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CLINICAL GUIDANCE

POLICY/PROCEDURE INFORMATION (Policy no CG001)	
Subject	**Care after Death Clinical Guidance CG001**
Applicable to	All staff of Nottinghamshire Hospice
Date issued	20 March 2024
Next review date	20 March 2027
Lead responsible	Director of Care
Guidance written by	Governance Lead
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CQC Standard	Caring, Responsive
Links to Policies/Procedures	Verification of Death Policy (CS012) Care After Death Guidance 4th edition July 2022 Hospice UK
Summary	This Guidance outlines the main issues that staff need to consider after a patient has died. It provides a step-by-step procedure for personal care.
Target Audience	All Care staff of Nottinghamshire Hospice

IMPORTANT NOTICE

Staff should refer to the Hospice website or Policies and Procedures folder on the 'N' drive for the most up to date Policy. If the review date of this document has expired it is still valid for 3 months. After that staff should seek advice from their clinical lead or manager.

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1.	**Introduction** The care we provide to people who have died has never been more important. This Guidance is written to provide support in providing that care. Care after death including personal care, is the first stage of a process (Appendix 1), that involves a range of professional groups. The process leads ultimately to cremation, burial or repatriation of the deceased. There are a range of professionals involved in care after death, including doctors, nurses, HCAs, funeral directors, police, bereavement workers, social workers and faith workers. Working together these individuals and the organisations they work for can ensure that the process runs smoothly. The family and those who were most important to the deceased are the only people who navigate the entire process and so it is important to ensure that they are supported and consulted along the way as appropriate.
2.	**Definitions** • **Advance Care Plan** A plan of future care and support, including medical treatment, made while people have the capacity to do so • **Confirmation of Death** Term used by medical colleagues – 'verification of death' • **Deceased** The deceased person • **Fixion Nail** A nail system commonly used to pin together bones that have been fractured. There is a risk of explosion during cremation. The GP must make the funeral directors aware prior to cremation. • **Key contact** The family and those people identified as being of most importance to the dying/deceased person

	• **MCCD** Medical Certificate of Cause of Death issuing this is the process of **Certification** • **Repatriation** To transport a person who has died – either their body or ashes – to another country. Funeral Directors will know the processes to follow for the body and the documents required. • **Viewing** Visiting the deceased person by their key contacts
3.	**Care after Death** The person/s present needs to be aware of any pertinent details in the deceased's Advance Care Plan that relates to care after death, and to act on this, as usually these wishes are time critical. • Wishes for repatriation: The local funeral director will advise and address the specific feasibilities. Respecting the spiritual, religious, and cultural wishes of the deceased and their key contacts, where possible, should be taken into consideration and ensuring legal obligations are met. • Ensuring timely verification of death • Preparing the deceased for viewing, where appropriate, and supporting the key contacts • Offering key contacts who are present the opportunity to participate in the process and supporting them to do so. If a person dies an expected death, in their own home but without family or a key contact, those who are caring for them at the time are responsible for the following: • Ensuring that the appropriate professional verifies the death

	• The property is secured and there is someone with the deceased until the funeral director can collect them • Ensuring, where relevant, that funeral directors are given information about possible organ and tissue retention and disposal methods • Ensuring that the privacy, dignity, and respect of the deceased is maintained at all times • Ensuring that the health and safety of everyone who comes into contact with the deceased is protected. The specific personal care of the deceased is covered below in section 7 and Procedure 1.
4.	**Recording the Death (Verification)** A Registered Nurse who has been appropriately trained can Verify the Death as outlined in the Hospice Verification of Death Policy (CS012). Otherwise, the GP practice is notified so that they can arrange the issuing of the MCCD. The official time of death is when the verification of the death takes place, however, it is important to record the actual time of death, particularly is there is a delay in getting the death verified. This may be important to the family, particularly in some cultures. For information required by mortuary staff and funeral directors see Appendix 3. If a carer is present with the person in the home, then they should be advised to call the GP practice (in hours) or 111 out of hours to ensure appropriate support and a plan to verify the death. If the ambulance service has been called and attended the deceased, they will have verified the death.
5.	**Issuing the Death Certificate** **Certification** is the process of **issuing a MCCD**, and this is the responsibility of a medical practitioner. It is good practice to ensure that, when the death need not be referred to the coroner, the MCCD is ideally issued within one working

	day so burial or cremation arrangements are not unduly delayed. At the present time, emailing of the MCCD to the Register Office is possible. The key contact notifies the registrar by telephone or email to begin the death registration process. Funeral directors can now do this on behalf of the family, if necessary. The GP notifies the registrar by email with a copy of the MCCD and contact for the bereaved key contact. The GP informs the key contact that the respective registrar has been sent the MCCD and that they must book an appointment using the online or telephone booking system, to attend that registrar's office to register the death in person. An electronic copy of the certificate for burial or cremation (known as the Green form), can be shared with the funeral directors. The death certificate (certified copy of the entry of death) can be emailed to the key contact and a hard copy will be posted in due course. If there is no access to email or internet an alternative method should be explored. The police can be of assistance in locating key contacts and breaking significant news if the staff are unaware of who this is. It is vital that when the death is expected, those with additional needs, e.g., interpreter or assistance to answer the phone, are thought about and strategies put in place for the call. The Coroner or Medical Examiner expects suspicious and unexpected deaths to be reported to the Coroner/Medical Examiner's Office. The Coroner or Medical Examiner's Office will then advise who can verify the death. If the Coroner or Medical Examiner's Office confirms that the nurse can verify death they can then do so. Police will determine whether or not a funeral director can be called to remove the body or whether the body needs to be transported to the QMC mortuary. As with all incidents, in the case of unexpected death, an incident form must be completed and recorded on the system as per the Nottinghamshire Hospice Reporting of Reporting of Incidents and Accidents Policy OP002. **Where the death is unexpected or notified to the police, a notification will be made to the Care Quality Commission within 24 hours.**

6.	**Referral to the Coroner** Appendix 2 details those deaths that need to be referred to the coroner for investigation. It is important to for staff know which deaths should be referred to the coroner in order for them prepare the key contacts both for a potential delay in the processing of the MCCD and the possibility of a post-mortem examination. If a safeguarding issue becomes apparent after death, clearly documented concerns should be raised with social services, the police, and the coroner in line with local processes and guidance. Where the person had an illness that requires referral to the coroner, (e.g., mesothelioma) but dying was anticipated, it is not necessary to involve the police. Referral to the coroner does not automatically require a post-mortem, but a post-mortem can be useful to assess the extent of the disease or other factors contributing to death.
7.	**Personal Care of the Deceased** **(See Procedure 1)** Some cultures may have people from their local faith community attend and help wash and prepare the deceased. Carry out all personal care of the deceased after death in accordance with safe manual handling guidance. It is best practice to do this with two appropriately trained people, one of whom needs to be a registered nurse or a health care assistant. The personal care after death needs to be carried out within two to four hours of the person dying, to preserve their appearance, condition and dignity. Tasks such as laying the deceased flat (while supporting the head with a pillow) and preparing the deceased need to be completed as soon as possible within this time. It is important to note that the body's core temperature will take time to lower and therefore refrigeration within four to six hours of death is optimum.

	If the deceased dies an expected death in their own home, then those present – either families or care agency staff - need to ensure the dignity of the deceased is maintained. If the person dies outside of their bed / sofa space, they can, with assistance, be returned safely to the bed / sofa and their bodies covered until the death can be verified. **Personal Protective Equipment (PPE)** To maintain the safety of those carrying out the personal care after death, these guidelines should be used in conjunction with the local Infection Prevention and Control policy and applied to all adult deaths irrespective of any COVID-19 status (i.e., not suspected, suspected, confirmed). Please note, local guidance should be referred to regarding the requirement of high-level or low-level PPE. Clothes that are contaminated or soiled should ideally, with key contact consent, be disposed of but can be washed if the key contacts wish. Place all clothing directly into a washing machine with a detergent wash (either bio or non-bio), at 60 degrees centigrade. Wipe down any hard items with warm soapy water and leave to dry or, if they are dishwasher safe, place in the dishwasher. Record all aspects of care after death in locally relevant documentation and identify the professionals involved.
8.	**Transfer of the Deceased to the Funeral Director** The privacy and dignity of the deceased on transfer from the place of death is paramount. Each organisation involved is responsible for ensuring that the procedures adopted to transfer bodies, including those who are bariatric, respect the values of personal dignity, A funeral director will usually undertake transfer, although on rare occasions the deceased's executor (generally a key contact) may also do this.

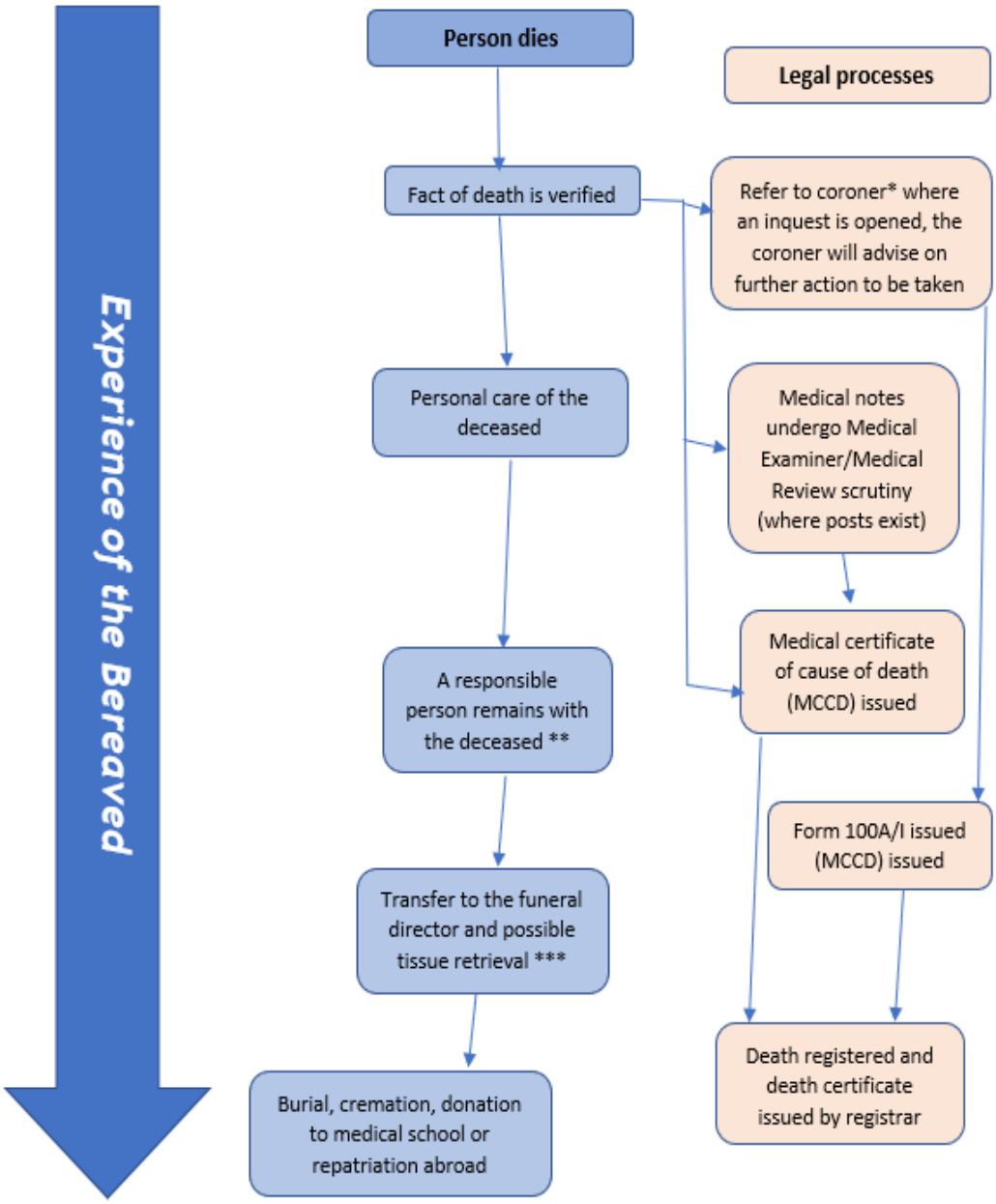
9.	**Cleaning the Room After Death** The process of environmental decontamination/cleaning should happen soon after the deceased is moved from the room. Special attention should be paid to frequently touched surfaces, e.g., medical equipment, door/toilet handles and surface areas and bed rails. They should be decontaminated as per IPC guidance.
10.	**Disposal of Medicines** **Appropriate disposal of controlled drugs** In the home setting family and key contacts should be advised to call the local pharmacy to arrange the return and safe disposal of controlled medicines. If there is no family or key contact, then the district nursing team or palliative care team should arrange for the collection and safe disposal at a local pharmacy in line with national guidance.
11.	**Supporting Staff, Family/Friends** **Staff** It is important to address any staff anxieties or concerns as a result of managing the deceased. It may be that staff involved in delivering bad news, managing property, and caring for the deceased require additional opportunities, such as a debrief, to explore emerging feelings in a safe, structured manner. Attention to, and being sensitive about, the individual's needs demonstrate a caring approach and can be instrumental in averting any future crises. **Family/Friends** For the person dying at home with care, in line with national guidance, it is essential that the health care professional who receives the call from the carer informing them of the death offers emotional and practical support to the caller at this time, and the GP practice supports the key contact after death.

	The Hospice provides a Bereavement Support Service (0115 962 1222 or via Care Coordination) that works with individuals who have been bereaved or whose loved one has had a palliative diagnosis.
12.	**Resources** • Bereavement Advice Centre. What to do when someone dies: step by step checklist. [Information for professionals] Available from: https://www.bereavementadvice.org/topics/what-to-do-when-someone-dies/step-by-step-checklist • Marie Curie. Providing care after death. [Internet] 2022. Available from: https://www.mariecurie.org.uk/professionals/palliative-care-knowledge-zone/final-days/care-after-death • Royal College of Nursing. Having courageous conversations by telephone or video during the COVID-19 pandemic. [Internet] 2020. Available from: https://www.rcn.org.uk/professional-development/publications/rcn-courageous-conversations-covid-19-uk-pub-009-236 • Royal College of Nursing. End of life care. Available from: https://www.rcn.org.uk/clinical-topics/end-of-life-care • Skills for Care. – End of life care [Internet] Available from: https://www.skillsforcare.org.uk/Learning-development/ongoing-learning-and-development/end-of-life-care/End-of-life-care.aspx

Appendices

1. Processes of Care for the Deceased
2. Deaths Requiring Coroner Investigation
3. Information Required by Mortuary Staff and Funeral Directors
4. Guide to Donning and Doffing PPE

Processes of Care for the Deceased



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

*See Appendix 2 for further information on deaths requiring Coroner investigation
**This may be where no responsible person is available, e.g., NOK
***Tissue donation is not possible where COVID-19 is suspected or confirmed

Appendix 2

Deaths Requiring Coroner Investigation

Deaths requiring referral to the coroner for investigation in England are where the cause of death is unknown, sudden, suspicious or unexplained, when the death may be:

- caused by violence, trauma or physical injury, whether intentional or otherwise
- caused by poisoning, drug related, including adverse drug reactions (reportable under the medicines and Healthcare Products Regulatory Agency (MHRA)
- the result of misadventure, intentional self-harm or possible suicide
- the result of neglect or failure to care
- related to a medical procedure or treatment, a failure of a piece of equipment, an operation or before recovering from the effects of an anaesthetic
- due to an injury, disease or industrial poisoning in the course of employment

or occurred

- where the deceased was not treated by a doctor during their last illness, or a doctor did not see or treat them for the condition from which they died
- while the deceased was in custody or state detention, whatever the cause.

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

Notification of infectious diseases

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

- Diagnosis of suspected (and/or confirmed) COVID-19 is a notifiable infectious disease.
- Registered medical practitioners have a statutory duty to inform their local health protection team of a diagnosis of a suspected notifiable infections disease, and without waiting for laboratory confirmation, at time of diagnosis.
- Registered medical practitioners in England are required to report COVID-19 positive deaths to NHS England

Appendix 3

Information required by funeral directors

- Identifying information including name, date of birth, address and NHS number (if known)
- Date and time of death
- Name of the doctor completing the MCCD
- Implantable devices – Funeral Directors will check with GP
- Current radioactive treatments
- Notifiable infections
- Any jewellery or spiritual/religious/cultural mementoes left on the deceased
- Name and signature of registered nurse responsible for the care after death
- Name and signature of any second healthcare professional who assisted with care
- Any wishes in regard to whole-body donation to science and tissue donation. Cornea donation can happen up to 24 hours after death and can take place in funeral homes

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

Public Health England

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

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

for health and social care settings

Donning or putting on PPE

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

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

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

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

4. Put on non-sterile nitrile gloves.

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

Doffing or taking off PPE

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

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

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

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

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

4. Once outside the patient room. Remove eye protection

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

6. Remove surgical mask.

7. Now wash your hands with soap and water.

Please refer to the PHE standard PPE video in the COVID-19 guidance collection:
www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-non-aerosol-generating-procedures
If you require the PPE for aerosol generating procedures (AGPs) please visit:
www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures

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Personal Care After Death

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

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

ACTION	RATIONALE
Adopt standard infection control precautions. Perform hand hygiene prior to donning selected PPE (see Appendix 4).	To ensure protection of the person carrying out the personal care from cross-contamination.
Lay the deceased on their back, adhering to manual handling policy; straighten their limbs, (if possible) with their arms lying by their sides or across their chest.	To maintain the deceased's dignity, ensure the deceased is lying straight prior to rigor mortis which occurs 2-6 hours after death.
Ensure the person is appropriately covered with a clean sheet. If it is not possible to lay the deceased flat due to a medical condition, or rigor mortis, then seek guidance from the funeral director. The funeral directors should be alerted if the deceased is bariatric.	To maintain the deceased's privacy and dignity. Alternative transportation may be required. To ensure they have the appropriate equipment to transfer the deceased.
Leave one pillow under the head.	Supports alignment and helps the mouth stay closed.
Close the eyes by applying light pressure for 30 seconds. This also applies when the deceased is donating their corneas. If the eyelids fail to close, then explain sensitively to the key contact/carers that the funeral director will resolve the issue. Do not apply tape over the eyelids.	To maintain their dignity, and for tissue protection in case of corneal donation Tape can mark the skin.

ACTION	RATIONALE
Tidy the hair as soon as possible after death and arrange into the preferred style, (if known). A lock of hair as a memento may be offered. Place in a plastic bag and seal.	To guide the funeral director for final presentation.
Clean the mouth to remove debris and secretions. * Caution where COVID-19 is suspected or confirmed. Clean and replace dentures as soon as possible after death. If they cannot be replaced send them with the deceased in a clearly identified receptacle.	For hygienic reasons. To retain the facial shape of the deceased. The funeral director will likely be able to secure in place.
Where the jaw may need additional support, place a small pillow or rolled up towel under the chin. Do not bind the jaw with bandages. Some people have jaws that will never close; notify the mortuary staff or funeral director if this is the case.	To close the mouth maintaining the facial shape for the deceased's dignity. This will leave pressure marks on the face.
Do not shave the deceased person. Usually, the funeral director will do this. Be aware that some faith groups prohibit shaving.	Shaving a deceased person when they are still warm can cause bruising and marking which only appears days later.
Drain the bladder by gently pressing on the lower abdomen for 30 seconds and collecting the urine in a receiver, or catheter bag where a urinary catheter is in situ.	The body can continue to excrete fluids after death.

ACTION	RATIONALE
Catheter bag and urinary catheters, to remain in situ if an HCA present but a clean bag is advised. RNs may remove the catheter if competent to do so. Pads and pants can be used to absorb any leakage of fluid from the urethra, vagina or rectum. Do not pack.	For hygiene reasons To prevent fluid leakage.
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. If the body is leaking profusely then take time, pre-transfer to the funeral home, to address the problem. Ensure mortuary staff and funeral directors are informed of any potential for profuse leakage.	Avoid strongly adhesive tape on any occlusive dressing as this can be difficult to remove at the funeral directors and can leave a permanent mark. To enable appropriate positioning of the deceased in the refrigeration areas.

ACTION	RATIONALE
Wash the deceased, unless requested not to do so for spiritual/religious/cultural reasons, or the death is being referred to the coroner. Key contacts and/or carers may wish to assist with washing, and they may have been caring for the person prior to death. They must be aware of the risks of potential COVID-19 infection and, depending on the place of death, wear PPE as instructed.	For hygienic and aesthetic reasons. Respecting the spiritual, religious, and cultural preferences of the deceased.
When moving the deceased air can be released; this should not be mistaken for breathing. *Caution where COVID-19 is suspected or confirmed, place cloth or facemask over the mouth of the deceased when moving them. Further soiling may also occur.	Sensitively share this information with the key contact or carer assisting with the personal care. To prevent the release of droplets from the respiratory tract during movement.

ACTION	RATIONALE
Dress the deceased appropriately before they go to the mortuary or funeral directors. This may be in a shroud or personal clothing depending on the place of death, local policy or wishes of the key contacts.	To ensure the deceased's dignity is always preserved.
Key contacts and/or carers may want to dress the deceased. As above, when moving the deceased, air can be released; this should not be mistaken for breathing.	Sensitively share this information with the key contact or carer dressing the deceased.
Further soiling may also occur.	To maintain their dignity and privacy.
The deceased should never go to the mortuary naked or be released naked to a funeral director from an organisation without a mortuary on site. The Funeral Director may ask for a second set of clothes for the deceased to be buried/ cremated in.	

ACTION	RATIONALE
Do not remove jewellery unless specifically requested by the key contact to do otherwise, and document this according to local policy.	To meet legal requirements and key contact's wishes.
Secure any rings left on with minimal tape, documented according to local policy.	To reduce the risk of the ring(s) falling off.
Be aware of spiritual/religious/cultural ornaments that need to remain with the deceased. Ensure these are clearly documented.	To respect the wishes of the deceased /key contact. Refer to their Advance Care Plan if in place.
In the community setting, it is recognised that identification of the deceased is likely to be via a verification of death form.	To ensure correct identification of the deceased.

ACTION	RATIONALE
If the body continues to leak, place it on absorbent pads and advise the funeral director.	To prevent risk of contamination to those handling the body from increased leakage of fluids.
Request transfer of the deceased	
In community settings such as community hospitals, care homes and hospices, local arrangements should be made with the funeral director for collection of the deceased, ideally within 4 hours of death. In the deceased's own home, support, guidance, and signposting with this may be needed depending on the circumstances.	Optimum time for refrigeration of the deceased is 4-6 hours. To ensure arrangements are in place for the transfer of the deceased to the funeral director or equivalent.

ACTION	RATIONALE
In the home of the deceased, advise the key contact of cleaning needs according to the Standard Infection Control Precautions. Where a hospital bed or any other loaned equipment is in the home, follow local policy on advice for decontamination and return of the equipment.	To eliminate potential spread of infection To eliminate cross-infection from contaminated gloves.
Remove PPE in the correct order (see Appendix 4) and dispose of as per local policy. Perform hand hygiene.	To eliminate cross-contamination.
Document in the clinical notes that personal care after death has been carried out and the conversation with and advice given to the key contact(s) of the deceased.	To ensure a clear record of events is recorded.
Give opportunity for staff debrief. Be sensitive to own and others experience of caring for the deceased prior to dying and/or at the time of death. Further support or reflection may be needed.	Allows for anxieties and concerns to be addressed at the time, giving recognition and validity to the feelings, and may avert potential of unexplored emotions reaching crisis point.