39	Intrapartum Guidelines	Trust-wide documents
40	Patients' Property (including valuables) & Lost Property (including valuables) Policy	Trust-wide documents
41	Patient Identification Policy	Trust-wide documents
42	NICE Guidance NG31 Care of the dying adult	www.nice.org.uk
43	Ambitions for palliative and end of life care	endoflifecareambitions.org.uk
44	NICE Quality Standard 144 Care of dying adults in the last days of life	www.nice.org.uk
45	NICE Quality Standard 13 End of life care for adults	www.nice.org.uk
46	Infection Prevention & Control, Isolation Policy	Trust-wide documents
47	(Acute) Registered Nurses and (GWH) Midwives Led Supply of To Take Away Medication (TTA Medication) Incorporating the use of TTA Pack Policy	Trust-wide documents
48	National End of Life Care Programme (2011) NHS End of Life Care Strategy	www.nhsiq.nhs.uk
49	Patients and Visitors Car Parking	Intranet – Parking
50	Chaplaincy Team Pages and Documents	Intranet – Chaplaincy
51	Matching Cultural Needs Guideline	http://gwh-intranet/media/58860/4chp-gdl-003_fullmatchingculturalneedsbooklet_v2_0.pdf
52	Patient Access to PALS- Care of the Dying	Intranet – Pals
53	Staff Support Services	Intranet – Occupational Health
54	Mortuary Team	Intranet – Bereavement Services
55	2nd Edition of Care After Death: Registered Nurse Verification of Expected Adult Death (RNVoEAD) guidance, 2019.	www.endoflifecareambitions.org
56	The Notification of Deaths Regulations 2019	www.legislation.gov
57	Gender Recognition Act 2004	www.legislation.gov
58	Gender Recognition Panel	www.gov.uk/apply-gender-recognition-certificate
59	Isolation policy	Trust-wide documents

Ref. No.	Document Title	Document Location
60	Data Protection Act 1998	www.legislation.gov
61	Equality Act 2010	www.legislation.gov
62	Freedom of Information Act 2000	www.legislation.gov
63	Mental Health Act 1983	www.legislation.gov
64	NHS Code of Conduct	https://www.gov.uk
65	The Caldicott Principles	https://www.igt.hscic.gov.uk
66	Resuscitation policy	Trust wide documents
67	Health Records Department Operational Policy and Procedure	Trust Wide Documents
68	NICE NG 142	www.nice.org.uk/guidance/NG142
69	Booking Funerals for Babies and Foetus	QPulse (reference number MOR-S-061 2.0
70	Funeral option Form A booking	Trust Wide Documents
71	Taking babies home – bereavement 2020	Trust Wide Documents

5.2 Consultation Process

The following is a list of Consultees in formulating this document and the date that they approved the document:

Job Title / Department	Date Consultee Agreed Document Contents
Divisional Manager – Lead Nurse Cancer and End of Life	23rd January 2020
Swindon Community Health Services Employee – End of Life Facilitator	8th January 2020
End User (Clinical Nurse Specialist)	7th January 2020
End User (Advanced Clinical Practitioner)	9th January 2020
Head of Midwifery / Maternity bereavement lead	27th April 2020
Estates and Facilities Management	24th December 2019
Legal Services Manager	13th January 2020
Mortuary Manager	24th January 2020
In reach Specialist Palliative Care Nurse	2nd March 2020
Consultant in Palliative Medicine	20th January 2020
Resuscitation Committee Representative	2nd January 2020
Infection, Prevention and Control	4TH March 2020
Chaplain	20th January 2020
Organ Donation Lead	4th March 2020

6 Equality Impact Assessment

An Equality Impact Assessment (EIA) has been completed for this document and can be found at Appendix A.

Appendix A - STAGE 1: Initial Screening For Equality Impact Assessment

At this stage, the following questions need to be considered:			
1	What is the name of the policy, strategy or project? Care of the Dying and Deceased Policy – Trust wide		
2.	Briefly describe the aim of the policy, strategy, and project. What needs or duty is it designed to meet? This policy guides practice in the care of the dying patient and the care of the deceased patient, until such time as the deceased is released, most usually to a Funeral Director for burial or cremation. The policy also provides direction for the care of family, friends and carers of the patient.		
3.	Is there any evidence or reason to believe that the policy, strategy or project could have an adverse or negative impact on any of the nine protected characteristics (as per Appendix A)?		**No**
4.	Is there evidence or other reason to believe that anyone with one or more of the nine protected characteristics have different needs and experiences that this policy is likely to assist i.e. there might be a *relative* adverse effect on other groups?		**No**
5.	Has prior consultation taken place with organisations or groups of persons with one or more of the nine protected characteristics of which has indicated a pre-existing problem which this policy, strategy, service redesign or project is likely to address?		**No**

Signed by the manager undertaking the assessment	Helen Winter
Date completed	23rd December 2019
Job Title	Lead Cancer and End of Life Nurse

On completion of Stage 1 required if you have answered YES to one or more of questions 3, 4 and 5 above you need to complete a STAGE 2 - Full Equality Impact Assessment

Equality Impact Assessment

Are we Treating Everyone Equally?

Define the document. What is the document about? What outcomes are expected?

Consider if your document/proposal affects any persons (Patients, Employees, Carers, Visitors, Volunteers and Members) with protected characteristics? Back up your considerations by local or national data, service information, audits, complaints and compliments, Friends & Family Test results, Staff Survey, etc.

If an adverse impact is identified what can be done to change this? Are there any barriers? Focus on outcomes and improvements. Plan and create actions that will mitigate against any identified inequalities.

If the document upon assessment is identified as having a positive impact, how can this be shared to maximise the benefits universally?

Trust Equality and Diversity Objectives

Better health outcomes for all	Improved patient access & experience	Empowered engaged & included staff	Inclusive leadership at all levels

Our Vision

Working together with our partners in health and social care, we will deliver accessible, personalised and integrated services for local people whether at home, in the community or in hospital empowering people to lead independent and healthier lives.