



hospice^{UK}

Third Edition Care after Death

Guidance for staff responsible for care after death



National
Nurse Consultant Group
Palliative Care



Royal College
of Nursing



The Royal College of Pathologists
Pathology: the science behind the cure

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Foreword

We welcome readers across the four nations to this third edition of “Care After Death: guidance for staff responsible for care after death”.

The need to give personalised compassionate care does not end when the person has died but continues with care after death, including supporting friends and families into bereavement. We recognise that each death is a uniquely individual experience that reflects many aspects, such as the illness the person has experienced, their personal preferences if a preference could be expressed, and the social, cultural and religious aspects of the person’s life.

It is five years since the second edition of the guidance was published and this was planned to be updated in line with the development of clinical practice in this area of care. However, with the arrival of COVID-19 we have worked to ensure the guidance reflects the Coronavirus Act 2020, and Public Health England’s infection prevention and control advice. We have also sought to ensure joint working with all those involved in the care of the deceased (including faith, spiritual and cultural leaders), the provision of bereavement services, and funeral directors.

We thank all the individuals representing organisations who have contributed so willingly and helpfully to this guidance and we look forward to continuing to work with you to keep this guidance current. We would recommend that commissioners of education and services consider the importance of this guidance in ensuring compassionate care for those who have died and those who are bereaved. This is even more important as we face a future with COVID-19.

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Glossary

Bariatric – a person who requires non-standard equipment for moving, handling, and transferring due to their weight, physical size, shape or width.

Care after death – a term used in place of 'last offices' and more befitting of our multi-cultural society, reflecting the variety of tasks of care at the time of death, including supporting the family and those identified as being of most importance to the deceased.

Cold room – a room chilled to preserve the body, enabling key contacts/carers to spend extended amounts of time with the deceased. Usually located in hospices.

Coroner – independent judicial officer appointed by local authority in England, Wales or Northern Ireland to investigate the cause and circumstance of a death. This includes where there is reasonable suspicion the death was violent or unnatural, or cause of death is unknown, or the death occurred whilst in custody or state detention, or the deceased was not seen by a doctor in the 28 days before they died.

Debrief – post-incident opportunity to discuss the event with support from another colleague or as a team, which provides the chance to talk about the emotional impact of the incident.

Endotracheal (ET) tube – a catheter that is inserted into the trachea to establish and/or maintain the airway and ensure the adequate exchange of oxygen and carbon dioxide.

Family Liaison Officer – supports key contacts with help to obtain answers to their questions regarding the circumstances of a death in prison and provides a clear point of contact with the Ombudsman's office.

Fixion nail - a self-locking expandable intramedullary nail system requiring no screws or fixings, commonly used to pin together bones that have been fractured. Once in place, the nail is expanded to lock hydraulically. There is a risk of explosion during cremation.

Implantable cardiac defibrillator – a device indwelling in the chest that delivers a therapeutic dose of electrical energy to a heart affected by an arrhythmia.

Key contact – a person identified as the central individual to communicate with. This could be a power of attorney for health and welfare, or a court appointed deputy, or an Independent Mental Capacity Advocate (IMCA). It could also be, for example, a husband, wife, son, or daughter; or a significant other, for example, a partner, friend, or neighbour.

Medical Certificate of the Cause of Death (MCCD) – a document given to key contacts to enable them to register the death and obtain the death certificate.

Medical Examiner – Senior medical doctor trained in legal and clinical elements of the death certification process. Appointed in England or Wales to be independent of the case when undertaking scrutiny of the circumstances of death.

Medical Examiner Officer – Supports the medical examiner in their role in scrutinising the circumstances and causes of death, and is a point of contact and source of advice for relatives of the deceased, healthcare professionals and coroner and registration services

Nursing Associate (NA) – a member of the nursing team (Band 4) who undertakes a nursing support role, provides care and support to patients and service users. Regulated in England by the Nursing and Midwifery Council (NMC) since July 2018.

Personal care after death – the physical preparation of the deceased after death and before transfer to the mortuary or funeral director.

Personal Protective Equipment (PPE) – PPE is equipment that will protect the user against health or safety risks at work including risks posed by micro-organisms including COVID-19. It includes disposable gloves, apron and surgical masks, and for aerosol generating procedures (AGP), includes eye protection, gowns and shoe protection too. Worn correctly, and used in conjunction with other practices such as hand hygiene and risk assessment PPE reduces the risk of infection to the wearer.

Procurator Fiscal - appointed by the Crown Office & Procurator Fiscal Service (COPFS) in Scotland to investigate sudden, suspicious or unexplained deaths. Acts on instructions of the Lord Advocate who has the responsibility in Scotland to investigate any death which requires further explanation.

Registered Nurse (RN) – a Registered Nurse who holds a valid registration with the Nursing and Midwifery Council (NMC) on the relevant part of the register.

Schwartz rounds - provides a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare¹. The purpose is to understand the challenges and rewards of providing care, not for solving problems, instead for providing staff with support and role model compassion².

Suspicious death – a death where crime is suspected, where an accident has occurred, when death conflicts with the medical prognosis or when a death occurs because of trauma in a medical setting.

Introduction

1. This guidance is written to support the care of the deceased adult during the time of the COVID-19 pandemic. There is concurrent guidance available for the care of the deceased child^{3 4} and for the death of a baby⁵. Staff providing the care of the deceased in all settings, including in the deceased's own home, will require clear guidance, training, and PPE to protect them whilst providing the care⁶. This guidance has relevance to all four nations (England, Wales, Scotland, and Northern Ireland) and respects both individual law and the evolution of clinical practice⁷. However, there is recognition that each of the four nations may need to tailor the guidance.
2. The care we provide to people who have died has never been more important. With restricted visiting of the dying⁸ and viewing of the deceased⁹ in hospitals, hospices and care homes, those dear to the deceased will require additional reassurance that all has been done to care for the deceased, and to maintain their dignity. Staff will need to find new and resourceful ways to meet the information, emotional and practical needs of the immediately bereaved, and these are likely to be via the use of remote technology¹⁰. Staff will be expected to work in cross organisational teams to support individuals who have specific communication needs, for example, the needs of children, young people, those with dementia or learning difficulties. Individuals should also be aware of local resources available to support both communication and key contacts. National resources exist to support this aspect of care¹¹. We recognise that competence to care for the deceased and support of their key contacts must be included in all training programmes, and we actively encourage this.
3. We are aware that this guidance will be subject to changing national and local policy and may be adapted as the COVID-19 situation evolves. We will be keen to learn from those working in clinical practice and the bereaved, and hope to reflect this in future editions of this guidance. Please note, infection prevention and control evidence related to COVID-19 and person-centred care is rapidly evolving, and further updates may be made to this guidance in response to this. In this guidance, existing work has been referenced where possible.
4. The guidance relates to other concurrent work:
 - Previous edition of the Care after Death guidance¹²
 - Special Edition Registered Nurse Verification of Expected Adult Death¹³
 - Academy of Medical Royal Colleges: code of practice for the diagnosis and confirmation of death¹⁴

- Reforming the Coroner and Death Certification Service¹⁵
 - National Medical Examiners good practice guidelines (England and Wales)¹⁶
 - Death Certification Review Service (Scotland)¹⁷
 - Leadership Alliance for the Care of Dying People – One chance to get it right¹⁸
 - Bereaved families’ experiences of organ and tissue donation, and perceived influences on their decision-making¹⁹
 - COVID-19 related infection prevention and control²⁰
 - Care of the deceased in COVID-19²¹
5. We note that even prior to the COVID-19 pandemic, deaths were increasing in number. There was a trend for more people dying outside the acute Trust, in their own home, (e.g. in care homes, private residences) and in institutions, (e.g. hospices, prisons and mental health settings). Whilst the effect of COVID-19 on the place of death is still to be evaluated, there is no doubt that staff in all care settings need to be familiar with this aspect of care.
 6. In this document the term ‘key contact’ is used and represents family and those people identified as being of most importance to the dying/deceased person. The shortened version is used for brevity and ease of reading. In line with the Mental Capacity Act 2005, the legal role given to people holding a Lasting Power of Attorney (LPA) is recognised. With respect to organ and tissue donation, medical practitioners should make every effort to establish the decision of the potential donor during his or her lifetime and support the fulfilment of this decision.
 7. Organ donation in the UK currently only occurs in intensive care units and to a much lesser extent, in emergency departments. In 2019 there were approximately 1600 organ donations and 3000 tissue donations compared to approximately 500,000 deaths²². In England and Wales, adults who have not opted in or out of donation can have their consent deemed^{23 24}. At the time of publication, deemed consent does not apply in Northern Ireland²⁵ or Scotland²⁶. With post-mortem examination, consent needs to be sought, unless the post-mortem examination is authorised by the coroner in England, Northern Ireland and Wales, and procurator fiscal in Scotland, where consent is not required²⁷.
 8. The term ‘deceased’ is used to represent the deceased person, and ‘viewing’ is used to represent the visiting of the deceased person by their key contacts. The shortened version is used only for brevity and ease of reading. The importance of personalising care is recognised. It is also noted that the same words can mean different things to professionals and key contacts. We urge professionals to use language that is meaningful to key

contacts.

9. It is also recognised that medical colleagues use the term 'confirmation of death'²⁸ rather than 'verification of death', as we have used in this document and related guidance²⁹. We also note that our medical colleagues find the term 'confirmation' helpful when discussing the recognition of death with families particularly in the context of organ donation³⁰. We look forward to working with our medical and wider multi-disciplinary colleagues as discussed³¹ to agree both the processes for verifying death in all clinical circumstance and the terminology. We note that Scotland has already moved to the term 'confirmation of death'³².
10. The flow diagram in Appendix 1 is intended as both a summary and for teaching purposes. It shows that care after death (including personal care after death) is the first stage of a process that involves a range of professional groups. This process of care leads ultimately to cremation, burial, or repatriation of the deceased. Professionals involved in care after death include doctors, nurses, healthcare assistants, mortuary staff, hospital porters, ambulance staff, bereavement officers, specialist liaison workers, for example, those who support individuals with learning disabilities and their key contacts, police, social care staff, funeral directors, pathologists, coroners, procurators fiscal, healthcare chaplains and faith leaders. Coordinated working between these individuals and organisations is vital if the process is to run smoothly. The family, and those people identified as being of most importance to the deceased person, are the only people who navigate this entire process. We urge professionals to be both mindful of all steps in the process, and their part in the coordination of care to benefit the bereaved experience of care after death.
11. When a person dies and they have no known family or they are unclaimed by their relatives and/or they have no remaining estate to pay for a funeral, they are entitled to a public health funeral of burial or cremation. In the UK, every local authority has a statutory duty to provide appropriate funeral arrangements³³. The local authority will endeavor to contact the person's closest relatives through any contact details or paperwork left by the deceased. There is also a nationwide tracing service and the Salvation Army can also attempt to identify lost relatives³⁴.
12. Whilst care after death in the community is usually undertaken by key contacts, it is important for staff to understand the role of community nursing and palliative care teams in supporting key contacts during this time, as appropriate. Some cultures may have people from their local faith community attend and help wash and prepare the deceased. Some key contacts may utilise the services of a death doula³⁵, a non-medical professional who makes themselves

available to the key contacts for support before, during and after a person's death. These people must be aware of the Public Health advice on infection prevention and control, and the associated risks of any contact with the deceased who is suspected of, or confirmed with, COVID-19, and of self-isolation protocols in line with current national guidelines on isolation.

13. Care after death includes:

- Respecting the spiritual, religious, and cultural wishes of the deceased and their key contacts, where possible, should be taken into consideration and ensuring legal obligations are met
- Ensuring timely verification of death
- Preparing the deceased for viewing, where appropriate, and supporting the key contacts
- Offering key contacts who are present the opportunity to participate in the process and supporting them to do so
- Facilitating people's wishes for organ and tissue donation where it is possible. Organ donation is only possible from intensive care units and emergency departments and can only be organised before the person dies, however whole-body donation to science and tissue donation is possible after death³⁶. Cornea donation can happen up to 24 hours after death and can take place in hospitals, hospices, and funeral homes³⁷.
- Ensuring, where relevant, that key contacts are informed about the need for post-mortem examination and given information about possible organ and tissue retention and disposal methods
- Preparing the deceased for transfer to the mortuary or the funeral director's premises
- Ensuring that the privacy, dignity, and respect of the deceased is maintained at all times
- Ensuring that the health and safety of everyone who comes into contact with the deceased is protected
- Returning the deceased's personal possessions to their key contacts
- Use of appropriate PPE in line with Public Health guidance.

Legal aspects

14. In this document, the term 'coroner' is used to represent the role of the coroner in England, Wales and Northern Ireland, and the procurator fiscal in Scotland. The shortened version is used only for brevity and ease of reading. It is essential to comply with legal requirements. See Appendix 2 for deaths that require an investigation by the coroner. It is useful to note that 40 per cent of all deaths in 2019 were reported to the coroner in England and Wales, a decrease of four per cent since 2018 and the lowest number since 1998³⁸.

An estimated 11,000 deaths are reported to the Crown Office and Procurator Fiscal Service (COPFS) in Scotland every year³⁹ which, for 2019, equates to approximately 19 per cent of all deaths in Scotland⁴⁰. In Northern Ireland there were 15,758 deaths in 2019 of which 28 per cent were referred to the coroner's office⁴¹.

15. All staff caring for the deceased need to ensure they are familiar with deaths that require such a referral, as this will facilitate the correct personal care and enable staff to prepare the key contacts both for a potential delay in the processing of the MCCD and the possibility of a post-mortem examination.
16. When there is a death of a person detained under the Mental Health Act or in custody, it must be reported to the coroner and will be subject to a coroner's inquest, or procurator's fiscal investigation if in Scotland. Such deaths will always be investigated by the coroner and police, and for those in custody by the Police Prisons Officer. A specialist forensic post-mortem examination is likely to be undertaken. Where the person was detained, or was liable to be detained, under the Mental Health Act at the time of death, the provider must notify the Care Quality Commission under Regulation 17 of the Health and Social Care Act 2008⁴². The team responsible for the deceased's care usually completes forms. For all expected deaths in prisons, the Prison and Probation Ombudsman will investigate the death and the findings will be shared with the coroner prior to the inquest.
17. Guidance is available on the care of vulnerable adults⁴³. If a safeguarding issue becomes apparent after death, clearly documented concerns should be raised with social services, the police, and the coroner in line with local processes and guidance.
18. Where the person had an illness that requires referral to the coroner, (e.g. mesothelioma) but dying was anticipated, it is not necessary to involve the police. Referral to the coroner does not automatically require a post-mortem, but a post-mortem can be useful to assess the extent of the disease or other factors contributing to death.
19. In the emergency period any doctor can complete the MCCD when the previous attending doctor is unable to do so, for example, through ill health. The deceased must have been seen in person or by video in the previous 28 days prior to death or in person after death.⁴⁴. They also require access to the relevant medical records and results of investigations. The consultant in charge of the care remains ultimately responsible for the deceased whilst under hospital/hospice care, and the general practitioner (GP) practice in primary care.
20. Where a doctor has not attended the deceased within 28 days of the death (including via video/visual consultation) or seen them after death in person, the MCCD may still be

completed, however, the death must be referred to the coroner⁴⁵.

21. From Spring 2021 it is possible that it will be statutory (in England and Wales) for all non-coronial deaths to be scrutinised through the medical examiner system. This will involve scrutiny of the medical notes by a medical examiner to agree the proposed cause of death through discussion with the certifying doctor, discussion of the cause of death with the key contact, and to establish if they have any concerns prior to the MCCD being released. In Scotland, the Certification of Death Act (2011) ensured a national review system for checks on MCCD accuracy⁴⁶.
22. The certifying medical practitioner has overall responsibility for identifying and communicating the presence of any implanted devices or radioactive substances. They are also responsible for identifying the appropriate person to deactivate and remove implants, to liaise with the appropriate medical physics department regarding radioactive treatments and to advise mortuary staff and funeral directors. For information required by mortuary staff and funeral directors see Appendix 3. Please note, all Government guidance has been updated in light of COVID-19.
23. The Coronavirus Act 2020 has amended the Cremation (England and Wales) Regulations 2008 and Cremation Form 5 is no longer required⁴⁷. The completion of the Cremation Confirmatory Certificate (Form C) is no longer required for cremation in Northern Ireland, and modifications have been made to Cremation Form B⁴⁸. In Scotland, the Certificate of Registration of Death (Form 14) is required for both cremation and burial and is issued by the Register Office once the death has been registered with the MCCD (Form 11)⁴⁹. All four nations have updated their registration of death processes to support electronic/remote registration⁵⁰.

Care after death

Responsibility for care after death

24. If present at the time of death, the registered nurse, doctor, ambulance clinician or appropriately trained registered professional⁵¹ needs to record the time, who was present, the nature of the death, and to record their own name and contact details in the nursing, medical or ambulance documentation.
25. They will need to record details of any relevant devices such as pacemakers and intrathecal devices, or Fixion nails. If the deceased person has a cardiac defibrillator which has not yet been deactivated⁵², local policy should be followed, and steps taken to ensure it is deactivated

before the person is moved to the mortuary or funeral director. None of these devices prevent cremation but they will need to be removed prior to cremation by appropriately trained mortuary staff or funeral director⁵³.

26. The person present needs to be aware of any pertinent details in the deceased's Advance Care Plan that relates to care after death, and to act on this, as usually these wishes are time critical. Such examples are:

- Spiritual, religious, and cultural preferences especially related to urgent release for burial or cremation⁵⁴. Where available, advice from the spiritual care or chaplaincy department can be sought to support with the wishes of the deceased and their key contacts.
- Wishes for repatriation: It should be noted that during this time of COVID-19 repatriation can be challenging. The local funeral director will advise and address the specific feasibilities⁵⁵
- Wishes for whole body donation: It is suggested that during this time of COVID-19 donors should have an alternative funeral plan as donations are unlikely to be accepted⁵⁶
- Wishes for organ and tissue donation: Donations are still being accepted but not from those who are COVID-19 positive or suspected⁵⁷

Referral to the coroner

27. For deaths that require referral to the coroner, please see Appendix 2. Please note that COVID-19 is a notifiable disease but not reportable to the coroner, further information of notification of infectious diseases is also found in Appendix 2. The following details may be required when reporting a death to the coroner:

- The professional's telephone contact number
- The deceased's name, address, date of birth
- GP details
- Key contact name(s), contact details and relationship to the deceased
- Date and time of death
- Details of the person who verified death
- Details of what happened leading up to the death, including who was present at the death

28. If the case is being referred to the coroner because the cause of death is unknown or the death is unexpected, seek advice before moving or removing anything that might be relevant to establishing the cause of death. It is anticipated that mental health and prison services

would have robust policies on unexpected death as all deaths would be referred to the coroner and would need police attendance at an undisturbed scene of death. If key contacts have any concerns about the death these should also be documented (and in this instance it is important to maintain the deceased body and environment and seek advice from the coroner).

Verification

29. When death occurs inform the medical practitioner primarily responsible for the person's care. In acute trusts it is helpful if verification occurs within one hour. In other settings it is helpful if it takes place within four hours. Verification of death needs to be completed by a doctor⁵⁸, appropriately registered nurse⁵⁹ or ambulance clinician⁶⁰ before the deceased is transferred from the care setting. For the emergency period of COVID-19 there are guidelines that confirm the above, and processes for the remote verification of death in extreme circumstances where no other trained professional can undertake this aspect of clinical care^{61 62 63 64}. In Scotland it is recognised that any registered professional can undertake this act of care with appropriate training⁶⁵.
30. It is important to note that due to Article 2 of the Human Rights Act 1988⁶⁶, and subsequent inquests, prisons are exempt from verification of death by registered nurses and other healthcare professionals. However, temporary local agreement may be reached with the Senior Coroner, Her Majesty's Prison and Probation Service (HMPPS) and the Prison and Probation Ombudsman where assurance is given, and robust training and governance is in place that is consistent with national verification processes in community settings⁶⁷.

Issuing of the Medical Certificate of the Cause of Death (MCCD)

31. **Verification** of death is the process of **confirming the fact of death**. It is different from certification of the cause of death. **Certification** is the process of **issuing a MCCD**, and this is the responsibility of a medical practitioner⁶⁸. It is good practice to ensure that, when the death need not be referred to the coroner, the MCCD is ideally issued within one working day so burial or cremation arrangements are not unduly delayed. At the present time, e-mailing of the MCCD to the Register Office is possible⁶⁹.
32. For hospitals in England and Wales where a medical examiner is appointed, there may be a delay of around half a day before the MCCD is issued⁷⁰ due to review and scrutiny of the proposed cause of death to ensure overall accuracy of the MCCD⁷¹.

Issuing of the Death Certificate (Certified copy of an entry of death)

33. The key contact notifies the registrar by telephone or email to begin the death registration

process. The scope of individuals entitled to be the key contact has been extended to include funeral directors on behalf of the family, if necessary. An electronic copy of the certificate for burial or cremation (known as the disposal form), can be shared with the funeral directors. The death certificate (certified copy of the entry of death) can be emailed to the key contact and a hard copy will be posted in due course⁷². If there is no access to email or internet an alternative method should be explored. The police can be of assistance in locating key contacts and breaking significant news if the care organisation are unaware of who this is.

Communication – with key contacts

34. During COVID-19 there are specific visiting guidelines for those who are dying in hospital, hospice and care home settings⁷³. It is essential that if the key contacts are not present at the time of death there is sensitive and honest communication with the key contact and that this has previously been agreed^{74 75}. During COVID-19, communication will often have to occur via telephone or virtually. This is extremely difficult for both the key contact to receive bad news and the health or social care professional delivering it. The key contact must be prepared for this call if possible and great care should be taken to ensure information is conveyed in a sensitive manner. For the person dying at home with care, in line with national guidance⁷⁶, it is essential that the health care professional who receives the call from the carer informing them of the death offers emotional and practical support to the caller at this time, and the GP practice supports the key contact after death⁷⁷.
35. It is vital that when the death is expected, those with additional needs, e.g. interpreter or assistance to answer the phone, are thought about and strategies put in place for the call. In this time of COVID-19, specific guidance has been developed by Health Education England (HEE) to help clinicians break bad news by phone⁷⁸. Additional resources for bereaved people with learning difficulties have been developed by Beyond Words⁷⁹. If children are involved, adults may require guidance on how best to convey the news to children⁸⁰.
36. After the death has been verified, always provide the key contact with information on the processes to be followed after a death. In hospital this would usually be to call the bereavement office so that details regarding whether the death is to be referred to the coroner, or what is to be written on the Medical Certificate of the Cause of Death, can be discussed. Where a hospital does not have a bereavement office, and in hospices and care homes, the key contact will be instructed to call the ward or care home manager, respectively. In the community, including where the person has died in their own home, the key contact would be instructed to call the GP on the next working day. The bereavement office, ward manager, hospice, care home or GP

surgery will be aware of bereavement agencies available to support key contacts in their local area and provide help in a supportive way. Please note, procedures for collecting the MCCD have changed with COVID-19 and it is now emailed directly to the Register Office.

Communication – with professionals

37. It is vital that processes are in place to protect confidentiality, and which continues after death. However, this does not prevent the use of sensible rules to safeguard the health and safety of all those who may care for the deceased⁸¹.
38. There needs to be clear communication regarding infection risk and the presence of implantable devices to mortuary staff and funeral directors. If the deceased had a notifiable infection there is detailed guidance available, including on infections requiring the use of a body bag⁸², and whilst it is not mandated for those who died of COVID-19, it is recommended in many circumstances⁸³. All those who previously cared for the deceased need to be notified of the death.

Responsibility for personal care after death

39. In NHS hospitals, hospices, and private nursing homes the personal care after death is the responsibility of a registered nurse, although this, and the packing of the deceased's property, may be delegated to a suitably trained healthcare support worker wearing appropriate PPE. The registered nurse is responsible for selecting and wearing PPE⁸⁴ correctly, identifying the deceased, being aware of when to refer to the coroner and communicating accurately with the mortuary or funeral director (in line with local policy). Public Health COVID-19 advice is that if a member of staff does need to provide care for the deceased, this should be kept to a minimum and correct PPE should be used.⁸⁵
40. In care homes without a registered nurse, the home manager is responsible for ensuring that professional carers are trained appropriately and that they have the relevant competence and PPE for the role. In prisons, personal care after death is the responsibility of the prison service (not prison healthcare), and all property is left for the family liaison officer to return to the key contact.
41. It is essential to update and organise the medical and nursing records⁸⁶ as quickly as possible so they are available to the bereavement team and other interested professionals, such as the medical examiner and pathologists.

Time requirements and viewing

42. The personal care after death needs to be carried out within two to four hours of the person

dying, to preserve their appearance, condition and dignity. Tasks such as laying the deceased flat (while supporting the head with a pillow) and preparing the deceased need to be completed as soon as possible within this time. It is important to note that the body's core temperature will take time to lower and therefore refrigeration within four to six hours of death is optimum⁸⁷.

43. Prior to COVID-19 all key contacts were usually offered the opportunity to view the deceased, and there is evidence that, even in traumatic circumstances, key contacts found this helpful⁸⁸. In COVID-19, viewing may not be permitted in acute hospitals in order to reduce infection risk, and later mortuary viewing may also not be possible depending on local arrangements⁸⁹. However, it should be noted that viewing is permitted when overseen by those who are experienced in the care of the deceased⁹⁰ and some hospices are able to facilitate viewings.
44. The key contact will be required to follow Infection Prevention and Control guidelines and the use of PPE. It is also possible for supported remote bereavement visits using visual digital technology⁹¹. Some hospitals have bereavement services that are familiar with the care needed to undertake this, e.g. Northern Care Alliance, and can be contacted for further information.
45. Key contacts should be guided on how to support children and young people who are also bereaved⁹².

Environment

46. The deceased needs to be cared for with dignity. In the past it had been suggested that such factors helping to contribute to this were a single room that had a feeling of homeliness, informal gathering spaces where key contacts can meet and confer, guest rooms for key contacts to stay and appropriate areas for viewing⁹³. Now, with visiting restricted in the dying period, and viewing of the deceased not generally permitted, it is helpful if the surrounding environment still conveys this respect, e.g. the room is tidy and organised as it would be if key contacts were present. It is important that the deceased's spiritual, religious and cultural wishes are attended to⁹⁴ and that the attitudes and behaviour of staff are respectful and reassuring of the care provided to the deceased; both to bereaved carers by phone (even if they are not physically present), and also to other members of staff, e.g. porters.
47. Residents in communal settings, such as care homes and prisons, have often built significant relationships with other residents and members of staff and they will need to be informed of the death. Consider how to address their need to know of the death within the boundaries of

confidentiality. If the person has died in an environment where other people may be distressed by the death then inform them sensitively, using relevant resources as appropriate, (e.g. those produced to assist those with learning disabilities⁹⁵), that the person has died. Be careful not to provide information about the cause and reason for death. Consider signposting to bereavement support in these settings.

Mementoes

48. Mementoes or keepsakes, (for example, locks of hair, handprints, etc.) may be offered and taken at the time of care after death. They should be taken on the ward or place of death and placed in a sealed bag, which must not be opened by the key contacts for at least 72 hours⁹⁶. Please note, where trained Anatomical Pathology Technologists (APT) are available, this may be facilitated in the mortuary.

Packing property

49. In the period of COVID-19 it is even more important that the deceased's property is cared for in line with infection control standards and returned safely to the key contact with advice to prevent cross infection⁹⁷. Using PPE, pack personal property, showing consideration for the feelings of those receiving it and in line with local policy. In the time of COVID-19, wipe down all 'hard' valuable items e.g. bank / credit cards / mobile phones etc. as per IPC guidelines⁹⁸. Once dry, they should be placed in a Valuables property envelope, and placed inside a clear plastic bag, labelled, and sealed. Non-laundered valuable items e.g. a cheque book must be placed in a separate Valuables property envelope and labelled with "Do not unseal until: DD/MM/YY" which will be at least 72 hours from the sealed date.

50. Clothes that are contaminated or soiled should ideally, with key contact consent, be disposed of but can be packed into property bags and stored in a clean area to return to the key contact if desired. The key contact collecting the property must be advised to wash hands carefully after handling any possessions initially. Place all clothing directly into a washing machine with a detergent wash (either bio or non-bio), at 60 degrees centigrade. Wipe down any hard items with warm soapy water and leave to dry or, if they are dishwasher safe, place in the dishwasher. For any sealed bag with an opening date: place it in a secure place and do not open until the stated date, (at least 72 hours after when it was sealed).

51. Record all aspects of care after death in locally relevant documentation and identify the professionals involved.

Transfer of the deceased from the place of death to the mortuary or funeral director

52. The privacy and dignity of the deceased on transfer from the place of death is paramount.

Each organisation involved is responsible for ensuring that the procedures adopted to transfer bodies, including those who are bariatric, respecting the values of personal dignity, and these are incorporated in the design of the concealment trolley and the way the deceased is covered. The deceased may be transferred in a bed with an appropriate cover or concealment trolley. It is not recommended to transfer the deceased in ways that might make them appear as alive to others, e.g. with an oxygen mask in situ. In community settings a funeral director will usually undertake transfer, although case law has determined that the deceased's executor (generally a key contact) may also do this⁹⁹.

Cleaning the space

53. The process of environmental decontamination/cleaning should happen soon after the deceased is moved from the area. Special attention should be paid to frequently touched surfaces, e.g. medical equipment¹⁰⁰, door/toilet handles and locker tops, call bells, over bed tables and bed rails. They should be decontaminated as per IPC guidance¹⁰¹.

Acknowledgement of the emotional impact

54. During these extraordinary times it is important to address any staff anxieties or concerns as a result of managing the deceased. It may be that staff involved in delivering bad news, managing property, and caring for the deceased require additional opportunities, such as a debrief, to explore emerging feelings in a safe, structured manner. Attention to, and being sensitive about, the individual's needs demonstrates a caring approach and can be instrumental in averting any future crises¹⁰².

Personal care after death

Personal Protective Equipment (PPE)

55. To maintain the safety of those carrying out the personal care after death, these guidelines should be used in conjunction with the local Infection Prevention and Control policy and applied to all adult deaths irrespective of any COVID-19 status (i.e. not suspected, suspected, confirmed)¹⁰³. Please note, local guidance should be referred to regarding the requirement of high-level or low-level PPE.

56. Equipment to be considered

It is essential to be well prepared before carrying out the personal care of the deceased. Thoughtful consideration should be given for the equipment needed to undertake the procedure with respect and dignity for the person, ensuring all equipment is gathered prior to

undertaking the personal care of the deceased.

- Personal Protective Equipment
- Clean bed sheets
- Shroud or clean clothing for the deceased
- Soap and towels (or equivalent)
- Mouthcare equipment
- Brush or Comb
- Contenance Pads
- Dressings
- Tape
- Name bands
- Mortuary label (or equivalent)
- Valuables envelopes and sealing plastic bags

Deaths requiring coroner involvement

57. Where the death has been referred to the coroner, there will be some parts of the personal care after death that cannot be carried out, and this will depend on the reason for referral.

58. **Forensic investigation referral:** When the death is being referred to the coroner as the circumstances surrounding the death give rise to suspicion, there should be minimal contact with the body. Leave all drains, tubes, intravenous (IV) cannulae and lines in situ and IV infusions clamped but intact (this includes syringes with controlled drugs from syringe pumps). Leave any urinary catheter in situ with the bag and contents. Do not wash the body or begin mouth care in case this destroys evidence. Continue using universal infection control measures to protect people and the scene from contamination. Mortuary staff can provide guidance on this at the time of death. Ensure the cardiac defibrillator is deactivated.

59. **Cause of death referral:** When the death is being referred to the coroner to investigate the cause of death, but where there are no suspicious circumstances, then leave IV cannulae and lines in situ and catheters spigotted. Infusions and medicines being administered prior to death via pumps can be taken down and disposed of, according to local policy, but must be recorded in nursing and medical documentation. The contents of catheter bags can be discarded according to local policy. Leave any ET tube in situ as cutting the tube deflates the balloon holding the tube in position. The increased mobility may enable the ET tube to become displaced during the handling of the body and any

possibility of movement will lead to confusion should the coroner need to investigate this through post-mortem examination. Personal care can then be given as for deaths without coroner involvement. Ensure the cardiac defibrillator is deactivated.

Deaths without coroner involvement

60. Particularly in the home setting, some key contacts/carers may wish to assist with the personal care. Prepare them sensitively for changes to the body after death and be aware of manual handling and infection control issues. Ensure the cardiac defibrillator is deactivated.

61. Carry out all personal care of the deceased after death in accordance with safe manual handling guidance. It is best practice to do this with two people, one of whom needs to be a registered nurse, nursing associate, or a suitably trained person.

Procedure: personal care after death

62. It is important to note that during this procedure, consideration must always be given to any care related to the deceased’s spiritual, religious, and cultural needs.

63. Where COVID-19 is either suspected or confirmed, special care must be taken in relation to moving the deceased or removing any aerosol generating equipment from the deceased*.

ACTION	RATIONALE
<p>Adopt standard infection control precautions:</p> <p>Perform hand hygiene prior to donning selected PPE (see Appendix 4).</p>	<p>To ensure protection of the person carrying out the personal care from cross-contamination.</p>
<p>Lay the deceased on their back, adhering to manual handling policy; straighten their limbs, (if possible) with their arms lying by their sides.</p> <p>Ensure the person is appropriately covered with a clean sheet.</p> <p>If it is not possible to lay the deceased flat due to a medical condition, or rigor mortis, then seek guidance from the mortuary staff or funeral director.</p> <p>The mortuary staff and porters, or funeral directors (depending on place of death), should be alerted if the deceased is bariatric</p>	<p>To maintain the deceased’s dignity, ensure the deceased is lying straight prior to rigor mortis which occurs 2-6 hours after death.</p> <p>To maintain the deceased’s privacy and dignity.</p> <p>Alternative transportation may be required</p> <p>To ensure they have the appropriate equipment to transfer the deceased.</p>

ACTION	RATIONALE
Leave one pillow under the head	Supports alignment and helps the mouth stay closed.
<p>Close the eyes by applying light pressure for 30 seconds. This also applies when the deceased is donating their corneas.</p> <p>If the eyelids fail to close, then explain sensitively to the key contact/carers that the funeral director will resolve the issue.</p> <p>Do not apply tape over the eyelids.</p>	<p>To maintain their dignity, and for tissue protection in case of corneal donation</p> <p>Tape can mark the skin</p>
<p>Tidy the hair as soon as possible after death and arrange into the preferred style, (if known)</p> <p>A lock of hair as a memento may be offered. Place in a plastic bag and seal.</p>	<p>To guide the funeral director for final presentation</p> <p>To remain sealed for at least 72 hours to eliminate the risk of cross infection.</p>
<p>Clean the mouth to remove debris and secretions. * <i>Caution where COVID-19 is suspected or confirmed</i></p> <p>Clean and replace dentures as soon as possible after death.</p> <p>If they cannot be replaced send them with the deceased in a clearly identified receptacle.</p>	<p>For hygienic reasons</p> <p>To retain the facial shape of the deceased</p> <p>The funeral director will likely be able to secure in place</p>
<p>Where the jaw may need additional support, place a small pillow or rolled up towel under the chin.</p> <p>Do not bind the jaw with bandages. Some people have jaws that will never close; notify the mortuary staff or funeral director if this is the case</p>	<p>To close the mouth maintaining the facial shape for the deceased's dignity</p> <p>This will leave pressure marks on the face</p>
<p>Do not shave the deceased person. Usually the funeral director will do this.</p> <p>Be aware that some faith groups prohibit shaving.</p>	<p>Shaving a deceased person when they are still warm can cause bruising and marking which only appears days later.</p>
<p>Drain the bladder by gently pressing on the lower abdomen for 30 seconds and collecting the urine in a receiver, or catheter bag where a urinary catheter is in situ.</p>	<p>The body can continue to excrete fluids after death</p>
<p>Remove catheter bag and spigot any urinary catheters, (if still in situ).</p>	<p>To prevent fluid leakage.</p>

ACTION	RATIONALE
<p>Pads and pants can be used to absorb any leakage of fluid from the urethra, vagina or rectum. Do not pack.</p>	
<p>Clamp any drains, and intravenous or subcutaneous lines still in situ. Remove any connected infusion lines and infusions.</p>	<p>To prevent leakage</p>
<p>Contain leakages from the oral cavity or tracheostomy sites by suctioning and positioning. Suction and spigot nasogastric tubes. * <i>Caution where COVID-19 is suspected or confirmed as this is an aerosol generating procedure and appropriate PPE should be worn</i></p> <p>Cover exuding wounds or unhealed surgical incisions with a clean, absorbent dressing and secure with an occlusive dressing.</p> <p>Leave stitches and clips intact. Cover stomas with a clean bag.</p> <p>If the body is leaking profusely then take time, pre-transfer to the mortuary or funeral home, to address the problem.</p> <p>Ensure mortuary staff and funeral directors are informed of any potential for profuse leakage.</p>	<p>Avoid strongly adhesive tape on any occlusive dressing as this can be difficult to remove at the funeral directors and can leave a permanent mark</p> <p>To enable appropriate positioning of the deceased in the refrigeration areas</p>
<p>Wash the deceased, unless requested not to do so for spiritual/religious/cultural reasons, or the death is being referred to the coroner.</p> <p>Key contacts and/or carers may wish to assist with washing, and they may have been caring for the person prior to death. They must be aware of the risks of potential COVID-19 infection and, depending on the place of death, wear PPE as instructed.</p> <p>When moving the deceased air can be released; this should not be mistaken for breathing. * <i>Caution where COVID-19 is suspected or confirmed</i></p> <p>Further soiling may also occur.</p>	<p>For hygienic and aesthetic reasons. Respecting the spiritual, religious, and cultural preferences of the deceased.</p> <p>Sensitively share this information with the key contact or carer assisting with the personal care.</p>
<p>Dress the deceased appropriately before they go to the mortuary or funeral directors. This may be in a shroud or</p>	<p>To ensure the deceased's dignity is always preserved</p>

ACTION	RATIONALE
<p>personal clothing depending on the place of death, local policy or wishes of the key contacts.</p> <p>Key contacts and/or carers may want to dress the deceased. As above, when moving the deceased, air can be released; this should not be mistaken for breathing. Further soiling may also occur.</p> <p>The deceased should never go to the mortuary naked or be released naked to a funeral director from an organisation without a mortuary on site.</p>	<p>Sensitively share this information with the key contact or carer dressing the deceased.</p> <p>To maintain their dignity and privacy</p>
<p>Remove jewellery in the presence of another member of staff, unless specifically requested by the key contact to do otherwise, and document this according to local policy.</p> <p>Any jewellery removed must be wiped down with disinfectant wipe, placed in a valuable's property envelope, and sealed in a clear plastic bag. Provide a signature if any jewellery is removed.</p> <p>Secure any rings left on with minimal tape, documented according to local policy.</p> <p>Be aware of spiritual/religious/cultural ornaments that need to remain with the deceased. Ensure these are clearly documented.</p>	<p>To meet legal requirements and key contact's wishes</p> <p>To remove the risk of infection from contamination of the jewellery, and to remain sealed for at least 72 hours to eliminate the risk of cross infection.</p> <p>To reduce the risk of the ring(s) falling off.</p> <p>To respect the wishes of the deceased /key contact. Refer to their Advance Care Plan if in place.</p>
<p>Clearly identify the deceased with a name band on their wrist or ankle.</p> <p>As a minimum this needs to identify their name, date of birth, address, (and ward if a hospital in-patient) and ideally their NHS number.</p> <p>In the community setting, it is recognised that identification of the deceased is likely to be via a verification of death form.</p> <p>Do not use a toe tag.</p>	<p>To ensure correct identification of the deceased.</p>
<p>With a clean sheet placed under the deceased, wrap the body ensuring face and feet are covered and all limbs are held securely in place.</p>	<p>To protect the condition of the deceased and avoid damage during transfer of the deceased.</p>

ACTION	RATIONALE
<p>Use tape to secure the sheet in place.</p> <p>Do not bind the sheet or tape too tightly.</p>	<p>This can cause abrasions and/or disfigurement.</p>
<p>Complete documentation such as the 'notification of death' card and attach to the outside of the sheet of the deceased.</p>	<p>To ensure correct identification of the deceased</p>
<p>If there is significant leakage, place the deceased into a body bag.</p> <p>A body bag may also be required for some infectious notifiable diseases.</p> <p>A body bag is not routinely required for COVID-19</p>	<p>To prevent risk of contamination to those handling the body from leakage of fluids.</p>
<p>If the body continues to leak, place it on absorbent pads in a body bag and advise the mortuary or funeral director.</p>	<p>To prevent risk of contamination to those handling the body from increased leakage of fluids.</p>
<p>Request transfer of the deceased:</p> <p>In hospital settings it is best practice for porters to take the deceased to the mortuary within one hour of request, to be refrigerated within four hours of death.</p> <p>In community settings such as community hospitals, care homes and hospices, local arrangements should be made with the funeral director for collection of the deceased, ideally within 4 hours of death.</p> <p>In the deceased's own home, local arrangements can be made by the key contacts. Support, guidance, and signposting with this may be needed depending on the circumstances.</p>	<p>Prevents distress to surrounding patients, and (if requested) ensures tissue donation can take place</p> <p>Optimum time for refrigeration of the deceased is 4-6 hours.</p> <p>To ensure arrangements are in place for the transfer of the deceased to the funeral director or equivalent.</p>
<p>Using PPE, pack the property of the deceased as per local policy and in line with infection prevention and control.</p> <p>Any hard valuables, such as bank cards and mobile phones, must be wiped down with disinfectant wipes, allowed to dry, placed in a Valuables property envelope, and sealed in a clear plastic bag. Provide a signature for any valuables.</p> <p>Ensure all property is packed with care and labelled with the deceased's details.</p>	<p>To reduce the risk of infection from contamination of the hard valuables, and to remain sealed for at least 72 hours to eliminate the risk of cross infection.</p>

ACTION	RATIONALE
<p>In the clinical setting, list all property in the property book (or equivalent).</p>	<p>Ensures a record of all property is available when handing over to the key contacts.</p>
<p>Clean the area as soon as possible after the deceased has been transferred.</p> <p>Soiled/infected linen need to be disposed of in line with COVID-19 infection control guidance</p> <p>Ensure contaminated gloves are disposed of and clean gloves are donned to carry out cleaning of the room. Perform hand hygiene between glove changes.</p> <p>In the clinical setting, follow local infection control policy for cleaning the area. Pay special attention to frequently touched surfaces such as door handles, bed frames, table tops etc. Follow local IPC policy for decontamination.</p> <p>In the home of the deceased, advise the key contact of cleaning needs, for example washing linen and clothing at 60 degrees.</p> <p>Where a hospital bed or any other loaned equipment is in the home, follow local policy on advice for decontamination and return of the equipment.</p>	<p>To eliminate potential spread of infection</p> <p>To eliminate cross-infection from contaminated gloves.</p>
<p>Remove PPE in the correct order (see Appendix 4) and dispose of as per local policy. Perform hand hygiene.</p>	<p>To eliminate cross-contamination</p>
<p>Document in the clinical notes that personal care after death has been carried out, and the property, including any valuables, has been listed, and the conversation with and advice given to the key contact(s) of the deceased.</p>	<p>To ensure a clear record of events is recorded</p>
<p>Give opportunity for staff debrief. Be sensitive to own and others experience of caring for the deceased prior to dying and/or at the time of death. Further support or reflection may be needed.</p>	<p>Allows for anxieties and concerns to be addressed at the time, giving recognition and validity to the feelings, and may avert potential of unexplored emotions reaching crisis point.</p>

Education and Training

Pre-registration training

64. We recognise that since the previous edition of care after death¹⁰⁴ education and training on all aspects of care after death are increasingly included on all relevant pre-registration training curriculum – particularly for medicine, nursing, and social care. Health and social care workers at every level should be able to access pre-registration training around the care and responsibilities in relation to a death, including spiritual, religious and cultural awareness, bereavement training and concepts of self-care¹⁰⁵. It is expected that mortuary staff will be working towards or have completed the training by the Royal Society for Public Health (RSPH) - Level 3 Diploma in Healthcare Science (Anatomical Pathology Technology).

Induction and continued professional development

65. Commissioners should ensure that all staff, regardless of sector or employer, have access to appropriate training. The pertinent aspects of care after death for the relevant staff are as follows:

STAFF GROUP	CARE AFTER DEATH TRAINING
<i>Medical Practitioners</i>	Communication about breaking bad news and managing difficult conversations, including through remote/virtual/telephone communications; verification of death; completion of MCCDs; appropriate referrals to the coroner and the new Medical Examiner system (England & Wales) / Death Certification Review Service (Scotland). <i>It is noted that Organ and Tissue donation after death is governed by different laws in different UK countries and training must be country specific and cover the different consent provisions with regard to post-mortem examination and possible organ and tissue retention and organ and tissue donation</i>
<i>Nursing Staff</i>	Communication about breaking bad news and managing difficult conversations, including through remote/virtual/telephone communications; verification of expected adult death; personal care after death including

	managing the deceased's property; coronial referrals and effect on viewing, documentation of care after death and the new Medical Examiner system / Death Certification Review Service (Scotland).
<i>Ambulance Clinicians</i>	Accessing electronic patient records that record people's wishes and preferences; communication about breaking bad news and managing difficult conversations; recognition of life extinct and supporting those present at the time of death; appropriate referrals to the coroner and documentation of care.
<i>Porter Staff</i>	Safe handling and transferring of the deceased while maintaining their dignity and respect; sensitive communication with those present at the bedside.
<i>Social Care Staff</i>	Training on personal care after death; sensitive communication with the bereaved and documentation of care
<i>Domestic Staff</i>	Awareness training on the needs of the bereaved.
<i>Bereavement Support/Liaison Staff</i>	Sensitive communication with the bereaved and bereavement support offered to key contacts; process for collection of MCCDs; referral to the coroner and the Medical Examiner system / Death Certification Review Service (Scotland).
<i>APT Mortuary staff</i>	Management of the deceased; supporting viewings; communication with families, and systemic working with others in the care setting and the new Medical Examiner system.

COVID-19

66. We recognise that COVID-19 has changed the landscape of healthcare, particularly the care of the deceased and the support of the bereaved. It is vital that employing organisations and training organisations now adjust their training to the needs of this time. Issues requiring attention include:

- The need for PPE when performing care after death
- Restrictions on viewing; with restricted visiting of the dying and viewing of the deceased,

all staff will require additional training on phone/remote video consultation work to support key contacts and also on communicating with the use of electronic tablets and remote devices.

- All organisations should consider the training requirements of appropriate staff to ensure the verification of death occurs in a timely manner
- Staff should also be aware that the MCCD is now emailed by the bereavement office (acute hospital), care home, hospice, or GP surgery to the Register Office. We recognise however that not all hospitals may have a bereavement office. In which case there are other mechanisms for the emailing of the MCCD to the registrar which is coordinated by APT staff in mortuaries.

Individual and team debrief

67. The opportunity for debriefing should be available for staff after a death¹⁰⁶. In places of care where deaths happen frequently, e.g. acute hospital trusts, debriefing may take place after exceptionally challenging deaths or when the cumulative effect of many deaths is recognised. Some Trusts offer After Action Reviews (AAR)¹⁰⁷ with a facilitator to support this reflective learning in practice. Schwartz rounds are also routinely organised in many organisations to offer further space for collaborative reflection and support¹⁰⁸. This can now be offered via a fully on-line, slightly smaller group-based Schwartz type round called Team Time¹⁰⁹.

Organisational learning

68. All incidents related to care after death should be accounted for within the organisation for local action and governance with escalation, according to the seriousness and widespread applicability of any learning points or actions. Serious incidents and near miss incidents that take place in a mortuary setting must be reported to the Human Tissue Authority (HTA)¹¹⁰. NB: HTA does not have jurisdiction in Scotland. All staff working in the mortuary should be aware of the reporting requirements and this should be addressed in training.

69. NHS Trusts are now required to participate in 'Learning from Deaths' with the purpose of extrapolating the learning and disseminating this information across the trust¹¹¹. In a community setting it is also considered good practice to adopt a multi-disciplinary approach to learning from deaths¹¹².

70. Compliments and positive correspondence from key contacts are also used to support learning and improvements in providing quality care Trust wide. They are also a great source for providing a morale boost within the workforce.

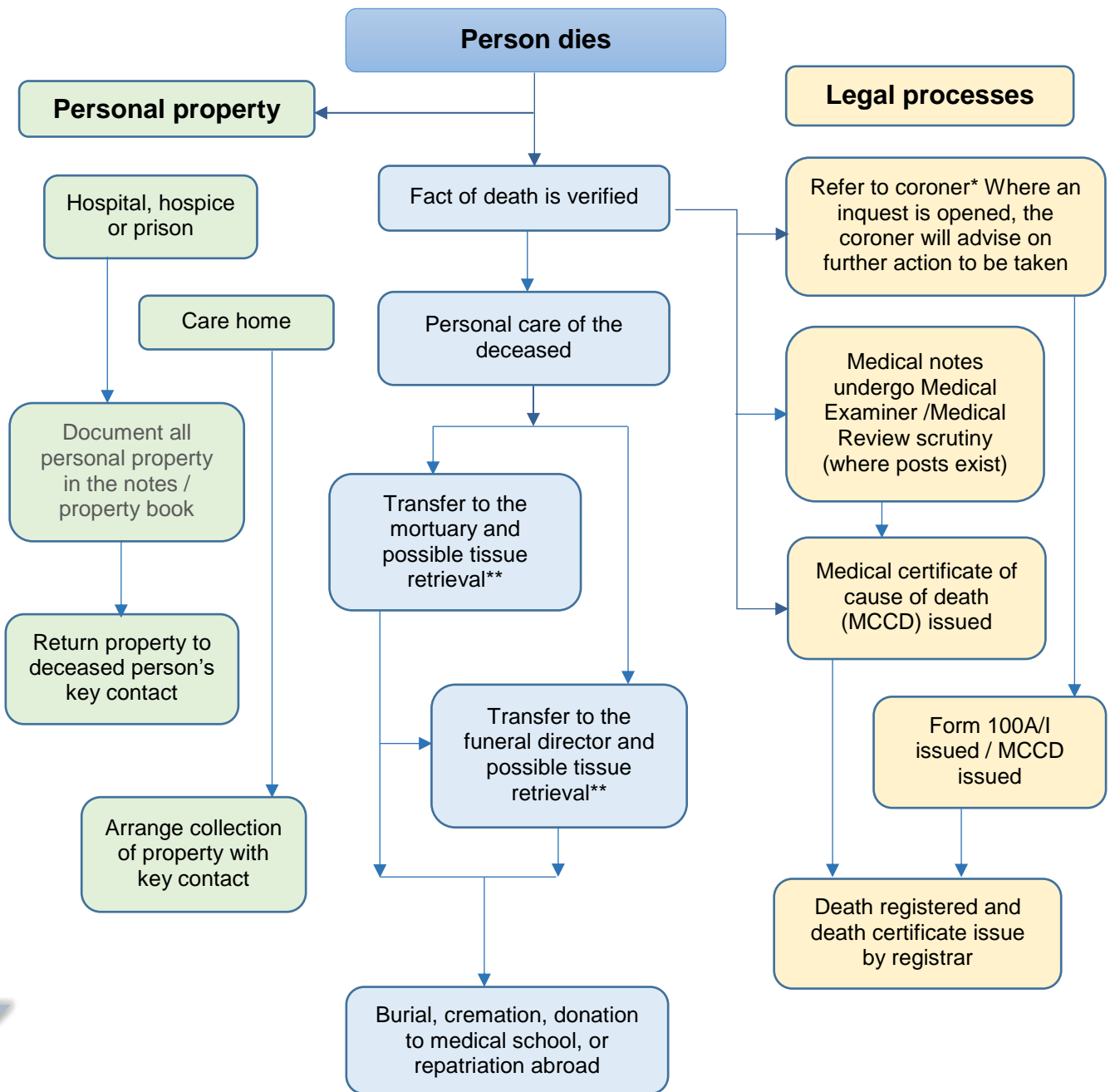
Further learning resources

- Bereavement Advice Centre – Information for Professionals
<https://www.bereavementadvice.org/topics/what-to-do-when-someone-dies/step-by-step-checklist/>
- Dying Matters – Understanding death and dying
<https://www.dyingmatters.org/page/resources-understanding-death-and-dying>
- Health Education England – Learning Hub (registration for access required)
<https://learninghub.nhs.uk>
- Marie Curie – End of life care resource: providing care after death
<https://www.mariecurie.org.uk/professionals/palliative-care-knowledge-zone/final-days/care-after-death>
- NHS Education for Scotland – Support around death (SAD) <http://www.sad.scot.nhs.uk/>
- Our Frontline – Mental Health at Work support by phone or text
<https://www.mentalhealthatwork.org.uk/ourfrontline/>
- RCN – conducting courageous conversations by telephone
<https://www.rcn.org.uk/professional-development/publications/rcn-courageous-conversations-covid-19-uk-pub-009-236>
- RCN – End of life care <https://www.rcn.org.uk/clinical-topics/end-of-life-care>
- RCN – promoting wellbeing in the workforce <https://www.rcn.org.uk/professional-development/professional-services/end-of-life-care-and-wellbeing-for-the-nursing-and-midwifery-workforce>
- Skills for Care – End of life care <https://www.skillsforcare.org.uk/Learning-development/ongoing-learning-and-development/end-of-life-care/End-of-life-care.aspx>

Appendix 1

Processes of care for the deceased

Experience of the Bereaved



This whole process should be set within the context of the deceased's spiritual, religious, and cultural wishes about care arrangements. Family members and carers should be given information and support.

* See Appendix 2 for further information on deaths requiring coroner investigation
 ** Tissue donation is not possible where COVID-19 is suspected or confirmed

Appendix 2

Deaths requiring coroner investigation

Deaths requiring referral to the coroner in England, Northern Ireland or Wales, and the procurator fiscal in Scotland, for investigation are where the cause of death is unknown, sudden, suspicious, or unexplained; when the death:^{113 114 115}

- may be caused by violence, trauma, or physical injury, whether intentional or otherwise
- may be caused by poisoning, drug related, including adverse drug reactions (reportable under the Medicines and Healthcare Products Regulatory Agency – MHRA)
- may be the result of misadventure, intentional self-harm, or possible suicide
- may be the result of neglect, including self-neglect, or failure of care
- may be related to a medical procedure or treatment, a failure of a piece of equipment, an operation or before recovering from the effects of an anaesthetic
- may be due to an injury, disease, or industrial poisoning in the course of employment
- occurred where the deceased was not treated by a doctor during their last illness, or a doctor did not see or treat them for the condition from which they died
- occurred while the deceased was in custody or state detention, whatever the cause.

A person who dies from a notifiable infectious disease, e.g. COVID-19, is not a reason on its own to refer the death to the coroner. ¹¹⁶

Notification of infectious diseases

Notifiable diseases are nationally reported in order to detect possible outbreaks of disease and epidemics as rapidly as possible, and it is important to note: ¹¹⁷

- Diagnosis of suspected (and/or confirmed) COVID-19 is a notifiable infectious disease.
- Registered medical practitioners have a statutory duty to inform their local health protection team of a diagnosis of a suspected notifiable infectious disease, and without waiting for laboratory confirmation, at time of diagnosis.
- Registered medical practitioners in England are required to report COVID-19 positive deaths to NHS England. In Scotland, deaths are reported to Public Health Scotland, and in Wales to Public Health Wales. For Northern Ireland, they are reported to the Public Health Agency of the Northern Ireland Health and Social Care.
- All laboratories where diagnostic testing is carried out must notify their national Public Health authority of any confirmation of a notifiable infectious disease.

Appendix 3

Information required by mortuary staff and funeral directors

Local policies should ensure that the following information is generated from the place of death and provided to mortuary staff and funeral directors:

- Identifying information including name, date of birth, address and NHS number (if known)
- Date and time of death
- Name of the doctor completing the MCCD
- Implantable devices
- Current radioactive treatments
- Notifiable infections
- Any jewellery or spiritual/religious/cultural mementoes left on the deceased
- Name and signature of registered nurse responsible for the care after death
- Name and signature of any second healthcare professional who assisted with care

Appendix 4 Guide to donning and doffing PPE¹¹⁸



Public Health
England

This guidance is issued jointly by the Department of Health and Social Care (DHSC), Public Health Wales (PHW), Public Health Agency (PHA) Northern Ireland, Health Protection Scotland (HPS), Public Health Scotland, Public Health England, and NHS England as official guidance.


Guide to donning and doffing standard Personal Protective Equipment (PPE)


for health and social care settings


Donning or putting on PPE

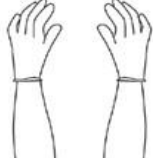
Before putting on the PPE, perform hand hygiene. Use alcohol handrub or gel or soap and water. Make sure you are hydrated and are not wearing any jewellery, bracelets, watches or stoned rings.


- 1 Put on your plastic apron, making sure it is tied securely at the back


- 2 Put on your surgical face mask, if tied, make sure securely tied at crown and nape of neck. Once it covers the nose, make sure it is extended to cover your mouth and chin.


- 3 Put on your eye protection if there is a risk of splashing


- 4 Put on non-sterile nitrile gloves.



- 5 You are now ready to enter the patient area.





Doffing or taking off PPE

Surgical masks are single session use, gloves and apron should be changed between patients.

- 1 Remove gloves, grasp the outside of the cuff of the glove and peel off, holding the glove in the gloved hand, insert the finger underneath and peel off second glove.



- 2 Perform hand hygiene using alcohol hand gel or rub, or soap and water.



- 3 Snap or unfasten apron ties the neck and allow to fall forward.





Snap waste ties and fold apron in on itself, not handling the outside as it is contaminated, and put into clinical waste.

- 4 Once outside the patient room. Remove eye protection


- 5 Perform hand hygiene using alcohol hand gel or rub, or soap and water.


- 6 Remove surgical mask.


- 7 Now wash your hands with soap and water.



Please refer to the PHE standard PPE video in the COVID-19 guidance collection:

www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-non-aerosol-generating-procedures

If you require the PPE for aerosol generating procedures (AGPs) please visit:

www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures

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Declared interests: conflict of Interest was considered, and no interest was declared

Equality: consideration has been given to equality and diversity issues in the development of this guidance

Review Date: September 2023 (or sooner as necessary)

User feedback: welcome via clinical@hospiceuk.org


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