Plymouth Community Healthcare (CIC)

# Verification of an Expected Death, Last Offices and Infection Prevention and Control when handling the deceased.

Version No 4.0

**Notice to staff using a paper copy of this guidance**

**The policies and procedures page of Intranet holds the most recent version of this guidance. Staff must ensure they are using the most recent guidance.**

**Please note that this policy will be reviewed in line with SystmOne - the new computerised system which will replace e-PEX.**

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**Asset Number:** **96**

## Reader Information and Asset Registration

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| **Author** | Professional Lead, District Nurse Matrons', Ward Managers' and<br>Consultant Nurse Infection Prevention and Control. |
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## Document Version Control

| Version Number | Details e.g. Updated or full review | Date | Author of Change | Description of Changes and Reason for Change |
|---|---|---|---|---|
| 1 | Full review | 01/03/2004 | Practice Facilitator | First full review |
| 1:1 | Redraft | 03/02/2006 | Deputy Manager, Public Information Service | Redrafting of v1 to meet with corporate standards |
| 2.0 | Full review | 21/12/2006 | Practice Facilitator; Community Matron (District Nursing) | Full review to incorporate Community nursing protocol with original protocol |
| 2:1 | Updated | 07/03/2007 | Internal Communications Officer | Formatted to bring in line with corporate standards. |
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| 2:3 | Reviewed | 08/04/2011 | Author | Reviewed, no changes made. |
| 3.0 | Full review | 10/10/2011 | Author | Full review to include end of life, verification of death and last offices. |
| 3.1 | Extended | November 2013 | Author | Extended no changes second to national changes to LCP. |
| 4.0 | Full review | December 2013 | Author | Full review to meet National changes, end of life, verification of death and last offices. |

**Contents**

## Verification of an Expected Death, Last Offices and Infection Prevention and Control when handling the deceased.

## 1. Introduction

1.1 This Policy is to ensure the delivery of high quality care in a sensitive manner to patients and their families during the end stages of their life. This will include Verification of an Expected Death, Last Offices and the application of infection prevention and control principles when handling the deceased.

1.2 This policy will enable the procedure of Verification of an Expected Death to be performed by Registered Nurses working within Plymouth Community Healthcare (PCH). The law requires Certification of Death to be performed by a Registered Medical Practitioner. Registered Nurses who have undergone appropriate training and have been assessed as competent may however, Verify a death that has occurred providing there is an explicit local ratified policy or protocol to allow such an action. Any such policy should only be used in situations where death is expected.

1.3 This policy relates to adults only (for the purpose of this policy this is over the age of 19).

## 2. Purpose

2.1 To assist Registered Nurses in preserving the dignity of the terminally ill patient and their relatives, by ensuring that last offices and the Verification of Death is timely, family wishes are respected and bereavement support is provided.

2.2 To ensure that the deceased are handled in a safe and appropriate dignified manner.

2.3 To minimise the risk to individuals when handling infected cadavers.

## 3. Duties

3.1 The Chief Executive is ultimately responsible for the contents of policies and their implementation.

3.2 The Locality and Deputy Locality Managers will be responsible for ensuring that all staff follow the standards set within this Policy.

3.3 Matrons and Managers are responsible for the implementation of this Policy.

3.4 All staff caring for End of Life patients and families will comply with all procedures in this Policy.

## 4. Definitions

4.1 For a list of definitions see appendix 1

## 5. Prior to death

5.1 Patients who are thought to be dying should be reviewed by the medical and nursing staff to ensure appropriate end of life care is given.

5.2 Patient's resuscitation status must be identified, recorded and communicated to all team members (refer to PCH Resuscitation Policy Appendix K: Treatment Escalation Plan (TEP) and Resuscitation Decision Record).

5.3 Decisions about resuscitation must be reviewed regularly to reassess changes in the patient's condition. If a patient's condition improves significantly following a decision that death is imminent, the appropriate registered medical practitioner must be consulted.

5.4 A dying patient's comfort, privacy and dignity should be maintained at all times. The patient's preferred priorities for care should be ascertained and efforts made to meet these wherever possible. All such discussions must be documented in the patient's clinical records.

5.5 The family/significant others must be kept informed of the patient's condition, prognosis and care decisions, with the patient's permission.

5.6 Within an inpatient setting a single side room should be offered to a dying patient and their family/significant others where possible. This may not always be possible, due to the needs of other patients, but an explanation should be given to the patient /family as to why this is not possible. Every effort should be made to provide short-term accommodation for family/ significant others wishing to stay. Family/significant others telephone numbers and relationship to patient should be recorded including agreed times to contact in case of impending death/death (i.e. at any time, not at night time).

5.7 Patient's and their families'/significant other's or in particular cases, patient's Lasting Power of Attorney's wishes regarding any specific actions to be taken at the time of impending death, at death or after death, should be ascertained. Details should be documented and the team made aware of these e.g. details of documented advanced decisions, involvement of spiritual support, religious and/or cultural requirements (ceremonial washing, mode of dress), organ/tissue donation (NHS Organ Donor Register), bequeathing bodies (Bristol), cremation, burial.

5.8 Where identified by the patient or family/significant others a relevant spiritual/ religious representative should be contacted to offer support and/or religious procedures prior to death.

5.9 The Chaplaincy and Spiritual Care Department of the organisation is based at

The Local Care Centre. The Chaplaincy and Spiritual Care Department are available to all members of staff, patients and their relatives for advice and support regarding the spiritual care of patients and their families, particularly with regards to “rites of passage”. The Chaplaincy is available to all people of all faiths and those of non faith-specific requirements may be arranged through the Chaplaincy Department.

5.10 The Chaplaincy and Spiritual Department is not a 24 hour service and does not operate over the weekends. There is a telephone answer machine service on 01752 434713. St Lukes Hospice has a list of on call faith leaders. For urgent matters the Lead Chaplain can be contacted via Switch board within normal working hours.

5.11 Cardiology must be informed if the patient has an implanted cardioverter defibrillator (ICD). The presence of this, or any other sensitive device, must be documented on the front of the patient’s records (see appendix 5).

5.12 Organ donation most commonly occurs in an intensive care setting, but tissue donation (e.g. eye and heart valves) is possible for many individuals. It is essential for staff to establish if the patient has previously expressed the wish to be a donor. If the patient is on the NHS Organ Donor register or carries a Donor Card, then that is a legal consent in line with the Human Tissue Act of 2004, and the next of kin cannot in law overturn that consent. However the law also recognizes that if a family/significant other is absolutely against donation, then it may not be appropriate to pursue further. For all deaths, The NHS Organ Donor Register should be checked by calling - 01179 757575. The Donor Transplant Coordinator should be informed (radio page via PHNT switchboard) if the patient is registered, carried a donor card or the family/significant other agree to donation.

## 6. Assessment of Infection Risk

In general, few organisms in a cadaver pose an infection risk. However, there are some important hazards to be considered. A practical risk assessment should include the following three categories of infections:

6.1 Infections that pose minimal transmission risk and are preventable with hygienic practice. Usually there is available prophylaxis or treatment for such infections. Examples are: chicken pox, influenza, measles, meningitis, mumps, rubella, scarlet fever and whooping cough

6.2 Infections causing severe human illness, but with limited or no transmission risk. Such infections may have intermediate insect and animal vectors, which are rarely met with in the UK. These infections may, however, be transmitted by accidental blood inoculations, transplantation or in research work. Examples are: yellow fever, rabies, malaria and anthrax

6.3 Infection hazards such as those listed below, which present a quantifiable risk.

a) Airborne droplets or particles – tuberculosis
b) Discharges from body orifices – typhoid and paratyphoid fevers, amoebic or bacillary dysentery and food poisoning
c) Inoculation risks – HIV infection, Hepatitis B and C infections, leptospirosis and brucellosis
d) Skin lesions due to **Staphylococcus aureus** and **Streptococcus pyogenes**
e) Skin infestations – Body lice and scabies.

6.4 The common infections that may present a risk to those handling cadavers are given in Appendix 8, along with information on the mode of reduction of infection transmission and guidance on necessary precautions. When the cause of death is suspected to have been due to the following infections, or if there is any doubt as to the handling of a potentially infectious cadaver, the Infection Prevention and Control Team or a Consultant Microbiologist must be contacted immediately: anthrax, smallpox, tetanus, leptospirosis (Weil's disease), cholera, rabies, relapsing fever and plague.

### 6.5 Risk and Standard Precautions

Given the difficulty in identifying infected cadavers, **all** cadavers should be regarded as potentially infected and standard precautions against infection must be used when undertaking any patient contact:

**a) Hand hygiene.** Hand washing and decontamination must be performed before and after contact with the cadaver and surrounding potentially contaminated environments (please refer to Hand Hygiene Policy). Hands should be washed with soap and water at the start and end of clinical duties, when hands are visibly soiled or potentially contaminated, and following the removal of gloves

**b) Protect lesions.** Cuts, abrasions and any lesion where the skin is broken must be covered with a waterproof dressing. Staff with exudating lesions or weeping dermatitis should avoid direct patient contact and seek advice from the Occupational Health Department

**c) Personal Protective Equipment (PPE).** Appropriate PPE (disposable gloves and plastic aprons) should be worn for all procedures where contact with blood or body fluids is expected. Gloves and aprons should be disposed of as clinical waste. Eye protection (goggles or face visor) and a high efficiency FFP3 disposable respirator mask should be worn during procedures likely to generate aerosols or droplets of blood or body fluids.

**d) Use and disposal of sharps.** Avoid unnecessary use of sharps the safer sharps equipment should be used and discarded immediately into recommended sharps containers which should not be more than two-thirds filled. For further information, see Policy on the Safe Disposal of Sharps.

e) **Spillage of body fluids on floors on hard surfaces.** Wear disposable gloves and a plastic apron (as well as eye protection if there is the potential for splashing) and then wipe up with paper towels, which should then be placed in a thick (400-gauge) orange clinical waste bag for incineration - if in an In-Patient Unit. Clean surface with warm water and detergent using a disposable cloth or mop, then bleach (0.1% (1000 parts per million) sodium hypochlorite (to surfaces that will tolerate it)). Sodium hypochlorite should be diluted with tepid, not hot, water. Wipe surfaces with a damp cloth to remove any residue: as per Decontamination Policy.

As guests in the patient's home, any cleaning must be done with the patient's consent, and, because there are many variables it may not be possible to follow the policy exactly

f) **Cleaning of other surfaces and equipment.** See Decontamination and Cleaning Policy.

g) **Management of inoculation injuries (including splashes in eyes, mouth or skin).** See Management of Inoculation Injuries, Policy and Procedures.

h) **Waste disposal.** All clinical waste contaminated with blood/body fluids should be put in a thick (400-gauge) orange clinical waste bag for incineration. In the community clinical waste collection service is provided where appropriate.

i) **Linen.** Linen should be disposed in accordance with the Linen Services Policy. Linen that is visibly contaminated with blood or body fluids should be placed in a water-soluble bag within a red linen bag for transport to Central Linen Services.

## 7. Verification of expected death

7.1 When the patient dies, the nurse has a duty to inform the appropriate registered medical practitioner (wherever possible this should be the patient's usual doctor) as the registered medical practitioner is the only person authorised to **certify** death.

7.2 In the event of an expected death, the registered medical practitioner may pre-arrange to be informed at another time - for example: if death occurs at night the registered medical practitioner may be informed the following morning. Out of normal working hours the appropriate registered medical practitioner will be informed, in the community this will be via Devon Doctors (D.Doc).- professional telephone line – 01392823564.

7.3 When it has been clearly agreed between the registered medical practitioner and nursing staff that further intervention would be inappropriate and death is expected to be imminent, a designated competent Registered Nurse working to this policy may be delegated to verify the death.

7.4 Verification of death by a Registered Nurse may only be undertaken where patients have been:

- Documented as an expected death and /or
- When there is a written Treatment Escalation Plan (TEP) and resuscitation decision record in the patient records

7.5 The Nursing and Midwifery Council guidelines (NMC 2012) regarding confirmation of death states that *"a nurse cannot legally certify death – this is one of the few activities required by law to be carried out by a registered medical practitioner. In the event of death, a registered nurse may confirm or verify a death has occurred, providing there is an explicit local protocol in place to allow such an action, which includes guidance on when other authorities, e.g. the police or the coroner, should be informed prior to removal of the body. The protocol should, however, only be used in situations where a death is expected. Nurses undertaking this responsibility must only do so providing they have received appropriate education and training and have been assessed as competent*".

7.6 Only Registered Nurses employed by Plymouth Community Healthcare, working to this policy and competent to do so, have the authority to verify an expected death, notify relatives and arrange for last offices and removal of the body to the appropriate place (e.g. funeral director).

7.7 Where a suitably qualified nurse is not available to verify death then a registered medical practitioner should attend as soon as reasonably practicable.

## 8. Procedure for Verifying an Expected Death

8.1 When death is suspected, the designated Registered Nurse must;

- Check absence of *Circulatory activity*: That there is absence of a pulse. This must be confirmed by palpation of the carotid pulse in the neck and observing the chest and listening for cardiac sounds with a stethoscope for one minute.

- Check absence of *Respiratory activity:* That there is an absence of respiratory movement and bronchial and tracheal sounds. This must be checked by observing the chest and listening with a stethoscope for one minute.

- Check absence of *cerebral activity*: That pupils are dilated and unresponsive to light. This should be verified by shining torchlight into both eyes. No response to painful stimuli should be confirmed by rubbing the sternum for 10 seconds.

8.2 The Verifying nurse will record the following details in the patient's medical/nursing records using the Verification of an Expected Death documentation (Appendix 2).

- The date and time of actual death

- The time of verification
- That they are verifying that death has occurred
- Place of Death (i.e. Hospital, home, temp.res).
- That the next of kin have been informed / have not been informed (and what arrangements are being made to inform them)
- The name(s), designation(s) and signature(s) of nurse(s) present.

8.3 The nurse should ensure they communicate appropriately with sensitivity and respect when informing relatives of the expected death either by telephone or face to face.

8.4 During the care of the deceased person the nurse should ensure they preserve the deceased person's privacy and dignity.

8.5 The nurse should advise the deceased's relatives that, except in exceptional circumstances, the patient's registered medical practitioner (GP) will issue a medical certificate of the cause of death within 24 hours. (At weekends and bank holidays the certificate should be produced on the next working day).Inpatient areas will be by the consulting Doctor available.

8.6 The nurse should give the deceased relatives the organisation's bereavement booklet and/or the Age UK bereavement booklet "What to do when someone dies" alongside the local information sheet.

8.7 The nurse, where appropriate could offer to contact the patients named religious, cultural and/or spiritual advisor.

## 9. Unexpected Death

9.1 In the case of an **unexpected** death, a medical practitioner must be called immediately to attend and verify death. Consideration should be given to the need for referral to the Coroner and police (see Coroner's guidance, Appendix 6).

9.2 Nurses must not verify any deaths which are not expected or where a post mortem or routine referral to the HM coroner's office is indicated, or if:

- The cause of the death is unknown
- The deceased was not seen by a certifying doctor either after death or within 14 days before death
- The death was violent, unnatural or was suspicious
- The death is of a child
- The death may be due to an industrial disease or related to the deceased employment
- The death may be due to an abortion
- The death may be suicide
- The death occurred during or shortly after detention in police or prison custody
- Death is of an unidentified person

- Death has occurred within 24 hours of onset of illness or where no firm clinical diagnosis has been made
- Death is 24 hours post-operative or post invasive procedures
- Death is following an untoward incident, fall or drug error
- Death has occurred as a result of negligence or malpractice
- Death is unclear or remotely suspicious

9.3 Where death has occurred in these circumstances it is an offence to move or otherwise interfere with the body or the surrounding evidence without instructions from the coroner.

9.4 Whenever a death is unexpected the nurse has a responsibility to initiate resuscitation in accordance with the Plymouth Community Healthcare Resuscitation Policy unless discussions of resuscitation have taken place and a decision is made that the patient is "Not for resuscitation" and this is clearly documented in the patient's notes or in a current and valid advanced care decision or Treatment Escalation Plan (TEP).

9.5 Details of death must be recorded in the patient's record/clinical pathway before the deceased's body can be removed by the funeral directors.

9.6 For cases of **unexpected** death, tubes or lines must be left in situ and spigoted or taped (e.g. catheters, nasogastric, drainage tubes and intravenous cannulae, or any other equipment associated with the patient's welfare). These may provide important information at autopsy. (Appendix 11)

9.7 In the event of an **unexpected** death within an Inpatient area the room should be left untouched and, if in a bay, then the curtains should remain around the patient and the following procedure undertaken:

- A member of staff is to remain with the patient.
- The police and On-Call-Manager/head of service is informed.
- A Serious Incident Requiring Investigation process is commenced.
- The patient will be collected by the Coroner.
- When the patient has left the room the room should be locked as this is a crime scene.
- Records to be photocopied.
- Police will visit the Ward.

9.8 Staff should ensure that all who need to know about the death are quickly and sensitively informed. This includes family/significant others, staff involved in patient's care and other patients on the ward. Staff should recognise the impact a death may have on other patients.

## 10. Death of a Patient Detained under the Mental Health Act 1983

10.1 The death of a patient detained under the Mental Health Act 1983 must be reported to the Care Quality Commission.

10.2 The senior nurse on the Ward at the time of the death must contact the Mental Health Act Office as soon as is practicable (telephone number 57609 or 53143) and in any event on the next working day. The Form must be completed and emailed to the MHA Manager on the next working day. This will then be forwarded to the Care Quality Commission within 3 working days of the death being confirmed. The form can be downloaded from the link below or the Mental Health Act information page, on the intranet. It is important that the form is completed accurately to allow the CQC to process and take appropriate action promptly.

http://www.cqc.org.uk/sites/default/files/media/documents/20121126_800139_v300_notification_death_of_a_patient_liable_to_be_detained_for_publication.doc

10.3 The Mental Health Act Manager will liaise with CQC to ensure the paperwork has been received and all the required information has been provided.

10.4 The On-Call-Manager and Director should be informed of the death of a detained patient.

## 11. Last Offices – General Procedures

11.1 In England, there are approximately 70,000 deaths each year due to infectious diseases. In addition, although infection may not have been the cause of death (as officially recorded), individuals may have either had an infectious illness at the time of death or else have been infected without showing any obvious signs or symptoms.

11.2 The body of a person who has been suffering from certain infectious diseases may remain infectious to those who handle it. Precautions for handling individuals with an infectious disease may therefore remain necessary following the person's death. The main potential sources of infection to be considered when handling cadavers are:

a) blood and other body fluids
b) waste products, such as faeces and urine
c) aerosols of infectious material, such as might be released when opening the body
d) direct contact (e.g. with the skin)
e) inoculation injury from a sharp object (e.g. needle or another sharp).

11.3 Doctors have a statutory duty to notify a 'proper officer' of the local authority of suspected cases of certain infectious diseases. There is also a requirement that those in charge of premises where there is a body of a person who died while suffering from an infectious disease take reasonable steps to prevent others unnecessarily coming into contact with, or proximity of that body. It is important to note that patient confidentiality continues after death.

11.4 Personal Protective Equipment (PPE) should be worn when washing and preparing the body. Special disinfection measures are not necessary after death

and washing the body with soap and water is adequate. If a family wishes to help with the washing and preparation of the body this should normally be allowed.

11.5 The body continues to secrete fluids after death. Open drainage sites should be sealed with an occlusive dressing. Clean, absorbent dressings should be applied to any wounds, secured with an occlusive dressing to prevent any further leakage from the wound site. For an **unexpected** death (one that is deemed notifiable to the coroner with an expected Post Mortem examination) all cannulae and tubing should not be removed, with the exception of endotracheal tubes which can be removed unless there could be doubt about its placement (e.g. someone who dies immediately after intubation). The site of each cannula should be marked on a body map (Appendix 10) which should accompany the body. For all **expected** deaths, endotracheal tubes and 'butterfly' needles should be removed. A dressing should be applied over 'butterfly' sites. All other cannulae should be left in the body as leakage poses a risk to mortuary and funeral staff and/or anybody handling the body **post mortem.**

11.6 A plastic cadaver bag should be used for **all** deceased bodies leaking body fluid. The body should be placed in the person's own clothes/nightwear, hospital gown/nightwear, a sheet or shroud, and then in the plastic cadaver bag, which must be carefully secured. The cadaver bag should be viewed as an adjunct to safe practice, rather than a requirement for all cadavers. In all cases, a safe working environment is a greater safeguard against infection than relying on the use of cadaver bags in all circumstances

11.7 The body should be removed to a cool environment (the mortuary) as soon as possible. For Inpatient Wards Plymouth Community Healthcare has a preferred undertaker which should be contacted. The nurse should use their own professional judgement if the family wish to use another undertaker.

11.8 For Inpatient areas the Funeral Director will complete the identification and tracking record form and the Ward Nurse will be required to sign the section regarding patient's property.

11.9 Certain implantable medical devices may be removed within the hospital mortuary. Guidance on safe removal of implantable defibrillators has been issued by the Medicines and Healthcare Products Regulatory Authority (MHRA). These and other devices, for example pacemakers, should be returned to the SDU for decontamination and then returned to the manufacturer for final disposal. This requires written consent from the relatives of the deceased.

11.10 If relatives wish to take the body abroad for a funeral, certificates may be required from the attending doctor and from the local Health Protection Unit to certify that the body is safe for transport. This will normally be organised by the undertakers, in liaison with the doctor and the local Infection Control Doctor or Health Protection Unit.

11.11 **Death of Patients with a Known or Suspected Infectious Disease**

11.12 Whenever a person who is known or suspected to be suffering from an infectious disease dies, it is the duty of the staff caring for them to ensure that those who need to handle the body, including relatives as well as mortuary, post-mortem and funeral personnel, are aware that there is a risk of infection. In all cases an Infection Control Notification Form (Appendix 9) must be completed. The form will state the danger of infection and the modes of transmission, explain the need for precautions to be taken, and will advise on procedures, including embalming and access to the deceased, without disclosure of the diagnosis. This is to ensure all relevant information about the deceased is available allowing appropriate protective measures to be instituted. The Infection Control Team should be contacted if help is required in completing this form. The completed form should accompany the body when released from the mortuary, so that information about any infection that poses a threat is communicated to the funeral director.

11.13 When there is a risk of infection from a body, the body must not be handled unnecessarily. The body should be placed in the person's own clothes/nightwear, hospital gown/nightwear, a sheet or shroud, and then in the plastic cadaver bag, which must be carefully secured. Once the body is sealed in the cadaver bag, protective clothing will no longer be necessary for those who handle the body.

11.14 Before being released, the cadaver should be labelled with the appropriate actions that need to be followed in a particular case. The identity labels and 'Notification of Death' labels should be attached in such a way that they may be read through a cadaver bag. Neither label should state the diagnosis. Attach identity bracelets to ankle and wrist for identification purposes. Although the diagnosis is confidential, tie a 'Danger of Infection' label around the ankle and wrist. A 'Danger of Infection' sticker must be attached to all three copies of the 'Notification of Death' Form. One copy of the Notice of Death form should go in the document wallet on the cadaver bag, one should be filed in the patient's notes and the other copy given to the staff transferring the deceased to the mortuary. Insert a label clearly identifying the deceased together with a "Danger of Infection" sticker into the document wallet on the outside of the Cadaver Bag. The identity labels and 'Notification of Death' labels should be attached in such a way that they can be read through the body bag.

11.15 Relatives and others who wish to view the body should be told if there is a risk of infection if they touch or kiss the deceased, and will be advised of any controls they need to take after contact, for example washing of hands. Certain infectious disease(s) will present a significant risk so relatives should be informed about the risks involved and provided with protective equipment if appropriate. Alternatively, viewing should take place either at a distance or by use of a viewing panel in the coffin or a viewing room with a glass screen. These recommendations also apply to deceased children.

## 12. Guidance for Leaving Cannulae and other Devices *in situ* following Death

12.1 An unexpected death refers to a death that occurs within 24 hours of an operation or was unexpected, and is deemed notifiable to the coroner with an expected Post Mortem examination. In these circumstances, all cannulae and tubing should not be removed, with the exception of endotracheal tubes which can be removed unless there could be doubt about its placement (e.g. someone who dies immediately after intubation). The site of each cannula should be marked on a body map (Appendix 10), which should accompany the body.

12.2 For all expected deaths, endo-tracheal tubes and 'butterfly' needles should be removed. A dressing should be applied over 'butterfly' sites. All other cannulae should be left in the body as leakage poses a risk to mortuary and funeral staff. As these may pose a risk of being dislodged by anybody handling the body **post mortem,** the following guidance should be adhered to:

a) all bags, giving sets etc should be removed from the cannula where possible

b) all cannulae and other devices should be securely fastened to the site of entry with surgical tape

c) padding in the form of gauze or an alternative should be applied over the site and fastened *in situ* with tape or a loose bandage. Cannulae and lines should be capped

d) a label should be attached securely to the outside of the body bag notifying any persons involved that the body still has lines attached (Appendix 11)

e) the porters or undertakers removing the body should be informed that the lines are still attached and care should be taken when handling

f) an entry should be made in the medical records stating that the above policy has been invoked due to the nature of death and subsequent coroner involvement, and Post Mortem examination being required.

## 13. Procedure for carrying out Last Offices

13.1 Last Offices should only be carried out following Verification of Death and recording of this. Staff performing last offices should ensure they adhere to standard infection control precautions

13.2 It is the final act of care that nurses can perform for the patient.

13.3 This should be carried out in an unhurried but timely manner, preserving the dignity of the patient at all times.

13.4 For many nurses last offices can be a fulfilling experience where they are meeting their final duty of care and respect for the patient. This can be a comfort to the deceased's relatives as it demonstrates that caring and nursing

interventions does not cease at time of death. Supporting the relatives of the deceased is a nursing role that requires sensitive management.

13.5 The body must not be handled unnecessarily. Details of last offices will vary according to the patient's cultural background and religious practices. It is essential for nurses to recognise and have respect for different religious practices in relation to death. It is important that information relating to these is established prior to undertaking the last offices. Similarly, all strands of equality and diversity should be recognised and respected. Specific guidance for major faith-groups can be found on the Healthnet site at http://nww.picts.nhs.uk/PHNetLive/DesktopDefault.aspx?tabid=238
In the event of last offices being performed by the undertaker this information should be passed onto them.

13.6 For procedures for last offices please see checklist in (Appendix 3) for Inpatient areas and (Appendix 4) for Community.

13.7 For the procedure for deactivation of ICD's see Appendix 5.

## 14. Procedure following Last Offices

14.1 All those involved in the care of a deceased person should respect the dignity, privacy and confidentiality of the person who has died and ensure that their body is secure at all times.

14.2 The deceased should be removed by the holding Funeral Director once the death has been verified and family/significant others have had time to say their goodbyes. The holding Funeral Director will be contacted to assess/respond. Unnecessary delays should be avoided. Ensure that the Removal of Body form has been signed by the holding Funeral Director: Inpatient areas only (Appendix 7).

14.3 Relatives/significant others present at the time of death or shortly after death should be offered emotional support and may be given a copy of the bereavement booklet (Age UK).

14.4 Details of the patient's death need to be inputted into the relevant IT system.

14.5 A medical certificate (cause of death) MCCD and Cremation Form (if required) must be completed by a medical practitioner who has treated the patient. **This must be done as soon as possible after death – and no later than the next working day (Inpatient areas only).**

14.6 It is the medical practitioner's responsibility to contact the coroner if this is necessary.

14.7 For Inpatient areas, having discussed the case with the Coroner the outcomes will either be a Coroners Part A or a Post Mortem. If a coroners post mortem is

required all patient notes should be gathered together for collection from the ward with the deceased by the Coroner's staff. In these incidences the Coroner has now taken over care of the deceased and will communicate directly with the family/significant other. See (Appendix 6) for check list for referral to Coroner's Officer.

14.8 If a hospital post mortem is required the medical practitioner needs to obtain the written consent of the next of kin/family/significant others before this can proceed.

14.9 For Inpatient areas, all of the deceased patient's property, including valuables must be entered into the property book. Valuables must remain in the ward safe or with the hospital cashier until the Bereavement Officer meets with the relatives. The property is returned to the next of kin with signatory confirmation. The Medical Certificate Cause of Death (MCCD) and in the case of a cremation the cremation form and property will be collected by the Bereavement Officer (MGH) from the Ward as soon as possible.

14.10 In the community the patient held record should be updated and the record removed from the patient's home and returned to the team base. If the death occurs out of hours the Out Of Hours District Nursing Team will leave a telephone message for the Caseload Holder requesting they collect the records in a sensitive timely manner.

14.11 With regards to equipment loaned to the patient the Health Professional should contact the Community Equipment Store and request collection of the equipment as soon as possible. This should be undertaken in a sensitive timely manner.

14.12 The deceased's family/significant others should be asked to contact the bereavement office by telephone after 10.00hrs on the next **working** day. In the community, the family/significant others of the deceased will need to liaise with the GP regarding the MCCD.

14.13 Family/significant others wishing to see the body will be given the opportunity to do so in the viewing area of their chosen funeral director. Viewing can be arranged with the chosen funeral directors when the body is in their care.

14.14 If a death has been referred to the coroner, opportunities for the family/significant others to see and care for the body may be restricted. Information from the coroner's office and close liaison with the family /significant others is therefore important in this respect.

14.15 If there is suspicion that the deceased may have had an infection then the funeral director should be made aware see (Appendix 8).

## 15. Staff Training and Competencies

15.1 All staff who have significant contact with dying patients and/or bereaved people should have available training and learning opportunities to enable them to develop accurate knowledge of policy and procedures and an appropriate level of knowledge and understanding of death, infection control, bereavement and loss. It is important that all staff consider the possible risks of infection associated with the deceased and they take appropriate steps to ensure the safety of themselves and others.

15.2 The death of a patient can create emotional pain or uncertainty for even the most experienced health professional. Staff are reminded of the value of talking their feelings through with a trusted colleague, use of clinical supervision or the opportunity to contact the Staff Health and Wellbeing Department for support.

15.3 All Registered Nurses verifying death must have the competencies, skills and knowledge to enable them to determine the physiological aspects of death. Training will be provided in order for Registered Nurses to achieve the required competencies.

15.4 Verifier criteria:

- Nurses must have a current NMC Registration and be employed by Plymouth Community Healthcare before undertaking the Verification of Expected Death training.
- Individual nurses must feel competent and confident in this practice as per NMC Code.
- Nurses must be assessed as competent in the skill required to Verify Death and a copy of this kept within the staff personal file.
- Staff will need to keep themselves updated on the policy, any changes in practice and complete the Assessment of Competence. (Appendix 13).

## 16. Monitoring Compliance and Effectiveness.

16.1 Service/Team-Leads/ Managers' will monitor through Documentation Audits and through Incident Reporting of Deaths.

Line Management Processes in each area will also review each Registered Nurse's CPD annually and identify any ongoing training needs.

## 17. ePEX Codes.

17.1 **2TREPAL** will be entered, against the individual's contact of care, following End of Life/Palliative treatment.
17.2 **3TERCAR** will be entered, against the individual's contact of care, following End of Life/Terminal Care treatment.
17.3 **3VOD** will be entered, against the individual's contact of care, following Verification of Death procedure completion.
17.4 **3BER** will be entered against the deceased family member(s)/significant other(s), following a bereavement support visit.

## 18. Bibliography and References.


Health and Safety Executive. Infection at Work: Controlling the risks of infection from human remains. a guide for those in funeral services (including embalmers) and those involved in exhumation. Health and Safety Executive, 2005.

Health and Safety executive (1999). *Control of substances Hazardous to Health Regulations. Approved Codes of practice for General COSHH, Carcinogens and Biological Agents*. HSE Books, Sudbury, UK.

Health and Safety Executive (1992). *Personal Protective Equipment at Work Regulations: Guidance on Regulations*. The Stationary Office, London.

*Removal of implantable cardioverter defibrillators* (ICDs) SN2002/(35) MHRA. Available at www.medical-devices.gov.uk .

Advisory Committee on Dangerous Pathogens and the Spongiform Encephalopathy Advisory Committee. Transmissible spongiform encephalopathy agents: Safe working and the prevention of infection. Annex H. 'After Death' Available at: http://www.advisorybodies.doh.gov.uk/acdp/tseguidance/tseguidance_annexh.pdf .

NHS Employers. The management of health, safety and welfare issues for NHS staff. NHS Employers 2005.

Plymouth Hospitals NHS Trust. Deceased Patient Policy.


**All policies are required to be electronically signed by the Lead Director. Proof of the e-signature is stored in the policies database.**

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

**Signed:** **Director of Operations**

**Date:** 15th January 2014

**DEFINITIONS** **Appendix 1**

**Expected Death** - can be defined as the death following a long period of illness, which has been identified as terminal and where no active intervention to prolong life is ongoing. Death is recognised as the expected outcome by the patient's relatives/close friends, by the healthcare team and by the person him/herself if in a condition to express a view.

**Lasting Power of Attorney** - Enduring Power of Attorney has now become Lasting Power of Attorney. It is a legal document that allows one person to act on behalf of another. The individual vested with power of attorney may have authority to sign on behalf of the person e.g. cheques and legal documents and to enforce his/her wishes.

**Advance Decisions to Refuse Treatment (ADRT)** - Also called a Living Will is a statement made by a patient indicating what his/her wishes are regarding future medical treatment. These wishes will become applicable when the patient is unable to make decisions or to communicate them. Because determination of treatment lies with the medical practitioner, an advanced directive can only cover refusal of medical treatment/care. www.adrtnhs.co.uk

**Medical Certificate Cause of Death (MCCD)** – Completed by the medical practitioner who attended the deceased. Records the cause of death and medical conditions that contributed to/lead to the death. This is not the Death Certificate which is issued by the Registrar on sight of the MCCD.

**Coroner** - an independent judicial officer appointed and paid for by the relevant local authorities who is responsible for investigating violent, unnatural deaths or sudden deaths of unknown cause and deaths in custody that are reported to them. The coroner works in close collaboration with the police.

**Coroners Part 'A'** - A Part 'A' describes the situation when a medical practitioner has discussed a patient's death with the Coroner or his officer and it is agreed that a post mortem is not required. It is also agreed between the coroner's office and the practitioner how the MCCD should be completed. The completed MCCD is faxed to the Coroner's office. A further communication takes place between the Coroner's office and the Registrar before the death certificate can be issued.

**Post Mortem** - A coroner's post mortem is undertaken by the authority of the coroner (it is different to a hospital post mortem). It is ordered because the coroner requires further clarification of the cause of death. Coroner's post mortems are undertaken at the Derriford mortuary.

**Paying Last Respects** – This is an expression used to describe the viewing of a deceased person by family/significant others.

**Significant Others** - A person, such as a family member or close friend, who is important or influential in one's life. A person whose close relationship with an individual affects that individual's behaviour and attitudes

**Implanted Cardiac Defibrillators** (ICD's)

**Medicines and healthcare products regulatory body** (MHRA)

**Personal Protective Equipment** (PPE)

**Centre for communicable diseases control -** CCDC

| Surname:<br><br>First Name: | NHS Number:<br><br>Date of Birth: | Plymouth Community HEALTHCARE |
|---|---|---|

## Verification of an Expected Adult Death by a Registered Nurse

**This patient's death is expected** (a case where discussions have taken place between the medical and nursing team and the patient/family and a decision has been made that no further intervention is appropriate. This must be recorded in the patient's medical and nursing notes). Completion of dated and signed Treatment Escalation Plan (TEP)

**Clinical observations of absence of life.**

| **RESPIRATORY** | Confirmed | **CIRCULATORY** | Confirmed | **CEREBRAL** | Confirmed |
|---|---|---|---|---|---|
| Absence of respiratory movement for 1 minute. | Yes/No | Absence of Carotid pulse for 1 minute | Yes/No | Pupils are dilated and not responding to light. | Yes/No |
| Absence of breath sounds for 1 minute. (Using a stethoscope) | Yes/No | Absence of heart sounds for 1 minute. (Using a stethoscope) | Yes/No | No reaction to painful stimuli | Yes/No |

**Clinical observations of absence of life should be repeated after 10 minutes if confirmation cannot be determined clearly.**

| **Date of Death** | **Persons present** | **Time of Death** (use 24hr clock) | **Time Verified** | **Place of Death** (i.e. hospital, home, temp.res). |
|---|---|---|---|---|
| | | | | |

**Comments:** i.e., equipment removed

| **Absence of life verified by:** | | | | | |
|---|---|---|---|---|---|
| **Name** | | | | | |
| **Designation** | | **Contact No.** | | | |
| **Signature** | | **Date** | | **Time** | |

BLANK  FOR PRINTING PURPOSES.

## Last Offices Hospital Check List (page 1 of 2)

**Appendix 3**

**Patient's surname:** **Forenames(s):**

**DOB:** **NHS Number:**

**Patient's address including postcode:**

**Religion:** **Gender:** **Ward:**

**Date/Time of Death:**

**Valuables left on Body: Y/N (list)**

**INVASIVE DEVICES IN SITU (e.g. Catheter/central line/pacemaker) Y/N (List Details)**

**INFECTION RISK: Y/N (Details)**

**Undertaker's name**

## Last Offices Hospital Check List (page 2 of 2).

| Surname:<br><br>First Name: | NHS Number:<br><br>Date of Birth: | Plymouth Community HEALTHCARE |
|---|---|---|

| ACTION | COMPLETE (Initial) |
|---|---|
| **Prepare the Patient's Property Check List B** | |
| 1. List all patients' property – checking contents with second person. | |
| 2. Record all valuables in the Property book, including any jewellery removed from the deceased – to be logged with the Cashier for safekeeping or in ward safe. | |
| 3. Valuables and/or property removed by the family/significant other should be recorded at the time. | |
| 4. Place property in patient's bag or Hospital Property bag – carefully & tidily. | |
| 5. Soiled clothing being returned to family/significant other need to be alginate bag & labelled. | |
| **Information to family/significant other/relatives/significant others. Check List C** | |
| 1. Details of any coroner or hospital post-mortem needed (Dr's to discuss) | |
| 2. information re: Bereavement office opening hours | |
| 3. Arrangements for viewing the body at a later stage at their chosen Funeral Directors viewing area. | |
| 4. Ascertain any known wishes regarding burial or cremation – record these | |
| 5. Information leaflet – 'What to do after Death' | |
| 6. Information & discussions held with the family/significant other must be recorded in the Patient's records. | |
| 7. Notify all health professionals involved in care. | |
| | |

| Completed By | | Completed By | | Procedure Verified by Nurse | |
|---|---|---|---|---|---|
| Name (Print) | | Name (Print) | | Name (Print) | |
| Position | | Position | | Position | |
| Date | | Date | | Date | |

## Last Offices Community Check List (page 1 of 2)

**Appendix 4**

**Patient's Surname:** **Forenames(s):**

**DOB:** **NHS Number:**

**Patient's address including post code:**

**Religion:** **Gender:** **Location:**

**Date/Time of Death:**

**Valuables left on Body: Y/N (list)**

**INVASIVE DEVICES IN SITU (e.g. Catheter/central line/pacemaker) Y/N**

**List Details:**

**INFECTION RISK: Y/N (Details)**

## Last Offices Community Check List (page 2 of 2).

| | | |
|---|---|---|
| Surname:<br><br>First Name: | NHS Number:<br><br>Date of Birth: | Plymouth Community HEALTHCARE |

**Undertakers name:**

| ACTION | COMPLETED Yes/No |
|---|---|
| 1.Follow infection prevention & control standard precautions as detailed in this policy when caring for the deceased. | |
| 2.Ensure dignity & privacy of deceased at all times. | |
| 3.Inform medical staff. Verification of death by appropriate person must be completed. Inform relatives. | |
| 4.Position body on back, place pillow under chin to support jaw, close Eyelids as able. | |
| 5.Offer chaplaincy support – taking into account cultural & religious requirements. | |
| 6.Insert dentures & close mouth (if dentures cannot be fitted ensure they are kept securely with body). | |
| 7.Record any Implanted cardiac defibrillators in situ to alert funeral directors staff. | |
| 8.Where necessary leave cannulae, catheters, wound dressings etc in situ & record in notes. | |
| 9.Remove all mechanical/electrical devices & plug tubes & drains - (unless coroner's case). | |
| 10. Where necessary discontinue Syringe Driver infusion, discard of Syringe contents record remaining mls---------- | |
| 11.Provide personal care unless specific religious preparation of body is required. | |
| 12.Dress deceased in nightwear/clothes provided. | |
| 13.Cover patient with appropriate bedding. Remove other linen and equipment. | |
| 14.Prepare for transfer to undertakers. | |
| 15.Notify all health professionals involved in care. | |
| 16. Discuss bereavement support with family. Issue bereavement leaflet. | |

| Completed By | | Completed By | | Procedure Verified by Nurse | |
|---|---|---|---|---|---|
| Name (Print) | | Name (Print) | | Name (Print) | |
| | | | | | |
| Position | | Position | | Position | |
| Date | | Date | | Date | |

## Deactivation of ICD's Appendix 5

1. Implanted Cardiac Defibrillators or ICDs.
   An increasing number of patients are having ICDs implanted particularly for the treatment of Heart Failure. Special precautions need to be taken with these devices.

2. If a patient is expected to die within weeks from a life limiting disease, it is advisable to have the ICD deactivated to prevent it firing inappropriately. An ICD can alter unstable cardiac rhythms and deprive a terminally ill patient of a timely, natural death.

3. Ideally a discussion should take place between the patient, family/significant other(s) and the medical team/GP. Decisions will need to be made about the management of the illness, the relevance of the defibrillator and the possibility of deactivation of the device in order to avoid unpleasant symptoms. ICD discharges can be physically and emotionally distressing for patients.

4. The Cardiologist's opinion should be sought and if deactivation is felt appropriate the Cardiologist will notify the Cardiac Physiologist in writing. The patient/family/significant others will then be contacted to arrange a suitable time for deactivating the device. A programmer is needed to deactivate the ICD. <u>There is currently no domiciliary deactivation service in the South West</u>.

5. ICD devices must be deactivated and removed before a patient is cremated (see Plymouth Hospitals NHS Procedure 5020). It is vital that mortuary staff are aware of the presence of an ICD as an active unit can give a mortuary technician removing it an unpleasant shock. The presence of an ICD should be clearly marked on the front of patients medical records. Ordinary pacemakers do not need to be deactivated prior to death.

**For further advice please contact:**Cardiology Department, Plymouth Hospitals NHS Trust, on **01752 763089 Monday – Friday 0900 – 1700** hours **Out of those working hours** please call Cardiac Consultant via switchboard **0845 155 8155**.

## Check list for referral to Coroner's Officer Appendix 6

- The cause of death is unknown
- Death cannot readily be certified as being due to natural causes.
- The deceased was not attended by the doctor during his/her last illness or was not seen within the last 14 days or viewed after death
- There are any suspicious circumstances or history of violence
- The death may be linked to an accident (whenever it occurred) or a fall
- There is any question of self-neglect or neglect by others
- The death has occurred or the illness arisen during or shortly after detention in police or prison custody (including voluntary attendance at a police station)
- The deceased was detained under the Mental Health Act
- The death is linked with an abortion
- The death might have been contributed to by the actions of the deceased (such as a history of drug or solvent abuse, self-injury or overdose)
- The death could be due to industrial disease or related in any way to the deceased's employment. See the long check list in the Medical Cause of Death Certificate book
- The death is due to a hospital acquired infection
- The death occurred during an operation or before full recovery from the effects of an anaesthetic or was in any way related to the anaesthetic (in any event a death within 24 hours should normally be referred)
- The death may be related to a medical procedure or treatment whether invasive or not
- The death may be due to lack of medical care
- There are any other unusual or disturbing features to the case
- The death occurs after admission to hospital within the period of any local rule (unless the admission was purely for terminal care)
- It may be wise to report any death where there is an allegation of medical mismanagement.

This note is for guidance only. If in any doubt contact the Coroner's Officers for further advice. Link to document – www.gro.gov.uk/medcert/

## Arrangements for transfer of Deceased from Inpatient areas

**Appendix 7**

## Acknowledgment of Receipt of Deceased Patient

This form is to be completed before the deceased patient is removed from Ward/unit and to be retained by the ward.

Name of Deceased: (first) _____

(family) _____

NHS Number _____

Personal clothing, effects and jewellery/items of value left on deceased:

| **Item** | **Location** |
|---|---|
| | |

Infection Control Issues

Ward staff to consult End of Life Policy incorporating Infection prevention and control.

On behalf of _____ I acknowledge receipt
(Name of Funeral Director or Coroner's Ambulance)
of the above named patient.

_____
(signature)

_____
(name in block capitals)

Date _____ Time_____ Unit/Ward _____

Staff signature and printed name _____ _____

Ward Staff to file this form within patient records.

## Appendix 8

# Management of Known or Suspected Infections that need Precautions after Death.

This table is for use in completing the Infection Control Notification Form which accompanies the body. The form gives important health and safety information to funeral workers and others. Most infections do not warrant special precautions following death, providing standard safe-working practices are adopted. Advice should be sought from the Infection Control Team or Consultant in Communicable Disease Control if in doubt. Recommendations also apply to deceased children. Use of cadaver bags is recommended for safe transport between the mortuary and funeral home for bodies that impose an infection risk.

| Infection | **Causative agent** | **Is a body bag needed?** | **Can the body be viewed?** | **Can hygienic preparation be carried out?** | **Can embalming be carried out?** |
|---|---|---|---|---|---|
| **Transmission - faecal-oral route** | | | | | |
| Dysentery (bacillary) | *Shigella dysenteriae* | Advised | Yes | Yes | Yes |
| Hepatitis A | Hepatitis A virus | Advised | Yes | Yes | Yes |
| Typhoid/paratyphoid fever | *Salmonella typhi*, *S. paratyphi* | Advised | Yes | Yes | Yes |
| Gross faecal soiling | | Advised | Yes | Yes | Yes |
| Food poisoning | | Advised | Yes | Yes | Yes |
| *Clostridium difficile* | *Clostridium difficile* | Advised | Yes | Yes | Yes |
| **Transmission – contact with blood or other body fluids (including via contaminated sharps)** | | | | | |
| HIV | Human Immunodeficiency Virus | Yes | Yes | Yes | No* |
| Hepatitis B,C and D | Hepatitis B virus<br>Hepatitis C virus<br>Hepatitis D virus | Yes | Yes | Yes | No* |
| Jaundice of suspected infective origin | | Yes | Yes | Yes | No* |
| **Transmission – respiratory route via airborne or droplet transmission**** | | | | | |
| Tuberculosis (including drug-resistant) | *Mycobacterium tuberculosis* | Advised | Yes | Yes | Yes |
| Meningococcal meningitis or septicaemia | *Neisseria meningitidis* | Advised | Yes | Yes | Yes |

| | | | | | |
|---|---|---|---|---|---|
| Non-meningococcal meningitis | Various bacteria (e.g. *Streptococcus pneumoniae*, *Haemophilus influenzae*) and viruses | No | Yes | Yes | Yes |
| Diphtheria | *Corynebacterium diphtheriae* | Advised | Yes | Yes | Yes |
| **Transmission – direct contact or indirect contact via contaminated objects** | | | | | |
| Invasive Streptococcal infection | *Streptococcus pyogenes* ('Group A Streptococcus') | Yes | Yes | No | No |
| MRSA | Methicillin-Resistant *Staphylococcus aureus* | No | Yes | Yes | Yes |
| **Other infections** | | | | | |
| Viral haemorrhagic Fevers (transmitted by contact with blood) | Viruses (e.g. Lassa fever virus, Ebola virus) | Yes | No | No | No |
| Transmissible Spongiform Encephalopathies **(**transmitted by puncture wounds, inoculation injuries, contamination of broken skin, splashing of mucous membranes) | Prions (e.g. Creutzfeld Jacob Disease) | Yes | Yes | Yes | No |

* The embalming of known or suspected hepatitis B or HIV-positive bodies is not recommended, but if held to be essential, particular care is necessary and the local Consultant in Communicable Disease Control should be advised of the situation to ensure that the procedure is carried out safely and lawfully and by an experienced embalmer.
** Place cloth or mask over deceased's mouth at all times

**If the infection is <u>not</u> on the list and you are in any doubt, contact the Infection Control Team.**

Department of Health guidelines are that cadaver bags should be used for typhus and are advised for the following: acute poliomyelitis, brucellosis, Scarlet Fever and Hepatitis A.

Other conditions requiring a body bag and with restriction of contact (except touching face) but should not be removed from bag are:

a) death in dialysis units
b) known intravenous drug user
c) severe secondary infection
d) gangrenous limbs and infected amputation sites
e) large pressure sores
f) leakage and discharge of body fluids likely
g) post-mortem
h) incipient decomposition.

## Appendix 9

# Infection Control Notification Form

| | | |
|---|---|---|
| Name of deceased | | |
| Date and time of death | | |
| Source hospital and ward | | |
| The deceased's remains are a potential source of infection: | | |
| Yes No Unknown | | (Ring as appropriate – see Note 1 below) |
| If yes (see Note 2), the remains present a risk of transmission by (ring as appropriate) | | |
| Inoculation | Aerosol | Ingestion |
| If 'Yes', instructions for handling remains (tick as appropriate) | | |
| Body bagging is necessary | | |
| Viewing is not recommended | | |
| Embalming presents high risk, e.g. HIV | | |
| Signed (Note 3) | | |
| Print name | | |
| On behalf of (hospital/mortuary/general practitioner) | | |
| | | |
| | | |
| | | |

**Notes**

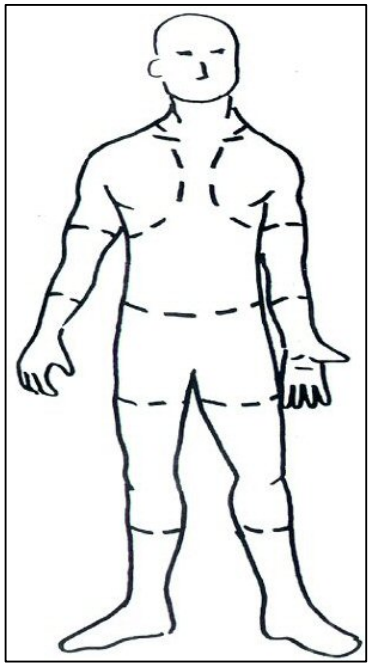
Note 1: Not all infected patients display typical symptoms, therefore some infections (including blood-borne viral infections) may not have been identified at the time of death.

Note 2: In accordance with health and safety law and the information provided in the Health Services Advisory Committee guidance, *Safe working and the prevention of infection in the mortuary and post-mortem room* (2nd edition 2002).

Note 3: In hospital cases, the doctor certifying death, in consultation with ward nursing staff, is asked to sign this notification sheet; where a post-mortem examination has been undertaken, the pathologist (or qualified Anatomical Pathology Technologist) is asked to sign this sheet; in non-hospital situations, the doctor certifying death is asked to sign this sheet.

## Appendix 10
## Body Map for Marking Cannulae and Other Devices Puncture Marks

**PATIENT NAME**: _____ **HOSP NO/NHS NO**:_____
**WARD**:_____ **DATE**:_____

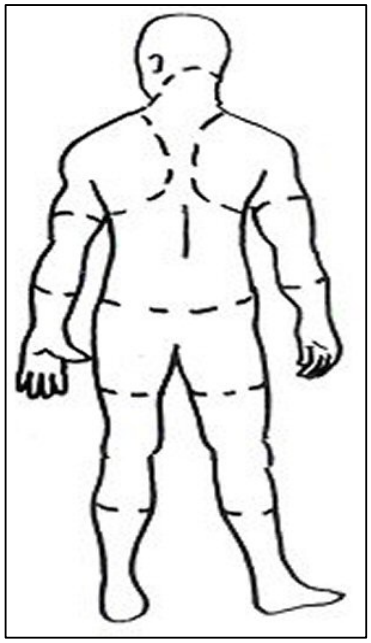


_____

_____

_____

_____



_____

_____

_____

_____

**COMPLETED BY** : _____ **SIGNATURE**: _____**STATUS** :_____

**Appendix 11**

**Label for Cadavers with Lines left in**

***CAUTION***

***LINES / CANNULAE***
**IN SITU**

## Appendix 12

# Infections that should be reported to the CCDC

| | |
|---|---|
| Suspected or proven infective diarrhoea and/or vomiting, especially when occurring in a cluster (including dysentery and food poisoning) | Meningitis (including 'aseptic', viral, bacterial and fungal) |
| Typhoid Fever | Meningococcal septicaemia |
| Diphtheria | Acute encephalitis |
| Acute poliomyelitis | Tuberculosis |
| Anthrax | Measles |
| Cholera | Mumps |
| Typhoid and paratyphoid fever | Rubella |
| Viral haemorrhagic fever | Scarlet Fever |
| Leprosy | Whooping cough |
| Leptospirosis | Ophthalmia neonatorum |
| Malaria | Viral Hepatitis |
| Plague | Rabies |
| Typhus | Relapsing fever |
| Tetanus | Smallpox |
| Yellow fever | |

**Assessment of Competence** **Appendix 13**

**Clinical skill:** **Confirmation of Expected Death in Adults**

**Name:**

| | |
|---|---|
| **Aim:** | The patient's death will be confirmed competently in a timely manner |
| **Objectives:** | The practitioner will be able to:<br>• Demonstrate understanding of the knowledge and skills necessary for confirmation of expected death.<br>• Demonstrate competency in performing the procedure. |
| **Training:** | Attendance at a training session and supervised practice. |
| **Assessment:** | Using performance criteria overleaf |
| **Update:** | Competence to be reviewed annually at Appraisal / Individual Performance Development Review (IPDR) |

**Skills and Knowledge**

- Accountability for expanded practice
- Legal responsibilities of confirming death
- Difference between confirming death and certifying death
- Religious, cultural and ethnic diversity
- The correct procedure used to confirm that death has occurred

**I certify that the above named Registered Health Care Practitioner has completed the theoretical assessment which covered the above:**

**Signed:** …… **Date:** ……

| | | | |
|---|---|---|---|
| **Print Name:** | …….. | **Position:** | …… |

| Skills Assessment | |
|---|---|
| Performance criteria: The practitioner will: | Performed safely (✓) |
| 1. Treat the deceased with respect | |
| 2. Confirm the absence of breathing for one minute | |
| 3. Confirm the absence of heart sounds for one minute | |
| 4. Confirm that the carotid pulse is absent | |
| 5. Confirm that the pupils are fixed and dilated | |
| 6. Confirm the death with family members in an appropriate manner | |
| 7. Complete the documentation correctly | |
| 8. Make an appropriate entry in the Nursing notes | |
| I confirm that the Registered Healthcare Practitioner named overleaf has completed the assessment competently. | |

| | | | |
|---|---|---|---|
| **Signed:** | …….. | **Date:** | …… |
| **Print Name:** | …… | **Position:** | …… |

**Assessor Comments:**

**Candidate Comments:**

Declaration
I confirm that I have had theoretical and practical instruction on how to safely and competently perform Confirmation of Expected Death and to comply with the policy and procedures of the Trust.

Signed:
……

| | |
|---|---|
| **Signed:** | …… |