A Whittington Hospital Clinical Policy

Caring for the Deceased

Date: 2002
Author: A O'Neil /D Wheeler
Specialty: General

CRITERIA FOR USE: Organ Donation, Death, Bereavement, Denominations, Body Bags

Contents: Summary, Personal Effects, Introduction, Referral to the Coroner, Useful Contact Numbers, Arranging Burial or Cremation, Informing Relatives and Next of Kin, References, Training, Multicultural/ Denominational Considerations, A Brief Review of Cultural Requirements (Appendix 1), Organ Donations, General Criteria for Organ Donation (Appendix 2), Viewing the Body, Last offices Check List (Appendix 3), Communicable Disease Report (Appendix 3A), Preparation of the Body/Last Offices, Reporting Death to the Coroner (Appendix 4)

➢Introduction

The policy addresses the following issues specifically:

- ☞ Bereavement and care of relatives
- ☞ Multi Cultural/Denominational Considerations
- ☞ Viewing the body
- ☞ Referral to the Coroner
- ☞ Dealing with personal effects
- ☞ Arranging burial and cremation
- ☞ Organ donation
- ☞ Meeting spiritual needs
- ☞ Referral to/Contacting the District Bereavement Co-ordinator
- ☞ Referral to/Contacting the Chaplainacy
- ☞ Referral to/Contacting the Mortician

➢*Useful Contact Numbers*

Trust Chaplain, Reverend Martin Inman, Chaplaincy Co-ordinator	020 7288 5337
Representatives of other faiths can be contacted via switchboard	020 7272 3070
Relatives Liaison Office	020 7288 3119
Mortuary Services Manager, Dean Jansen	020 7288 5330
General Office	020 7288 5135
Coroner's Office	020 7387 4882

➢*1. Informing Relatives & Next of Kin*

1.1 The patient's care plan should identify the patient's next of kin and specifically state who should be contacted in the event of deterioration in condition or death of the patient. The identity of the person to be contacted in the first instance should be agreed between the ward staff and relatives/carers. If the first person to be contacted cannot be agreed, the next of kin should be contacted. The identified person should be contacted as soon as possible following deterioration in condition or death of the patient.

1.2 If death is expected, medical staff should discuss with the relatives to what extent resuscitative measures should be performed (refer to resuscitation policy).

1.3 Medical staff must also ensure that other relevant agencies are informed, for example, the General Practitioner, community staff and any others who have been involved in the patient's care.

1.4 Ensuring that the religious denomination is documented in the care plans of all admitted patients will assist in caring for needs of the bereaved in cases of expected and unexpected death. Where specified in the patient's care plan, the patient's spiritual adviser or minister should be contacted. The Chaplaincy will also provide support for patients and the bereaved of all faiths, and those who have no religious beliefs.

➢*2. Care of Relatives*

2.1 Following a death, emotional and spiritual needs of relatives should be provided for. Support of relatives should be provided by the ward staff in the first instance. A Chaplain's care should be offered in all cases. It is acknowledged in the field of bereavement that relatives often benefit from being able to leave hospital as soon after the death has occurred as possible, and formal support is more beneficial one to two days later after the initial shock has subsided. Spiritual needs of patients and relatives can be provided more effectively if ward staff ensure that the Chaplaincy are involved in care of patients and relatives before death has occurred, provided this is the patients choice, when a death is expected.

2.2 Following death of a patient, ward staff should ensure that relatives are able to travel home safely, and should assist in arranging transport home where necessary by contacting more distant relatives or arranging a taxi for the patient. Arranging a taxi via the hospital transport department is acceptable in exceptional circumstances (for example, for individuals who have been transported to hospital with their relatives by ambulance and have no means of getting home).

2.3 Staff should be able to recognise dangerous reactions to grief in relatives or friends of the deceased. Relatives in a distraught state who are in need of urgent medical attention should be referred to the Accident and Emergency department, again staff should ensure relatives are able to get home safely.

➢*3. Multicultural/Denominational Considerations*

3.1 Staff need to be aware of needs related to religion, culture and gender in a multi-faith, multi- cultural society. There may be specific requirements regarding treatment of the body after death. If death is expected and if deemed appropriate, special requirements should be discussed with the relatives/carers and clearly specified on the front sheet of the care plan. Where death is not expected or such discussions with relatives have not been possible, the hospital chaplinacy can be contacted in the first instance for advice. In some cultures, touching or treating the body after death is forbidden, advice should therefore be sought before any procedures are undertaken if religious and cultural requirements are unknown. A limited amount of information on cultural issues is given in Appendix 1 of this policy.

➢*4. Organ Donation*

4.1 The possibility of organ donation (including corneal and tissue donation) should be considered. Some types of donation do not require continuation of life support and can be donated up to 24 hours after death. (See Appendix 2)

4.2 Consent for organ donation must be obtained from the next of kin, even if a signed organ donor card is found amongst the patients' personal effects. Organ donation is arranged via the Regional Transplant Co-ordinator (contact number and procedure are available in the Intensive Care Unit, the Accident and Emergency Department). Corneal donation is arranged through Moorefields Eye Hospital.

4.3 Donation to medical science is arranged through the Anatomy School.

➢*5. Viewing the Body*

5.1 Relatives wishing to view the body should be accommodated. A leaflet for relatives, explaining the procedure, is available (*Coping with death the first few hours*[1]). Relatives should be made aware that they may have to wait some time while the viewing is arranged, especially if out of hours. Encouragement should be given to view during daylight hours when the death relates to an in-patient.

➢*6. Preparation of the Body / Last Offices*

The following actions are to be taken following the death of a patient.

Section 1 refers to the actions to be taken in the event of an expected or uncomplicated death.

Section 2 refers to the actions to be taken following:

a) death occurring within 24 hours of an operation,
b) unexpected death, unknown cause of death, patient brought in dead
c) deceased patient with a communicable disease,
d) patients who have received radioactive substances.
e) patients who have prostheses INCLUDING pacemakers.

This should be read in conjunction with

- mortuary policy on the transfer of bodies to the mortuary.
- policy and guideline for the confirmation of death by nurses.

SECTION 1 - EXPECTED OR UNCOMPLICATED DEATH

The Last Offices check list (Appendix 3) must be completed for ALL patients.

1. Inform medical staff.

[1] Currently under review by Jane Wilson

An expected death may be verified by a registered nurse (see Policy)

An expected death must subsequently be certified by the attending medical officer. Confirmation of death must be recorded in a patient's medical and nursing notes.

2. Inform and offer support to relatives and/or next of kin. If not contactable, police may be able to assist.

3. Lay the patient on his/her back. Close his/her eyelids. Remove all but one pillow. Support the jaw by placing a pillow or rolled-up towel on the chest underneath the jaw. Remove any mechanical aids such as syringe drivers, heel pads, etc. Straighten the limbs.

4. Drain the bladder by pressing on the lower abdomen. Pack orifices with gauze if heavy fluid secretion is present. Wear gloves and plastic apron. If there is likely to be a leakage of blood or body fluids a body bag must be used and note on check list.

5. Remove dressings, drainage tubes etc., unless otherwise instructed e.g. if death occurs within 24 hours of an operation (see Section 2). Open wounds or drainage sites may need to be sealed with an occlusive dressing.

6. Any battery operated prostheses (Pacemaker, hearing aid etc.) must be noted (see Section 2 on the check list)

7. Wash the patient, unless requested not to do so for religious/cultural reasons (see Appendix 1)

   Family and carers may wish to assist with washing, to continue to provide the care given in the period before the death.

8. Remove all jewellery, in the presence of another nurse, unless requested to do otherwise and record in valuables book.

9. Dress patient in shroud, or specified clothing, unless requested to do otherwise.

10. Label one wrist and one ankle with an identification band. Print the patient's name, hospital number, date of birth and religion (if possible). Pseudonyms will not be accepted by mortuary staff. In the event of the patient's name not being known, then the tag must state UNKNOWN MALE or UNKNOWN FEMALE. Complete any documents such as notification of death cards. Tape one securely to the shroud.

11. Wrap the body in a sheet, ensuring that the face and feet are covered and that all limbs are held securely in position.

12. Secure the sheet with tape.

13. If body is to be placed in a body bag, first wrap in a disposable sheet.

14. Tape the second notification of death card to the outside of the sheet or body bag. If a body bag is used the doctor who certifies the patient dead MUST indicate on a label, whether the patient may be viewed, embalmed and/or hygienically prepared in accordance with CDR guidelines, (Appendix A). The precise infectious cause of death must not be stated for reasons of confidentiality.

15. Request the portering staff to remove the body.
Screen off the area from the view of the other patients/visitors.

16. Check the patient's property with a second nurse. List the property in the valuables or property book, including any left on the body. If out of hours lock the property in a safe place and transfer property with the patient record to the relatives liaison office during office hours.

17. Complete appropriate nursing documentation. Ensure Last Offices check list is fully completed, which portering staff will take to the mortuary when removing the body.

SECTION 2

Action to be taken following the unexpected death, or complicated death of a patient.

a. Death occurring within 24 hours of an operation.

Last Offices should be carried out as above except that all tubes, drains, etc. must be left in place as a post mortem may be required.

b. Unexpected death, unknown cause of death, patient brought in dead.

Last Offices should be carried out as described above. However, staff should be aware that a post mortem may be required and it is therefore essential to ascertain from medical staff whether drains, IV's, syringe drivers, etc. should be left in place.

c. Patient with a communicable disease.

Patients who have had specific infections may need to be placed in a body bag. Please refer to Last Offices check list (appendix 3&3a) which details guidance with respect to the need for body bags, whether hygienic preparation is acceptable, the suitability of viewing, and whether or not embalming is advised. If there is risk of blood or body fluids leakage, a body bag MUST be used. If there

is risk of infection, the label in the pocket of the body bag MUST indicate if the body may be viewed, embalmed and/or hygienically prepared. To respect the deceased right to confidentiality, it is not acceptable to state the infectious condition. If further advice is required, please contact the Infection Control Department, extension 3261.

d. Patients who have received radioactive substances, eg systemic radioactive iodine, gold grains or colloidal radioactive solution or who have had insertion of caesium needles or applicators or irridium wires or hairpins.

When dealing with a cadaver that is radioactive, minimum handling is to be undertaken. The on-call medical technical officer for the Mortuary will contact the senior radiographer or consultant radiologist for further advice.

e. Prostheses - Any battery operated prostheses (Pacemaker, hearing aid etc.) must be documented on the Last Offices check list as they will require removal before cremation. If a pacemaker is not removed it will almost certainly explode in the crematorium furnace, which will result in damage and injury for which the Trust will be liable. For further details contact mortuary services manager extension 5696.

➢*7. Personal Effects & the Relatives Liaison Office*

7.1 Personal effects should be clearly labeled and a property list identifying all items should be included with the property. Whilst in the ward area, valuable items, money or pension books should be kept in a locked cupboard. These should be conveyed to the relatives' liaison office as soon as possible following the death of the patient. The property list should include detailed descriptions of all valuable items (eg a one sentence description of any jewellery, ie specifying yellow metal or white stones as necessary to avoid conflict over value, or contents of wallets and purses) to aid identification. Personal property must be contained in proper carrier bags/containers (as opposed to bin liners or rubbish sacks which should not be used) to be returned to relatives.

7.2 The relatives should be given the leaflet "*Coping with Death ;the first few hours*"[2] With clear instructions regarding collection of personal effects, valuables and the death certificate before they leave the hospital at the time of death. Ensure that the relatives are aware they should phone the relatives liaison office to arrange a suitable time for them to collect the personal effects and obtain the necessary documentation to register the death. The relatives liaison office will give information regarding the details and documentation they will require when the death is registered (date and place of birth and death, full names and maiden names, occupation of deceased and their spouse,

[2] Under Review (Jane Wilson)

pension details, date of birth of deceased's spouse, if married, and the deceased's medical card).

➢8. Referral to the Coroner

In certain situations, the death must be referred to the coroner. Referral to the coroner must be made by the attending medical officer if:

- the death was unexpected
- the diagnosis is unsure, or the doctor has been in attendance for less than 24 hours
- the death was due to a medical error
- the death was due to drugs
- patient was not under the care of a doctor at the time of death ie died at home of natural causes and was not being treated for any illness
- the doctor responsible for the care of the patient did not see him/her within 14 days before death
- the death occurred during or within 24 hours of surgery
- the death occurred when the patient was under anaesthetic or within 24 hours of recovery from anaesthetic
- the death may have been caused by industrial disease or injury
- the death may have been caused by violence, neglect, poisoning or abortion

See also Appendix 4 for more detail/examples. If in doubt, the attending doctor should discuss the case with the coroner as soon as possible.

➢9. Arranging Burial or Cremation

9.1 Arrangements for burial or cremation are usually made by the next of kin. If it is confirmed that there is no next of kin, friend or acquaintance, to register the death or organise the funeral, and no monies or estates are found, the finance department should be contacted. In these instances, if the patient was an in-patient at the time of death, it is either the local council or the Trust who are responsible for arranging and financing the burial. Relatives requiring assistance with funeral arrangements should be advised to enquire at the Relatives liaison offices when collecting property and the

death certificate. Relatives should be made aware that the Chaplaincy can offer advice concerning funeral services or arrangements.

➢*References*

- HSG(92) 8: “Patients who die in hospital”HSG(92)2 “Meeting the spiritual needs of patients and staff
- Communicable Disease Report Vol 5:5, April 1995.
- Verification of Death by Nursing Staff
- The Royal Marsden NHS Trust Manual of Clinical Nursing Procedure (2000) 5th edition. Blackwell Science.

➢*Training Requirements*

Members of staff requiring training in dealing with the bereaved should contact their line manager to access relevant programmes

Appendix 1: A Brief Review of Cultural Requirements

Buddhist patients and families

Most Buddhists prefer cremation, but this is a matter of personal choice. cremation is normally carried out between three and seven days after the death.
There is no religious objection to organ donation or post mortem.

Hindu patients and families

Adult Hindus are traditionally cremated. Young children and infants may be buried. Cremation or burial should take place as soon as possible, preferably within 24 hours.

There is no Hindu prohibition against organ donation, although individual families may find it unacceptable.

There is no Hindu prohibition against post mortem, although again some people find them unacceptable. Some families may be concerned that all the organs are returned to the body before cremation or burial.

Jehovah's Witness patients and families

There are no specific religious requirements for the disposal of the body.

There is no religious objection to organ donation or to post mortem.

Jewish patients and families

Burial normally takes place as soon as possible, usually within 24 hours and arrangements should not be delayed for hospital or administrative convenience. Staff will expedite matters as quickly as possible. In some areas registrars make special arrangements so that Orthodox Jews can register a death on a Saturday.

Only until 12am on Saturday mornings.

If a person dies on the Sabbath (Saturday) or a religious holiday, the funeral will normally take place on Sunday or after the holiday.

Members of the family or the community may wish to sit with the body until it is removed from the hospital. A quiet room will be needed for this. More information and advice can be obtained from your local synagogue, or from the Jewish Memorial Council, Woburn House, Upper Woburn Place, London WC1 (020 7387 3081) and the United Synagogue and Burial Society at the above address, (020 7387 7891, 24 hour answerphone).

For Orthodox Jews a body must be buried, never cremated.

Orthodox Jews do not permit post mortem unless they are required by law.

Orthodox Jews do not permit any action which would mar or dishonour the body. Organ donation is therefore normally forbidden. Last offices should be performed by members of the synagogue.

Muslim patients and families

Muslims are buried, not cremated. According to Islamic Law and practice, Muslims must be buried as soon as possible, normally within 24 hours.

Very strict Muslims are likely to be completely against organ transplants, but some may consider them acceptable.

In Islam, the body of a Muslim is considered to belong to God, and strictly speaking, no part of a dead body should be cut out or harmed. Post mortems are normally forbidden unless required for legal reasons. If a post mortem is required, the reasons for it must be explained clearly to the family.

Sikh patients and families

Sikhs are normally cremated, not buried. The cremation takes place as soon as possible, usually within 24 hours of the death.

A stillborn baby, or a baby who dies within a few days of birth, may be buried.

There is no religious prohibition against organ donation.

There is no religious prohibition against post mortems, but it is important that cremation takes place as soon as possible.

Appendix 2: General Criteria for Organ Donation

Small bowel	Up to 30 years of age
Pancreas	Up to 45 years of age
Femoral bone and knee joint	Up to 45 years of age
Femoral bone only	Up to 60 years of age (females)
Heart valves	Up to 60 years of age
Heart and lungs	Up to 60 years of age
Femoral bone only	Up to 70 years of age (males)
Liver	Up to 75 years of age
Kidneys	Up to 75 years of age
Skin from back and buttocks	Up to 85 years of age
Cornea	No age limit

Brain and spinal cord can also be donated for research purposes.

For further information or if you are unsure about the suitability of organs for transplantation, please contact the regional transplant co-ordinator (on call 24 hours) via 020 7725 2774and leave a short message.

Appendix 3: Last Offices Check List

WHITTINGTON HOSPITAL NHS TRUST

Name	**Hosp number (If not known give D.O.B.)**	**Ward/Dept.**

LAST OFFICES CHECK LIST
TO BE COMPLETED PRIOR TO THE BODY BEING REMOVED FROM THE WARD AND TO BE SENT
TO THE MORTUARY WITH THE BODY

			COMMENTS	**Signature**
Religious denomination				
Jewellery kept on body If YES, please give details / Description and state location **Record in valuables book &death notice**	**Y / N**			
Any other property If YES, please give details and state location (i.e. false teeth) **Record in property book**	**Y / N**			
Identification Bracelets *Must have two* *Check same name, DOB &Hospital Number on both*	Wrist	**Y / N**		
	Ankle	**Y / N**		
Eyes Closed If NO, use small piece of damp gauze to hold lids closed	**Y / N**			
Mouth Closed	**Y / N**			
Artifical Prosthetics left on body e.g. eye, leg, wig, hearing aid, dentures	**Y / N**			
Pacemaker Check medical records	**Y / N**			
Internal defibrillator in situ	**Y / N**			

Infectious/Communicable Disease (see appendix 3A for guidance)	**Y / N**		
Body Fluids Leaking If YES, use body bag	**Y / N**		
Cadaver in Body Bag If YES, please state reason if one other than above	**Y / N**		
Note if death was anticipated, remove all cannulae and tubing. In other events, leave cannulae and tubing in situ.			

Body details checked by:

Reg. Nurse_____Print name _____Date_____

RN / Support staff _____ Print name _____

Appendix 3A: *Communicable Diseases Report*

Table 1 Guidelines for handling cadavers with infections notifiable in England and Wales

Degree of risk	Infection	Bagging	Viewing	Embalming	Hygienic preparation
Low	Acute encephalitis	No	Yes	Yes	Yes
	Leprosy	No	Yes	Yes	Yes
	Measles	No	Yes	Yes	Yes
	Meningitis (except meningococcal)	No	Yes	Yes	Yes
	Mumps	No	Yes	Yes	Yes
	Opthalmia neonatorum	No	Yes	Yes	Yes
	Rubella	No	Yes	Yes	Yes
	Tetanus	No	Yes	Yes	Yes
	Whooping cough	No	Yes	Yes	Yes
Medium	Relapsing fever	Yes	Yes	Yes	Yes
	Food poisoning	Yes	Yes	Yes	Yes
	Hepatitis A	Yes	Yes	Yes	Yes
	Acute poliomyelitis	No	Yes	Yes	Yes
	Diphtheria	Yes	Yes	Yes*	Yes
	Dysentery	Yes	Yes	Yes	Yes
	Leptosprirosis (Weil's disease)	No	Yes	Yes	Yes
	Malaria	No	Yes	Yes	Yes
	Meningococcal septicaemia (with or without meningitis)	Yes	Yes	Yes*	Yes
	Paratyphoid fever	Yes	Yes	Yes	Yes
	Cholera	No	Yes	Yes	Yes
	Scarlet fever	Yes	Yes	Yes*	Yes
	Tuberculosis	Yes	Yes	Yes	Yes
	Typhoid fever	Yes	Yes	Yes	Yes
	Typhus	Yes	No	No	No
High	Hepatitis B, C and non-A, Non-B	Yes	Yes	No	No
High (Rare)	Anthrax	Yes	No	No	No
	Plague	Y es	No	No	No
	Rabies	Yes	No	No	No
	Smallpox	Yes	No	No	No
	Viral haemorrhagic fever	Yes	No	No	No
	Yellow fever	Yes	No	No	No

Table 2 Guidelines for handling cadavers with infections that are not notifiable in England and Wales

Low	Chickenpox/shingles	No	Yes	Yes	Yes
	Cryptosporidiosis	No	Yes	Yes	Yes
	Dermatophytosis	No	Yes	Yes	Yes
	Legionellosis	No	Yes	Yes	Yes
	Lyme disease	No	Yes	Yes	Yes
	Orf	No	Yes	Yes	Yes
	Psittacosis	No	Yes	Yes	Yes
	Methicillin resistant *Staphylococcus aureus*	No	Yes	Yes	Yes
	Tetanus	No	Yes	Yes	Yes
Medium	HIV/AIDS	Yes	Yes	No	Yes
	Haemorrhagic fever with renal syndrome	No	Yes	Yes	Yes
	Q fever	No	Yes	Yes	Yes
High	Transmissible spongiform encephalopathies (for example Creutzfeldt-Jakob disease)	Yes	No*	No	No
	Invasive group A streptococcal infection	Yes	No	No	No

* Requires particular care during embalming.

Definitions:

Bagging: ……	placing the body in a plastic body bag.
Viewing: ……	allowing the bereaved to see, touch, and spend time with the body before disposal.
Embalming ……	injecting chemical preservatives into the body to slow the process of decay. Cosmetic work may be included.
Hygienic preparation:……	cleaning and tidying the body so it presents a suitable appearance for viewing (an alternative to embalming).

Appendix 4 : Reporting Death to the Coroner

ALL VIOLENT SUDDEN or UNNATURAL deaths should be reported to the Coroner whether or not specifically covered in the following list:

ABORTION: If not natural; specifically death by reason of attempted self induced abortion or where there may be criminal interference.

ACCIDENT/MISADVENTURE: This is a very broad category including injury in a major disaster; road traffic accidents; falls at home, in the street, at a residential home or in hospital. Post operative deaths give rise to problems as to whether the death is natural but all post operative deaths linked to surgery or anaesthetic should be reported eg pulmonary embolism following repair of a fractured femurs septicaemia, osteomyelitis, gangrene and tetanus if following injury however slight.

ALCOHOL: Acute poisoning but not chronic alcoholism unless there is some other reason for referral other than the word alcohol in the medical cause of death.

ANAESTHETICS: All deaths in any way related to the administration of anaesthesia.

BIRTH: Death by reason of lack of care at birth eg abandoned baby.

CARE: A natural death may be aggravated by lack of care neglect or self neglect including hypothermia and these are natural deaths which should be reported.

CERTIFIED MENTAL PATIENTS: All deaths in hospital or elsewhere, NOT voluntary patients or non mental patients in a mental hospital unless they fall under another heading.

COMPLAINTS: Where there is any suggestion that relatives are not satisfied with treatment care or diagnosis. This may prove a valuable safeguard for Doctors, Medical and Nursing staff and often permits a resolution of what may be a misunderstanding or merely a lack of communication.

CRIME: Or suspicion of crime. The Police should also be informed.

DISEASES: Notifiable diseases and those which may give rise to public concern for their or their family's safety.

DRUGS: All drug related deaths including dependence on drugs and on dependent abuse, side effects and misuse.

FIRE: Death through burns or smoke inhalation.

INDUSTRIAL DISEASES: Arising out of the deceased's employment or a previous employment. This includes diseases covered by Factories Acts, prescribed diseases, exposure to toxic substances or radiation and industrial pulmonary diseases.

Since medical knowledge, legal changes and the use of new substances has broadened this area any suspected causal connection between death and employment should be included as and where the disease itself suggests contact with or exposure to a substance.

INJURY: Where not from accident but possibly self inflicted or cause unknown.

OPERATION: Where the operation has caused, contributed to death or death is incidental within one year and a day of the operation.

PENSIONS: Where deceased was in receipt of an Industrial or service disability pension; where deceased was diagnosed as suffering from an industrial disease in life although not the immediate cause of death.

POISONING: From any cause and including carbon monoxide.

PRISONERS: In custody whether in police cells, prison or under arrest even if the death occurs in hospital.

STILL BIRTHS: Only where there is an element of doubt as to whether there is a live birth.

ROAD TRAFFIC ACCIDENTS: See Accidents above. This includes running down and natural death while driving.

UNCONSCIOUS: Any circumstances where the deceased is brought in unconscious.

UNEXPECTED OR SUDDEN DEATH: Where a diagnosis is unsure or where a Doctor has been in attendance for less than 24 hours.

PLEASE NOTE THAT REFERRAL TO THE CORONER CARRIES NO DISCREDITABLE IMPLICATIONS AT ALL