

Guidance for staff responsible for care after death (last offices)

Developed by the National End of Life Care Programme
and National Nurse Consultant Group (Palliative Care)



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To be reviewed: April 2014

Foreword

Caring for a person at the end of their life, and after death, is enormously important and a privilege. There is only one chance to get it right and it is not at all easy to coordinate everything that needs to happen. This guidance will help with that.

The DH End of Life Care Strategy (2008) for England set out a pathway of care covering each step in the end of life care journey. This document is written for all health and social care professionals, who care for the person who has died and their carers, and details the key elements of care provision in the immediate period following death – the final step of the end of life care pathway. Responsibilities for caring for the deceased moves between differing professions and teams - nurses, doctors, porters, mortuary staff, pathologists, coroners, funeral directors and bereavement teams – and implementation of this guidance will help prevent either duplication of roles or gaps in care provision.

In developing this guidance there was a review of the evidence base and then four rounds of consensus building for those areas of practice not yet fully researched. Throughout this process, over one hundred

individuals – representing all organisations with a responsibility for caring for people after death – have demonstrated a willingness to work together and share professional expertise. We view these people as our partners in this work and they have shaped a cogent and cohesive pathway for delivery of care after death that honours the integrity and wishes of the person who has died. Importantly, it also puts the deceased and their carers at the focus of the care, whilst balancing the needs of the legal and coronial system and the health and safety of staff.

This guidance is designed to underpin training for all those involved – in the pre-registration curriculum, post registration training, professional training and the training of carers – and will helpfully affect how we can explain good practice in this sensitive area of practice in the future.

We recognise and acknowledge the important role that all staff play in caring for the deceased and their carers. It is a rewarding area of care, but the lack of clear guidance and training can make it challenging. This guidance and the associated e-learning modules are an important step in addressing this gap.



Claire Henry
Director
National End of Life Care Programme



Jo Wilson
Macmillan Consultant Nurse Practitioner
National Nurse Consultant Group Palliative Care

Introduction

The nurses' role at the end of life extends beyond death to provide care for the deceased person and support to their family and carers. The physical care given by nurses following death in hospitals has traditionally been referred to as 'last offices'. However, in this guidance we refer to 'care after death', a term more befitting of our multi-cultural society.

This guidance does not use the term 'last offices' because we wish to move away from the link with the military and religious origins of nursing and the association with 'last rites', a Christian sacrament and prayer administered to the dying¹, and because 'last offices' only applies to the physical preparation of the body.

The new terminology 'care after death' is intended to reflect the differing nursing tasks involved, including on-going support of the family and carers. The physical preparation of the body itself will be called 'personal care after death'.

The person who provides the care after death takes part in a significant process which has sometimes been surrounded in ritual. Although based on comparatively straightforward procedures, it requires sensitive and skilled communication, addressing the needs of family members/carers and respecting the integrity of the person who has died. It is a very difficult time for those who have been bereaved and can be emotionally challenging for nurses.

Care after death is a key responsibility for registered nurses in hospitals.² In other settings (such as care and nursing homes, hospices and people's own homes) those responsible can also include carers, social care staff, GPs and funeral directors.

The diagram on page 4 shows that care after death, while being the last act of nursing care, is the first stage of a pathway that involves a range of professional groups. This process leads ultimately to cremation or burial of the body.

Professionals involved in this pathway include doctors, mortuary staff, hospital porters, ambulance staff, bereavement officers, police, social care staff, funeral directors, pathologists, coroners and faith leaders. Co-ordinated working between these individuals and organisations is vital if the process is to run smoothly.

Care after death includes:

- Honouring the spiritual or cultural wishes of the deceased person and their family/carers while ensuring legal obligations are met
- Preparing the body for transfer to the mortuary or the funeral director's premises
- Offering family and carers present the opportunity to participate in the process and supporting them to do so
- Ensuring that the privacy and dignity of the deceased person is maintained
- Ensuring that the health and safety of everyone who comes into contact with the body is protected

¹ *Nursing care of dead bodies: a discursive analysis of last offices*, B Quedest/T Rudge, *Journal of Advanced Nursing*, Mar 2003 (vol 41, issue 6) pp 553-60

² *"Till death us do part?" The nurse's role in the care of the dead: a historical perspective: 1850-2004*, C Blum, *Geriatric Nursing*, Jan-Feb 2006 pp 58-63

- Honouring people's wishes for organ and tissue donation
- Returning the deceased person's personal possessions to their relatives.

The nature of the death and the context in which it has occurred affects how care is provided, as well as the level of support needed by those who have been bereaved. For example, some deaths are expected or peaceful while others may be sudden or traumatic. As a result, families and carers are likely to have a range of responses and needs and each may also have differing views about how the person should be cared for after death. They may be very protective of the deceased person, feeling that their loved one has 'suffered enough'.³ Appropriate and sensitive nursing care at this time is therefore vital.

This guidance is for nurses and those who have nursing tasks delegated to them. It is also relevant for all health and social care professionals who work with people at the end of life, having been written with the co-operation of a wide range of related professional organisations. It sets out key principles and is intended as a guide for training, as well as for informing the development of organisational protocols for this area of care. It also aims to provide a consistent view that accommodates England's diverse religious and multi-cultural beliefs.

Existing work has been referenced where possible. Where published research was not available, a consensus⁴ approach was taken, based on nationally recommended guidelines developed by the Royal Marsden Hospital⁵ and involving key national stakeholders (see appendix 3). The National Nurse Consultant

Group (Palliative Care) led the project, working with the National End of Life Care Programme, the Department of Health and other partners.

The term 'family', rather than 'next of kin', has been used throughout because it is more representative of modern living arrangements, where people involved may not all be blood relations. With respect to organ donation and postmortem, however, consent needs to be sought from the person with the highest qualifying familial relationship.⁶

The guidance relates to other concurrent national work:

- NICE development of and consultation on the end of life care Quality Standard
- DH revision of the 2005 guidance *When a Patient Dies*
- Revision by Cruse Bereavement Care and the Bereavement Services Association of the 2001 document by the London Bereavement Network which it called *Standards for bereavement care in the UK**
- Introduction of new regulations on death certification process.

Two new e-learning modules will also support the implementation of this guidance. They are being developed by End of Life Care for All (e-ELCA), commissioned by the Department of Health and the National End of Life Care Programme and delivered by e-learning for Healthcare (e-LfH), in partnership with the Association of Palliative Medicine of Great Britain and Ireland. For more information, go to www.e-lfh.org.uk/projects/e-elca.

*The London Bereavement Network no longer exists. *Standards for bereavement care in the UK* does not reflect the views of the Department of Health and will be renamed as part of its 2011 revision.

³ *Why relatives do not donate organs for transplant: 'sacrifice' or 'gift of life'?*, Sque et al (2007), Journal of Advanced Nursing, Jan 2008 (vol 61, issue 2) pp 134-44

⁴ *Consensus methods for medical and health services research*, J Jones/D Hunter, British Medical Journal, 5 Aug 1995 (vol 311, issue 7001) pp 376-80

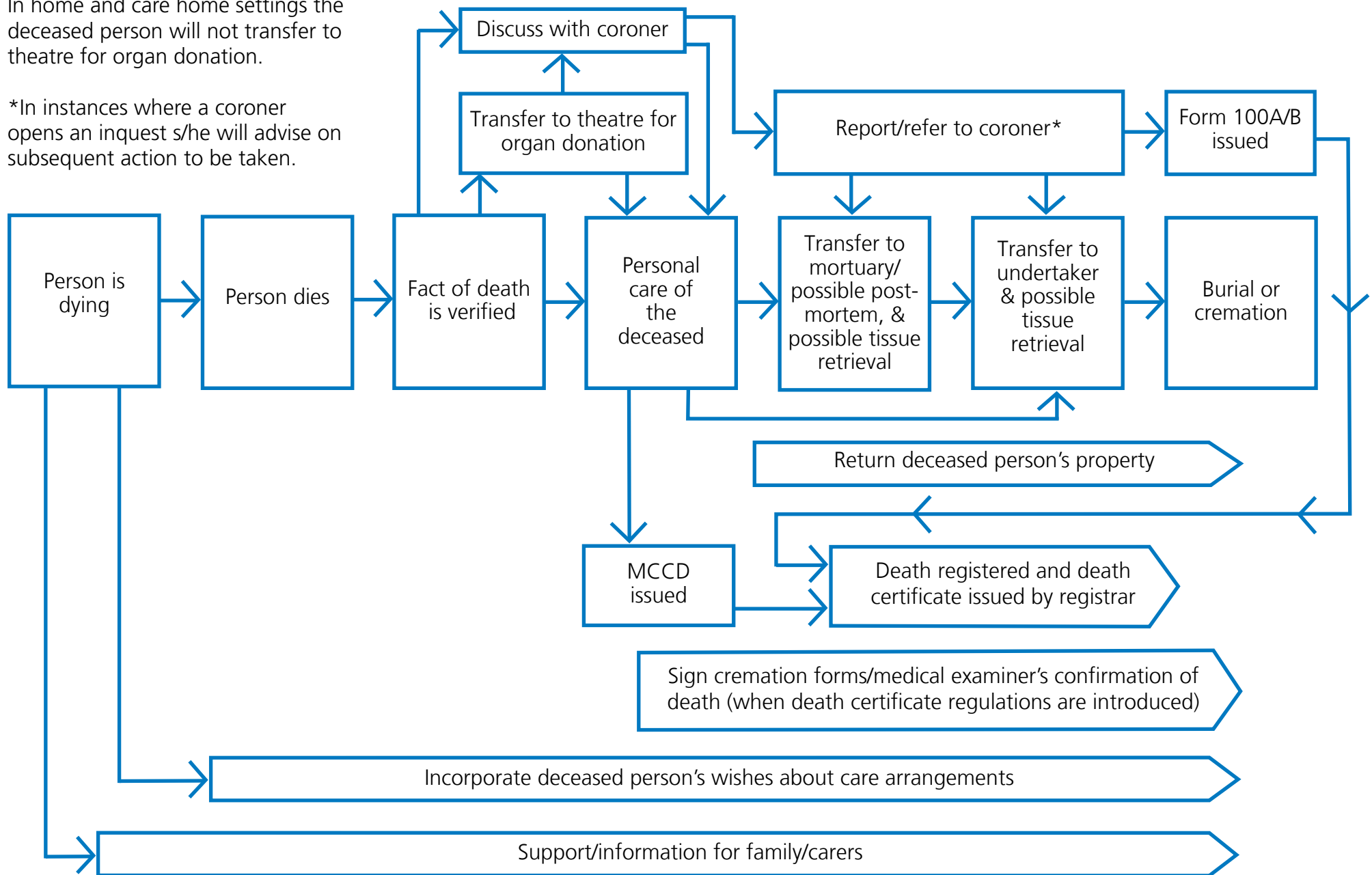
⁵ *The Royal Marsden Hospital manual of clinical nursing procedures (seventh edition)*, L Dougherty/S Lister (editors), 2008

⁶ *Code of practice 1: consent* (Consent requirements part 2: tissue from the deceased), Human Tissue Authority, 2009

Pathways of care for the deceased person

In home and care home settings the deceased person will not transfer to theatre for organ donation.

*In instances where a coroner opens an inquest s/he will advise on subsequent action to be taken.



Care before death

1. While it can be hard to identify when someone is dying, there is guidance regarding complex decision-making⁷ and care.⁸
2. Where dying is anticipated and predictable, it is important that agreement is reached between medical and nursing teams, patients and their families about clinical decisions. These include whether to attempt cardio-pulmonary resuscitation, whether to use the Liverpool Care Pathway⁸ (or equivalent) or whether treatment ceilings are required. If an implanted cardiac device is in situ it is important to assess whether it should be left in place, as it may affect the dying phase. Pacing therapy is not normally discontinued but the deactivation of implantable cardiac defibrillators needs to be considered.⁹
3. Unambiguous communication on all of the above decisions ensures there is clarity about whether the death is expected or not and allows for appropriate preparation of the dying person and their family/carers.
4. In care home and home settings where death is expected, it is crucial that the GP reviews the person regularly and at least every 14 days, both from a care point of view and in order that a Medical Certificate of Cause of Death (MCCD) can be appropriately issued without involving the coroner.
5. Wherever possible, assess the dying person's wishes regarding organ, tissue and body donation and possible post-mortem examination – and document this in a way that is consistent across organisations and accessible at the time of death.
6. Whole body donation can only be agreed by individuals themselves and not by anybody else on their behalf after death.¹⁰
7. If an individual's wishes regarding organ and tissue donation were not formally recorded before death, consent can be sought from a nominated representative or someone else in a qualifying relationship, if they believe the deceased wanted to donate.¹¹ Advice on consent is available from NHS Blood and Transplant (NHSBT) specialist nurses organ donation (SN-OD) who are based in acute trusts, or by contacting NHSBT directly - <http://www.uktransplant.org.uk/ukt/>.
8. While organ donation can only take place within an acute trust, tissue donation can be facilitated in either an acute trust or a community setting. The registered health professional caring for the dying person and their family needs to contact NHSBT to assess donor suitability. NHSBT will advise on the next steps. However, if the death requires investigation, the coroner may prevent donation because the criminal justice system takes precedence in such circumstances. Every case therefore needs to be discussed with the local coroner and the NHSBT SN-OD will facilitate this.
9. Identify and document in advance any spiritual, cultural or practical wishes the dying person and their family/carers may have for the time of death or afterwards, particularly regarding urgent release for burial or cremation. This can be done as part of the advance care planning

⁷ *Treatment and care towards the end of life: good practice in decision making*, General Medical Council, 2010

⁸ *Care of the dying: a pathway to excellence (second edition)*, J Ellershaw/S Wilkinson (editors), 2010

⁹ *Implantable cardioverter defibrillators in patients who are reaching the end of life*, British Heart Foundation, 2007

¹⁰ *How to donate your body* (body & brain donation information pack), Human Tissue Authority website, 2011

¹¹ *Human Tissue Act 2004*

process¹² or it can be completed nearer the point of death.

10. Ask the person (if this is possible and/or appropriate) who they wish to be present at the time of their death. If this is not possible, try to find out from the family/carers, as well as details of how they wish the news of the death to be communicated if they are not present.¹³ Relevant contact details will need to be recorded and readily accessible by all appropriate staff.
11. Accommodate people's preferences for place of death wherever possible. In communal settings offer people and their families the option of single room accommodation (if available). This can engender a feeling of homeliness, allows dying people to rest, gives them privacy and enables them to have family to stay for extended periods without intruding on others.¹⁴ Not all dying people, however, will want a single room and the evidence indicates that while it can be distressing for others to witness a death it can also be comforting when the process is well managed.¹⁵
12. Deliver care that is sensitive to the cultural and religious needs and personal preferences of the dying person and their family/carers.¹⁶

Care at the time of death

13. If present at the time of death, the

registered nurse, doctor, ambulance personnel or appropriately trained healthcare worker needs to record the time, who was present, the nature of the death, and details of any relevant devices (such as cardiac defibrillators), as well as their own name and contact details in the nursing, medical or ambulance documentation. If relatives have any concerns about the death these should also be documented.

14. When death occurs inform the medical practitioner primarily responsible for that person's care. Verification needs to be completed by a doctor or appropriately qualified nurse¹⁷ before the body is transferred from the care setting. Nurses need to be aware of local guidance regarding the criteria for verifying death, which should be in line with national guidance.^{18,19} In an acute trust it is helpful if verification occurs within one hour while in other settings it should take place as soon as possible.
15. Record verification of death, the date and time this occurred in the notes and/or care pathway documentation, along with the name and contact details of the responsible practitioner. Be aware of local policy regarding nurses who are able to verify death.
16. The professional verifying the death is responsible for confirming the identity of the deceased person (where known) using the terminology of 'identified to

¹² *Planning for your future care: a guide*, National End of Life Care Programme/National Council for Palliative Care/ University of Nottingham, 2009

¹³ *Care of the dying: a pathway to excellence (second edition)*, J Ellershaw/S Wilkinson (editors), 2010

¹⁴ *Improving environments for care at the end of life: lessons from eight UK pilot programmes*, S Waller et al, The King's Fund, 2008

¹⁵ *Impact of witnessing death on hospice patients*, Payne et al, Social Science and Medicine, Dec 1996 (vol 43, issue 12) pp 1785-94

¹⁶ *The code: standards of conduct, performance and ethics for nurses and midwives*, Nursing and Midwifery Council, 2008

¹⁷ *Death certification and investigation in England, Wales and Northern Ireland: the report of a fundamental review*, Home Office, 2003

¹⁸ Confirmation (verification) of expected deaths by registered nurse ([RCN Direct online advice](#)), Royal College of Nursing website

¹⁹ *A code of practice for the diagnosis and confirmation of death*, Academy of Medical Royal Colleges, 2008

me as'. This requires name, date of birth, address and NHS number (if known). It is good practice for the person verifying the death to attach name bands with this information to the wrist or ankle of the deceased person. The following details are required when reporting a death to the coroner: the professional's telephone/ bleep number; the deceased person's name, address, date of birth and GP details; family members' names, contact details and relationship to the deceased person; date and time of death; details of the person who pronounced life extinct and details of what happened leading up to the death.

17. The practitioner who verified the death ascertains whether the person had a known or suspected infection²⁰ and whether this is notifiable. In such cases, they should then follow their local infection control policy regarding reporting responsibilities. It is vital that processes are in place to protect confidentiality, which continues after death. However, this does not prevent the use of sensible rules to safeguard the health and safety of all those who may care for the deceased.²¹ There needs to be clear communication regarding infection risk and the presence of implantable devices to mortuary staff and funeral directors. If the deceased person had a notifiable infection there is detailed guidance available, including on the infections that require a body bag.²²
18. If the case is being referred to the coroner, seek advice before interfering with anything that might be relevant to establishing the cause of death.

19. If the relatives or carers are not present at the time of death they need to be informed by a professional with appropriate communication skills²³ and offered support, including access to a spiritual leader or other appropriate person.
20. When the death is unexpected, the health or social care professionals involved in caring for the person when they died need to inform the family face-to-face (whenever possible). They need the necessary communication skills to do this and to ensure there is appropriate support – such as an interpreter service – available where there may be communication barriers. They need to be aware of the physical environment and the needs of any children present. Adults may require guidance on how best to convey the news to children who are not present. If the deceased person was living in a care home but died in hospital, inform the home too, because staff may know about the person's wishes around death.
21. The police can be of assistance in locating relatives and breaking significant news.

Best practice and legal issues

22. It is essential to comply with legal requirements.²⁴ For deaths that require an investigation by the coroner please see appendix 1. It is worth noting that 46 percent of all deaths were reported to the coroner in 2009.²⁵ Nurses need to ensure they are familiar with deaths that require such a referral as this will facilitate the correct personal care and enable nurses

²⁰ *The management of health, safety and welfare issues for NHS staff (new edition)*, NHS Employers, 2005

²¹ *Health and safety essential guide* (Occupational health: handling infected cadavers), NHS Employers website, 2010 (This online resource replaces the healthy workplaces handbook)

²² *The infection hazards of human cadavers: guidelines on precautions to be taken with cadavers of those who have died with a known or suspected infection*, Health Protection Agency North West, 2004

²³ *Common core competences and principles for health and social care workers working with adults at the end of life*, National End of Life Programme/Skills for Health/Skills for Care/Department of Health, 2009

²⁴ *Dealing with death: a handbook of practices, procedures and law (second edition)*, J Green/M Green, 2006

²⁵ *Statistics on deaths reported to the coroners England and Wales, 2009*, Ministry of Justice, 2010

- to prepare the family both for a potential delay in the processing of the MCCD and the possibility of a postmortem examination.
23. Guidance is available on the care of adults who are vulnerable while they are alive.^{26,27} If a safeguarding issue becomes apparent after death, clearly documented local links are required through which to raise concerns with social services, police and the coroner.
 24. Where the person had a known illness that requires referral to the coroner (eg mesothelioma) but dying is anticipated, it is not necessary to involve the police.
 25. It is best practice for certifying doctors to see and identify the person before completing the MCCD, but it is essential that prior to cremation a second doctor has viewed and examined the deceased and completed the relevant cremation paperwork. With the new certification process it will be mandatory for the certifying doctor to both identify the deceased and confirm the presence of any implants/devices. Information on the new certification process is available.²⁸
 26. The certifying medical practitioner has overall responsibility for identifying and communicating the presence of any implanted devices or radioactive substances. They are also responsible for identifying the appropriate person to deactivate and remove implants, to liaise with the appropriate medical physics department regarding radioactive treatments and advise mortuary staff and funeral directors. For information required by mortuary staff and funeral directors see appendix 2.
 27. It is good practice to ensure that, when the death need not be referred to the coroner, the MCCD is issued within one working day so burial or cremation arrangements are not unduly delayed. Cultural or religious practices may require it to be completed on the same day, so organisational processes are needed to address this wherever possible. If cremation is preferred then complete the appropriate forms and procedures within two working days.
 28. On the very few occasions (approximately three percent of all postmortems) when death is suspicious or unexplained and a special forensic postmortem is required, the family can only view the body with the agreement of the coroner and police. The limitations placed on viewing will depend on the nature of the death. In many cases there will be few restrictions but if the death is regarded as suspicious it will be important not to permit any potential contamination of forensic evidence.
 29. In NHS hospitals and private nursing homes the personal care after death is the responsibility of a registered nurse, although this and the packing of the property may be delegated to a suitably trained healthcare assistant. The registered nurse is responsible for correctly identifying the deceased person and communicating accurately with the mortuary or funeral director (in line with local policy). In care homes without a registered nurse, the home manager is responsible for ensuring that professional carers are trained appropriately and that

Care after death

Responsibility

²⁶ *No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*, Home Office/Department of Health, 2000

²⁷ *Safeguarding adults: a national framework of standards for good practice and outcomes in adult protection work*, Association of Directors of Social Services, 2005

²⁸ *Improving the process of death certification in England and Wales: overview of programme*, Department of Health, 2010

they have the relevant competence for the role.

Environment

30. The deceased was once a living person and therefore needs to be cared for with dignity. It is helpful if the surrounding environment conveys this respect. This includes the attitudes and behaviour of staff, particularly as bereaved people can experience high levels of anxiety and/or depression. Evidence suggests that the wider end of life care environment - for example, the journey to the mortuary and how the deceased's possessions are handled – not only has an immediate impact on relatives but also impacts on their subsequent bereavement.²⁹
31. The personal care after death needs to be carried out within two to four hours of the person dying, to preserve their appearance, condition and dignity. It is important to note that the body's core temperature will take time to lower and therefore refrigeration within four hours of the death is optimum. Tasks such as laying the deceased flat (while supporting the head with a pillow) and preparing them and the room for viewing, need to be completed as soon as possible within this time. When families cannot view the body on a hospital ward make arrangements for viewing at another appropriate location, such as a viewing room attached to a mortuary. In community settings there may be more flexibility for viewing arrangements.
32. Residents in communal settings, such as care homes and prisons, have often built significant relationships with other residents and members of staff.³⁰ Consider how to address their needs within the boundaries of patient confidentiality. If the person has died in an environment where other people may be distressed by the death then sensitively inform them that the person has died, being careful not to provide information about the cause and reason for death. Consider signposting to bereavement support in these settings.
33. Pack personal property showing consideration for the feelings of those receiving it and in line with local policy. Discuss the issue of soiled clothes sensitively with the family and ask whether they wish them to be disposed of or returned.
34. Provide the family with written information on the processes to be followed after death, including how to collect the MCCD, where to register the death and the role of the funeral director and bereavement support agencies. Be aware of the information available for relatives in their local area and the nurse's role in ensuring that written information is given in a supportive way. Offer to guide people through its content and give them the opportunity to ask questions.
35. Notify all other relevant professionals involved in the person's care that the person has died.

Viewing the deceased

36. Unless the death is suspicious and needs referring to the coroner and police, let the family sit with their relative if they wish in the period immediately after death. Offer age appropriate support; for example, parents may wish a bereaved child to take a favourite toy to the hospital viewing room/funeral directors. Even after a traumatic death, relatives need the opportunity to view the deceased

²⁹ *Improving environments for care at the end of life: lessons from eight UK pilot programmes*, S Waller et al, The King's Fund, 2008

³⁰ *The metaphor of 'family' in staff communication about dying and death*, M Moss et al, Journals of Gerontology series B, Sep 2003 pp S290-6

person and decide which family member, if any, should identify the body. Prepare them for what they might see and explain any legal reasons why the body cannot be touched.³¹ It should be noted that many mortuary staff have advanced skills in reconstruction and bodies may be more acceptable for viewing after post-mortem examination, though relatives need to know that the capacity for such reconstruction will differ greatly from case to case. Discussion with local mortuary staff on this issue can be valuable.

37. Many hospices have cold rooms that offer the family the opportunity to view the body beyond the time possible in other environments. In this facility the room temperature needs to be kept below twelve degrees centigrade and preferably between four to eight degrees centigrade. This may not be tolerable for relatives who wish to be in the room for extended periods and there are now cold beds and blankets that can offer effective cooling systems. Viewing beyond three days after death is not advised due to the natural deterioration of the body that takes place after this time.

Personal care after death

Death requiring coronial involvement

38. Where the death is being referred to the coroner and there is any complaint about the care of the patient, or the circumstances surrounding the death give rise to suspicion that means the death requires forensic investigation, then leave all intravenous cannulae and lines in situ and intravenous infusions clamped but intact. Leave any catheter in situ with the bag and contents. Do not wash the body or begin mouth care in case it destroys evidence. Continue using universal infection measures to protect people and

the scene from contamination. Mortuary staff can provide guidance on this at the time of death.

39. Where the death is being referred to the coroner to investigate the cause of death, but where there are no suspicious circumstances, then leave intravenous cannulae and lines in situ and catheters spigotted. Infusions and medicines being administered prior to death via pumps can be taken down and disposed of according to local policy and recorded and documented in nursing and medical documentation. The contents of catheter bags can be discarded according to local policy.
40. Leave endotracheal (ET) tubes in situ. This is because cutting the tube deflates the balloon that holds the tube in position. The increased mobility may enable the ET tube to become displaced during the handling of the body and any possibility of movement will lead to confusion should the coroner need to investigate this through postmortem.
41. Sensitively inform the family that after the coroner's involvement ET tubes or lines will be removed and they will then be able to spend time with the deceased. They can also do this at the funeral director's premises.

Death without coronial involvement

42. Some family members/carers may wish to assist with the personal care in acknowledgement of individual wishes, religious or cultural requirements. Prepare them sensitively for changes to the body after death and be aware of manual handling and infection control issues.
43. Carry out all personal care of the body after death in accordance with safe

³¹ *Viewing the body after bereavement due to traumatic death: qualitative study in the UK*, A Chapple/S Ziebland, *British Medical Journal*, 8 May 2010 (vol 340, issue 7754) pp 988-89

manual handling guidance. It is best practice to do this with two people, one of whom needs to be a registered nurse or a suitably trained person.

44. Lay the deceased person on their back, adhering to manual handling policy; straighten their limbs (if possible) with their arms lying by their sides. Leave one pillow under the head as it supports alignment and helps the mouth stay closed. If it is not possible to lay the body flat due to a medical condition then inform the mortuary staff or funeral director.
 45. Close the eyes by applying light pressure for 30 seconds. If this fails then explain sensitively to the family/carers that the funeral director will resolve the issue. If corneal or eye donation is to take place close the eyes with gauze (moistened with normal saline) to prevent them drying out.
 46. Clean the mouth to remove debris and secretions. Clean and replace dentures as soon as possible after death. If they cannot be replaced send them with the body in a clearly identified receptacle.
 47. Tidy the hair as soon as possible after death and arrange into the preferred style (if known) to guide the funeral director for final presentation.
 48. Shaving a deceased person when they are still warm can cause bruising and marking which only appears days later. Usually the funeral director will do this. If the family/carers request it earlier then sensitively discuss the consequences and document this in the notes. Be aware that some faith groups prohibit shaving.
 49. Support the jaw by placing a pillow or rolled up towel underneath (remove it before the family/carers view the person).
- Avoid binding with bandages to close the mouth as this can leave pressure marks on the face. Some people have deformed jaws that will never close – notify the mortuary staff or funeral director if this is the case.
50. When the death is not being referred to the coroner remove mechanical aids, such as syringe drivers, apply gauze and tape to syringe driver sites and document disposal of medication.
 51. Do not tie the penis. Spigot any urinary catheters. Pads and pants can be used to absorb any leakage of fluid from the urethra, vagina or rectum.
 52. Contain leakages from the oral cavity or tracheostomy sites by suctioning and positioning. Suction and spigot naso-gastric tubes. Cover exuding wounds or unhealed surgical incisions with a clean, absorbent dressing and secure with an occlusive dressing. Leave stitches and clips intact. Cover stomas with a clean bag. Clamp drains (remove the bottles), pad around wounds and seal with an occlusive dressing. Avoid waterproof, strongly adhesive tape as this can be difficult to remove at the funeral directors and can leave a permanent mark. Cap intravenous lines and leave them in situ. If the body is leaking profusely then take time, pre transfer to the mortuary, to address the problem. Be aware that, where there is no referral to the coroner, tubes and lines may be removed in a community setting.
 53. It is the responsibility of mortuary staff to discuss with the funeral director collecting the body their capacity to remove intravenous lines, drains, indwelling catheters, etc. If they are unable to remove these then the mortuary technician needs to attend to this before releasing the body. When a family member collects the deceased

- then mortuary staff must remove all intravenous lines, drains, indwelling catheters etc. When release to a funeral director is prompt in order to ensure same day burial the funeral director needs to ensure all lines are removed in case family members wish to bathe or dress the body.
54. Clean and dress the deceased person appropriately (use of shrouds is common practice in many acute hospitals) before they go to the mortuary. They should never go to the mortuary naked or be released naked to a funeral director from an organisation without a mortuary. Be aware that soiling can occur. The funeral director will dress them in their own clothes. In community settings the district or community nurse may offer to do this, and in some instances the family may want to do it themselves. If this is the case they need to be advised sensitively on how to deal with soiling.
 55. Remove jewellery (apart from the wedding ring) in the presence of another member of staff, unless specifically requested by the family to do otherwise, and document this according to local policy. Be aware of religious ornaments that need to remain with the deceased. Secure any rings left on with minimal tape, documented according to local policy. Provide a signature if any jewellery is removed. Procedures are needed to account for this information to onward caregivers.
 56. Clearly identify the deceased person with a name band on their wrist or ankle (avoid toe tags). As a minimum this needs to identify their name, date of birth, address, ward (if a hospital in-patient) and ideally their NHS number. The person responsible for identification is the person that verifies the death.
 57. Provided no leakage is expected and there is no notifiable disease present, the body can be wrapped in a sheet and taped lightly to ensure it can be moved safely. Do not bind the sheet or tape too tightly as this can cause disfigurement. If there is significant leakage or a notifiable infection is present put the deceased into a body bag.³²
 58. It is the role of the mortuary staff to pack orifices, not the nurse. If the body continues to leak, place it on absorbent pads in a body bag and advise the mortuary or funeral director.
 59. Request removal of the body. In hospital settings it is best practice for porters to take the body from the ward to the mortuary within one hour of request so it can be refrigerated within four hours of death. This ensures that tissue donation can take place (if requested) and prevents distress to surrounding patients. In hospital settings all bodies are released via the mortuary.
- ## Transfer of the deceased person
60. The privacy and dignity of the deceased on transfer from the place of death is paramount.³³ Each organisation involved is responsible for ensuring that the procedures adopted to transfer bodies respect the values of personal dignity and that these are incorporated in the design of the concealment trolley and the way the body is covered. Place the body in an appropriate container to avoid causing distress to others. In community settings a funeral director will usually undertake transfer, although case law has determined that the deceased's executor (generally a family member) may also do this.³⁴

³² *The infection hazards of human cadavers: guidelines on precautions to be taken with cadavers of those who have died with a known or suspected infection*, Health Protection Agency North West, 2004

³³ *Improving environments for care at the end of life: lessons from eight UK pilot programmes*, S Waller et al, The King's Fund, 2008

³⁴ *Davies' law of burial, cremation and exhumation (seventh edition)*, M Russell Davies/D Smale (editor), 2002

61. Follow standard infection control precautions during transfer and remove gloves when moving the body along corridors, as there is no risk of infection once the body is placed on the trolley. Try to retain a sense of the person's dignity in transit, avoiding busy public spaces if possible. Hospital porters may need training on this issue.
62. If the family are using a viewing room alongside a mortuary it is good practice for registered nurses to help them find it, ensure mortuary staff know to expect them and, if necessary, arrange for the family to be accompanied.

Recording care after death

63. Record all aspects of care after death in nursing and medical documentation and identify the professionals involved.³⁵ Update and organise the medical and nursing records as quickly as possible so they are available to the bereavement team and other interested professionals, such as pathologists.

Glossary

Cardiac defibrillator – a device that delivers a therapeutic dose of electrical energy to a heart affected by arrhythmia.

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

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

Liverpool Care Pathway³⁶ – an integrated pathway of care, including documentation, that is used at the bedside to guide the care of the dying patient and the support of the family.

Medical certificate of the cause of death (MCCD) – a document given to families to enable them to register the death and gain the death certificate.

Form 100A – issued by the coroner to the registrar to say that an inquest is not necessary and the death registration procedures may continue.

Form 100B – issued by the coroner to the registrar to say that an inquest is not necessary but that a postmortem has been carried out. It states the cause of death as ascertained by that examination.

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

Appendix 1: deaths requiring coronial investigations

A death should be reported to the coroner when:³⁷

- The cause of death is unknown
- There is no attending practitioner or the attending practitioner(s) are unavailable within a prescribed period
- The death may have been caused by violence, trauma or physical injury, whether intentional or otherwise
- The death may have been caused by poisoning
- The death may be the result of intentional self harm
- The death may be the result of neglect or failure of care
- The death may be related to a medical procedure or treatment
- The death may be due to an injury or disease received in the course of employment, or industrial poisoning
- The death occurred while the deceased was in custody or state detention, whatever the cause of death.

More detailed information is available from the Ministry of Justice publication *A guide to coroners and inquests* (2010).³⁸

³⁶ *Care of the dying: a pathway to excellence (second edition)*, J Ellershaw/S Wilkinson (editors), 2010

³⁷ *Reform of the coroner system next stage: preparing for implementation (consultation paper)*, Ministry of Justice, 2010

³⁸ *A guide to coroners and inquests*, Ministry of Justice, 2010

Appendix 2: information required by mortuary staff and funeral directors

A new form will be created to communicate information about the deceased to mortuary staff and funeral directors (alongside the new death certification process).

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

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

Appendix 3: key stakeholders involved in the development of this guidance

The following list includes all the stakeholders who contributed to the development of this document. Some took part in a consultation process while others attended a workshop designed to resolve areas of non-consensus that arose from the consultation.

Alison Conner
Nurse consultant palliative care
Hartlepool and District Hospice

Amanda Mathieson
Community matron
Leicester City Community Health Services

Amanda Morgan-Taylor
Director of quality development
Craegmoor

Amanda Rolland
Workstream lead – clinical standards and patient experience
NHS East Midlands

Amanda Small*
Team manager, South Central Organ Donation Service
NHS Blood and Transplant

André Rebello
Honorary secretary
Coroners' Society of England & Wales

Andrew Davies
Honorary secretary
Association for Palliative Medicine of Great Britain and Ireland

Ann Chalmers
Chief executive
Child Bereavement Charity

Ann Mackay
Director of policy
English Community Care Association

Anna-Marie Stevens
Macmillan nurse consultant cancer/palliative care
The Royal Marsden NHS Foundation Trust

Avril McConnachie
Associate director of nursing
East Kent Hospitals University NHS Foundation Trust

Bee Wee
Clinical lead
e-End of Life Care for All

Carole Mula
Macmillan nurse consultant palliative care
Christie NHS Foundation Trust

Catherine Deakin
Policy officer
Council of Deans of Health

Chris Rudge
National clinical director for transplantation
Department of Health

Chris Ward
Nurse consultant adult palliative care
NHS North Yorkshire and York Community & Mental Health Services

Christine Hurst
Senior lecturer in coroner's officer studies
Coroners' Officers Association

Claire Henry**
National programme director
National End of Life Care Programme

Claire Mills
Organ Donation Taskforce implementation lead
Department of Health

David Foster**
Deputy chief nursing officer
Department of Health

David Whitmore*
Senior clinical adviser to the medical director
London Ambulance Service NHS Trust

Dawn Chaplin**
Project director bereavement care
University Hospitals Birmingham

Denise Berry
Clinical governance advisor emergency care and medicine
Sherwood Forest Hospitals NHS Foundation Trust

Diane Laverty
Nurse consultant palliative care
St Joseph's Hospice

Douglas Davies
Director, Centre for Death and Life Studies
Durham University

Emily Sam
Deputy director of policy and parliamentary affairs
National Council for Palliative Care

Emyr Wyn Benbow*
Senior lecturer in pathology
Royal College of Pathologists

Fidelma Murphy*
Regulation manager
Human Tissue Authority

Fiona Hicks
Consultant in palliative medicine
Leeds Teaching Hospitals NHS Trust

Fiona Murphy*
Clinical lead for bereavement & donation
Royal Bolton Hospital NHS Foundation Trust

Frances Campion-Smith
Director of nursing and clinical services
BMI Healthcare

Gail Adams
Head of nursing
Unison

Graham Robin Brown
Consultant and honorary lecturer in dermatology
NHS East Midlands

Gweneth Irvine
Care specialist team manager (safeguarding lead)
Anchor Trust

Helen Corner
Clinical associate
Gold Standards Framework centre

Helen Thurkettle
Nurse consultant palliative care
Southwark Primary Care Trust

Jacqui Graves
Clinical programme manager
Macmillan Cancer Support

James Beattie
Consultant cardiologist/national clinical lead
NHS Improvement

James Lowell*
Chair
Association of Anatomical Pathology Technicians

Jan McFadyen
Nurse consultant palliative care
Sussex Community NHS Trust

Jan Vickers
Nurse consultant palliative care
Royal Liverpool NHS Trust

Jane Thompson-Hill**
Macmillan nurse consultant palliative care
University Hospital of North Staffordshire NHS Trust

Jeremy Field
Managing director
CPJ Field and Co Funeral Directors

Jill Beckhelling
Palliative care nurse consultant
Trinity Hospice

Jo Hockley
Nurse consultant palliative care
St Christopher's Hospice

Judith Bernstein
Head of current coroner policy
Coroners and Burials division
Ministry of Justice

Judith Herbert**
Policy manager
End of life care team
Department of Health

Karen Devanny
Senior nurse - clinical developments
South East Coast SHA

Karen Henry
Palliative care team leader
Leeds Teaching Hospitals Trust

Katherine Hopkins
Macmillan nurse consultant/lead clinician
palliative care
Royal Free Hampstead NHS Trust

Katherine Murphy
Chief executive
Patients' Association

Katie Lindsey**
Project manager
National End of Life Care Programme

Keith Albans*
Group director - chaplaincy & spirituality
MHA Care Group

Kevin Farrell*
Coroner's officer
Coroner's Officers Association

Laurence Buckman
Chair, General Practitioners Committee
British Medical Association

Lesley Morrey*
Clinical practice development manager
Abbeyfield Society

Lesley Rutherford
Nurse consultant palliative care
Belfast City Hospital

Lisa Barton*
End of life care lead
Milton Keynes Community Health Services

Liz Clements
Community matron
Community Health Oxfordshire/Sue Ryder
Care

Liz Cornish*
Head of care
Douglas House hospice

Louise Bradbury
Liverpool Care Pathway facilitator
East Sussex Hospitals Trust

Louise Molina
Interim manager
When a Patient Dies guidance
Department of Health

Lucy Sutton
Associate director for end of life care
programme
NHS South Central

Lynn Young
Primary care adviser
Royal College of Nursing

Maggie Bisset
Nurse consultant palliative care
Camden Primary Care Trust

Maggie Stobbart-Rowlands*
GSFCH programme manager
Gold Standards Framework centre

Magi Sque**
Chair in clinical practice and innovation
University of Wolverhampton and
The Royal Wolverhampton Hospitals NHS
Trust

Margaret Kendall
Nurse consultant palliative care
Warrington and Halton Hospitals NHS
Foundation Trust

Mark Freeman*
Offender health primary and social care lead
Department of Health

Mark Green*
Senior trust bereavement care co-ordinator
Southampton General Hospital

Mel McEvoy
Nurse consultant in cancer and palliative care
North Tees and Hartlepool NHS Foundation
Trust

Michael Apple
Sessional general practitioner

Michael Connolly
Consultant nurse in supportive and palliative
care
University Hospital of South Manchester

Michael Keegan*
Policy adviser
General Medical Council

Patricia Dale
Lead nurse bereavement services
Royal Free Hampstead NHS Trust

Paul Ader
Death certification programme team
Department of Health

Pete O'Neill
Chief executive officer
National Society of Allied and Independent
Funeral Directors

Peter Jones
Human tissue and consent team
Department of Health

Rekha Elaswarapu
Strategy development manager (older people)
Care Quality Commission

Roger Thompson
Director of standards and registration
Nursing and Midwifery Council

Ros Cook*
Macmillan nurse consultant for end of life
care
NHS Sutton and Merton

Roy Palmer
Medical secretary
Coroners' Society of England and Wales

Sally Mirando
Macmillan consultant nurse/associate lecturer
Herefordshire PCT

Sarah Waller*
Director, Enhancing the Healing Environment
programme
The King's Fund

Sharon Blackburn
Policy & communications director
National Care Forum

Sheilah Blackwell**
Nurse consultant palliative care
South Staffordshire PCT

Sheila Scott
Chief executive
National Care Association

Stephen Ingle
Nurse consultant palliative care
Salford Royal NHS Foundation

Stephen Lock**
Senior policy manager
End of life care team
Department of Health

Steve Barnes*
President
Association of Hospice and Palliative Care
Chaplains

Sue Duke**
Consultant practitioner in cancer and palliative
care/senior lecturer
University of Southampton

Sue Saville*
Executive member
National Association of Funeral Directors

Surinder Kumar
General practitioner
British Medical Association (GPC)

Susan Flatts
Nurse consultant palliative and supportive care
East Kent Hospitals University NHS Foundation
Trust

Susi Lund**
Nurse consultant end of life care
Royal Berkshire NHS Foundation Trust

Teresa Tate
Deputy national clinical director for end of life
care
Barts and the London NHS Trust

Tina Lee
Pathology programme, fragility fractures
programme and clinical audit
Clinical policy and strategy division
Department of Health

Triona Norman
Policy lead for organ donation and
transplantation
Department of Health

Trish Corcoran
Nurse consultant palliative care
St Luke's Hospice

Vicky Howard
Liverpool Care Pathway facilitator
Northampton General Hospital NHS Trust

Vicky Robinson
Nurse consultant palliative care
Guy's and St Thomas' NHS Foundation Trust

Wendy Churchouse
Clinical lead CHD, heart failure and non-
malignant palliative care
Education for Health

Key:

* Took part in workshop event

** Took part in and helped facilitate
workshop event

**This document was written and
edited by:**

Jo Wilson **

Macmillan consultant nurse practitioner
palliative care

Heatherwood and Wexham Park NHS Trust

Caroline White**

Writer/editor

Furner Communications/National End of Life
Care Programme

