CARE OF THE BEREAVED
GUIDELINES FOR BEST PRACTICE

Amendments

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Compiled by: Judith Allford, Head of Pastoral Care
Dr Barry Quinn RN, Macmillan Lead Nurse Cancer & Palliative Care in Consultation with the End of Life Steering Group

Ratified by: Clinical Governance Committee

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Impact Assessment: Judith Allford
ASHFORD AND ST PETER’S HOSPITALS NHS TRUST

PROCEDURE FOR THE CARE OF THE BEREAVED

See also:
• End of Life Care Strategy
• Communicating Significant news: Guidelines for Best Practice
• Last Offices Nursing Procedure including Last Offices for an Infectious Patient
• Patient’s property policy and procedures
• Mortuary Viewing policy and procedure
• Policy and procedure for the early release of the deceased patient out of normal working hours
• Meeting the Patient’s Religious Needs:
  • Bereavement booklet: Help for the bereaved,
  • Guidelines following the loss of a baby after miscarriage, stillbirth, termination of pregnancy for abnormality, and neo-natal death
• Guidelines to Follow in the Event of a Death Occurring on the Neo-Natal Intensive Care Unit
• Resuscitation Policy
• Handling Deaths at Ashford Hospital)
• Bereavement Office: Doctor’s Training Pack,
• Guidance for Doctors on Post-Mortem Examinations,
• Tissue Donation Policy
• Guidelines for Using Interpreting Service

INTRODUCTION

In July 2008 the Department of Health launched its End of Life Care Strategy. The Executive Summary of the Strategy highlights apparent inconsistence in the level and quality of care being offered at the present time to the dying patient and their families/carers both before and after the death of the patient. “Some people do indeed die as they would have wished, but many others do not. Some people experience excellent care in hospitals, hospices, care homes and in their own homes. But the reality is that many do not.” The purpose of the Strategy is to set out key areas in which care can and should be improved. It addresses both the last days of a patient’s life and care after death. It also looks at involving and supporting families and carers and at the care that family/carers may require after the death of a loved one. It also addresses issues around training and developing staff.

Material prepared for the End of Life Care Work Stream within the Surrey Primary Care Trust indicates that at any one time about 25% of inpatients in acute hospitals are in the last year of life. In the light of this Commissioners of acute care will in future require evidence that both the dying patient and their carers are provided with “appropriate support both during the patient’s time in Hospital and in the period around death”. This Bereavement Policy aims to reflect areas of good practice within our Trust and to encourage a consistency in standards and in practice across all parts of the Trust.

The issues that this policy seeks to address include communication issues particularly with reference to breaking bad news, the provision of appropriate religious and spiritual support, the privacy and dignity of the patient and his/her family/carers, issues relating to the care of the deceased patient and to the information and support offered to the bereaved following their loss. By drawing on examples of existing good practice this policy aims to set a standard that is eminently acceptable and achievable within the constraints of the acute hospital setting

Reference is made throughout the policy to other Trust policies and supporting documents. All of these are available on Trust Net or in hard copy either in the clinical areas or through the Bereavement Office.

The policy has been prepared with the input and support of the Trust End of Life Care Steering Group. It has been impact assessed with the help of a group of local religious/faith leaders and
representatives. The End of Life Care Steering Group aims to provide a constant review of the policy and of its implementation across the Trust.

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1. POLICY STATEMENT

In caring for those bereaved within the Trust members of staff are committed to ensuring:

a) Privacy and Dignity
The care offered to the deceased patient and to his/her relatives/carers/next of kin should promote the dignity and well-being of each individual. Basic measures of establishing privacy should always be observed. Arrangements for the bereaved to view the deceased, to collect personal effects and relevant paperwork, and to raise any questions or concerns that they may have, should be conducted in surroundings which enable privacy needs to be met.

Sensitivity and courtesy must be exercised at all times. Those who are bereaved will be experiencing a variety of feelings including shock, sorrow and even anger. Members of staff who are caring for those who are bereaved should be careful to ensure that their tone and manner are appropriate at all times. It is important not to appear rushed or impatient and consideration should be given to the offer of additional support, such as that of the Chaplaincy, where this would be helpful.

b) Religious and cultural needs are addressed
The deceased patient and his/her relatives/carers/next of kin should be cared for in such a way that their specific needs of gender, disability, ethnicity, age, sexual orientation, religion, culture and language are adequately addressed. Specific religious and cultural practices should be facilitated wherever possible and access should always be offered to a religious representative of choice. The Trust Guidelines for using Interpreting Services should be consulted when necessary.

c) Verbal and written information is available and accurate
The bereaved must be given immediate access to both verbal and written information which will enable them to understand the process that must be followed after the patient’s death. This information must include telephone contact numbers, location and times of opening for the Bereavement Office, guidance concerning the registration of the patient’s death and preliminary information regarding making funeral arrangements. Where the death is to be referred to the Coroner this must be explained verbally and backed up by appropriate written information. Care must be taken to ensure that specific communication needs, including visual or auditory impairment and interpretation needs are addressed accordingly and appropriately.

d) Consideration is given, where appropriate, to the facilitation of longer term support
Written information should also direct the bereaved to appropriate sources of advice such as Social Services Departments, Citizens Advice Bureau and national and local self-help groups for the bereaved. Literature should also provide information about individuals and departments within the Trust who can help to provide access to longer-term support where necessary.

e) Staff providing bereavement care are appropriately trained, supervised and supported
All staff involved in the care of the deceased patient and the bereaved should receive appropriate training and support. This should include emotional and psychological support as well as in-service education and training. Consideration should be given to the need for debriefing following critical incidents or after a protracted period of bereavement on a specific ward or unit (See Section 2h).
2. PROCEDURE FOR THE CARE OF THE BEREAVED IN THE WARDS AND CLINICAL AREAS

a) Communicating significant news (See Trust Policy: Communicating significant news: Guidelines for Best Practice.) Sensitive information relating to the death of a patient should be given in a manner that is easily accessible and understood. In all situations the privacy and dignity of the deceased patient and the bereaved are paramount. The aim must be to offer the highest possible standard of care whilst recognising the inevitable constraints of space and staffing resources. Wherever possible a room should be identified on the ward/unit where the breaking of bad news can take place in private. Bad news should not normally be given by telephone but in many circumstances this is, or may be, necessary. Calls should therefore be made in private wherever possible and the staff member making the call should try to establish that the bereaved has access to support.

b) Completion of Last Offices

Last Offices must be completed in accordance with the RMH Manual Procedure and the needs of the bereaved observed and met appropriately. The Notification of Death, the Mortuary Admission Form and the Last Offices Check List (copies of which are available on the wards) must all be completed and the Bereavement Office (ext 2319) must be informed of the death as soon as possible. This must be done whenever a death occurs by leaving a voice-mail message. It is essential that this administration is adequately completed in order to facilitate best practice care of the bereaved. The check list includes locally appropriate information to aid last offices nursing procedure at ASPH.

c) Privacy and dignity (including provision of private space)

If the bereaved are present when the patient dies, or subsequently come into the hospital they must be offered the support and privacy that they need. They may wish to make telephone calls, and, if possible, office space should be made available to them. They should be offered a cup of tea or coffee and a member of the ward/clinical area staff should be designated to spend time with them. If this is difficult to achieve, perhaps because the ward/clinical area is very busy, the Unit Clinical Nurse Lead, a member of the Pastoral and Spiritual Care (Chaplaincy) Team, or, at weekends and at night, the Clinical Site Nurse Practitioner (CSNP) should be contacted for additional support (see Appendix 1). During normal working hours there is a small Quiet Room available in the Bereavement Office. This is available for the use of Clinical and Support staff who wish to speak to bereaved relatives/carers without being disturbed. Requests to use the room must be made to the Bereavement Officer (Ext.2319/2516). See Protocol for the Use of small counselling room (Appendix 2).

d) Meeting religious and cultural needs

The bereaved should always be asked whether there are any specific religious or cultural needs which should be addressed. They should be asked if they wish to see a member of the Trust Chaplaincy Team or another religious representative of their choice. A member of the Chaplaincy Team is always available in an emergency 24/7 and can be contacted via the Hospital Switchboard. The Trust folder “Meeting the Patient’s Religious Needs” is available on all wards and units and contains advice on meeting specific religious needs at the time of death as well as relevant telephone contact numbers.

There is a Multi-Faith Centre on both hospital sites as follows:

- Ashford Hospital – the Centre is located to the left of the main hospital entrance and includes a Chapel, Multi-Faith Prayer Room, Quiet Room and Ablutions Room
- St Peter’s Hospital – The Multi-Faith Centre is located at the rear of the Accident & Emergency Department. It includes a Chapel, Multi-Faith Prayer Room, Quiet Room and Ablutions Room.
Both centres are open all day, every day but are normally locked at night. However, in the event of a bereaved family requesting to use the Centre at night, the Security staff can facilitate this.

e) Care of deceased patient’s property
The property of the deceased patient should be cared for in accordance with the RMH Manual Last Offices Nursing Procedure and the Patient’s Property Policy.

f) Provision of verbal and written information
If the bereaved are present at the time of death, or later attend the ward/unit, they must be given a copy of the Trust Bereavement Booklet before they leave. If the bereaved do not wish to come into the hospital they should be given the telephone number of the Bereavement Office (01932 722319/01932 722516). It must be explained that they will need to telephone the Bereavement Office to make an appointment before they can collect the medical certificate of death and any remaining property.

g) Emotional and psychological support
The bereaved may ask to see the Doctor or Nurse who has been caring for the patient and this should be facilitated if at all possible, or an appointment should be made for them to do so at a later date. They should be advised of other possible avenues of support – e.g. their own GP, the Trust Specialist Palliative Care Team, the Hospital Chaplaincy.

h) Debriefing/support for staff
Consideration should be given to the needs of staff. The nurses caring for the bereaved may appreciate some support or a brief break after the care has been completed. The shift leader is responsible for facilitating this and it may be necessary to contact the Unit Clinical Nurse Lead, or, out of normal hours, the CSNP (see Appendix 1), for additional support. More junior members of staff, who may be experiencing their first death on the ward, should also be given the opportunity for debriefing and for raising any concerns they may have. It is the responsibility of the shift leader to ensure that, as far as possible, both nursing and medical staff receive appropriate support. The Employee Assistance Programme (0800 282193) is available 24 hours and the Trust Chaplaincy Team provides a 24 hour “on call” service via the Switchboard.

3. THE ROLE OF THE BEREAVEMENT OFFICE

The Bereavement Office states as its aim:

- To provide a sensitive, efficient and timely service to the next of kin of patients who die at Ashford and St Peter’s Hospitals NHS Trust.

- To educate and inform staff and members of the Trust of the role of the Bereavement Office and of how to achieve best practice.

- To promote the image of the Trust as caring not only for its patients but also for those with whom they share their lives.

The Trust Bereavement Office is responsible for the following areas of bereavement care:

a) Provision of information/Completion of paperwork

The Bereavement Office is responsible for the regular review, and for facilitating the production of the Trust Bereavement Booklet. The Office is also responsible for directing the bereaved to relevant sources of information regarding financial help with funeral arrangements.

It is the responsibility of the Trust Bereavement Officer to ensure that all documentation required to register the death of the patient and to transfer the deceased patient from
the care of the Trust to the care of the Funeral Director is efficiently and accurately completed. This will involve contacting the appropriate medical staff and supporting them in the completion of the medical certificate of death and, where necessary, the cremation papers. The Bereavement Officer will complete the Body Release Form to enable the Funeral Director to collect the deceased from the Trust Mortuary.

The Bereavement Officer is also responsible for entering the death in the Death Register and for completing the Deceased Patient’s Information Sheet with the name of the Doctor who has completed the Death Certificate, the medical cause of death, the number of the entry in the Death Register, and the date.

b) Care of Patient’s property

Any property belonging to the deceased patient not already removed by the next of kin will be brought to the Bereavement Office by the Porters. This may include valuables, which should be packed separately and will be stored in the Office safe until collected. When next of kin come to collect property/valuables the Bereavement Officer will obtain the signature of the person taking responsibility for the property.

complete the property book, ensuring that any cash and valuables are logged separately, and obtain the signature of the person taking responsibility for the property.

c) Administrative and practical support for the Bereaved

➢ Provision of death certificate

The next of kin should have been informed on the ward/area/unit where the patient died that they should only attend the Bereavement Office having first telephoned and made an appointment. This will prevent additional distress being caused if the Medical Certificate of the Cause of Death has not been completed. The necessary paperwork should therefore be immediately available when the next of kin/carers arrive and they will be shown into the waiting room where they will be given any remaining property, the Medical Certificate of Death, and an invitation to the Trust Memorial Service. It is the responsibility of the Bereavement Officer to explain the process of registration and the information that the Registrar will require. The next of kin/carers will be given printed directions to the Registrar’s Office in Weybridge.

➢ Liaison, as appropriate, with the Coroner’s Office

If the death is to be referred to the Coroner the Bereavement Officer will almost certainly not meet the relatives face to face since the Coroner’s Officers will handle the necessary administration and paperwork. However, it is the responsibility of the Bereavement Officer to ensure that the next of kin/carers have been informed of the referral and that they have the Coroner’s Officers telephone number. The death of the patient, when appropriate, must be referred to the Coroner by the Doctor, but it may be necessary for the Bereavement Officer to liaise with the Coroner’s Officers and to facilitate their contact with the bereaved. The Coroner’s Office can be contacted on 01483 637300. A written referral will be required, the Electronic Referral Form is available on Trustnet and in the Bereavement Office.

➢ Liaison with local funeral directors

Once the Funeral has been arranged the Funeral Director will contact the Bereavement Office to arrange collection of the Body Release Form and the cremation papers. If the body is to be buried the Bereavement Officer will fax the Body Release Form to the Mortuary. The Bereavement Officer will also receive
from the Funeral Directors the disbursement payments for the Doctors completing cremation papers.

The Bereavement Officer is not permitted to recommend a particular Funeral Director. However, the Trust Booklet “Help for the Bereaved” includes advertising material from a number of local Funeral Directors. In addition, local Funeral Directors are also permitted to make available written information regarding their services in the Bereavement Office Waiting Room.

d) Making hospital funeral arrangements

If a deceased patient has no next of kin and no-one who is able/willing to make funeral arrangements for them, the Trust has a statutory responsibility to make appropriate funeral arrangements through the Trust contract Funeral Directors. It is the role of the Bereavement Office to discharge this responsibility. This will include the registering of the death, facilitating the investigation of the affairs of the deceased in order to determine whether there are friends/relatives/legal representatives who need to be informed of the death and whether there are monies available to recoup the cost to the Trust of funeral arrangements. The Bereavement Officer is also responsible for ensuring that the funeral arrangements comply as far as possible with any prior wishes/requests of the deceased patient, if these are known. The Bereavement Officer will also liaise with the appropriate Trust Chaplain who will usually conduct the funeral service. The Bereavement Officer may also be required to liaise with the Treasury Solicitor.

e) Immediate emotional support (listening)

The Bereavement Office will normally be the bereaved relatives/carers first point of contact with the Trust following the death of the patient. The Bereavement Officer is not a trained counsellor but aims to provide an appropriate and sympathetic listening approach to the bereaved within an environment that affords both privacy and quiet.

f) Referral/Recommendation to internal and external agencies.

It is the responsibility of the Bereavement Officers to ensure that the patient’s GP has been informed of the patient’s death, and to inform the Trust Medical Records Department and Social Services Department.

If the Bereavement Officer has reason to believe that the bereaved relatives/carers may be in need of additional bereavement care or support, it would be appropriate to draw their attention to written information regarding the availability of external support agencies such as CRUSE or other more specialist providers of bereavement care. A wide range of contact telephone numbers is included in the Trust Bereavement Booklet. The Trust Chaplaincy also offers an informal listening service to bereaved relatives/carers who may find this helpful and details are given in the Bereavement Booklet.

g) Arranging a Viewing in the Mortuary Chapel of Rest/Viewing Room

Next of Kin may on occasion request to see the deceased in the Mortuary Chapel of Rest/Viewing Room. During normal working hours it is the responsibility of the Bereavement Officer to facilitate this by liaising with Mortuary Staff (SPH site) or the appropriate ward staff (AH) in order to arrange a mutually convenient time for an appointment and by providing verbal directions to the mortuary.

Viewings out of hours can only be arranged in the most exceptional circumstances. See Section 11, The Role of the Mortuary Staff and the Trust Mortuary Viewing Procedure. The Bereavement Officers may be able to encourage next of kin to wait to
view the deceased patient once he/she has been transferred to the more suitable environment of the Funeral Director’s Chapel of Rest.

Where there is specific religious/cultural need, the Mortuary staff are able to facilitate the preparation of the body of the deceased patient by his/her family, but arrangements for this must also be made through the Bereavement Office or, out of hours, through the Site Co-ordinator/CSNP (see Appendix I).

h) Meeting Specific Religious and Cultural Needs.

The Bereavement Office is responsible for the review of the Policy relating to the Early Release of the Deceased Patient. When Early Release is requested it is often on religious/cultural grounds and it is the responsibility of the Bereavement Officers, during normal working hours to facilitate this process. This may involve liaison with the Registrar’s Office, and with the Coroner’s Officers, particularly when an “Out of England Order” and/or a “Free from Infection” Certificate is required.

Out of hours it is the responsibility of the Site Co-ordinator or Clinical Site Nurse Practitioner to facilitate this process. Please see section 10, Meeting the Religious and Cultural Needs of the Bereaved – Early Release of the Deceased Patient.

i) The Care of Bereaved Parents.

Parents bereaved of children are largely cared for in the department where the death has occurred – ie. the Labour Ward, the Neo-Natal Unit, the Paediatric Ward or Paediatric A&E. Paperwork is completed in these areas and most parents would not attend the Bereavement Office. However, the Bereavement Office must always be informed of the death of a baby or child, including that of a pre-24 week infant. The deaths of all babies and children will be entered in the Death Register. The Bereavement Officer is also responsible for arranging, normally through the Trust Transport Department, the transportation and collection of stillborn infants, deceased babies or children, who are to be taken to another hospital for Post Mortem. The Bereavement Officer will liaise extensively with members of staff who are involved in the care of bereaved parents and is always willing to offer advice and support.

j) Staff Training/Support

The Bereavement Officers are involved in Trust Induction and in relevant Training Programmes provided by the Trust. The Bereavement Office is also represented on the Trust End of Life Care Steering Group.

k) Provision of quiet space

There is a small Quiet Room within the Bereavement Offices on the St. Peter’s site. See Section 2(c) for details.

4. THE ROLE OF THE SPECIALIST PALLIATIVE CARE SERVICE

- When a patient has been referred to the Specialist Palliative Care team he/she will be assigned to the care of a named member of the team. Issues of pain and symptom control will necessarily be addressed, but the approach to care will be a holistic one. It is recognised that the bereavement process, for both the patient and their relatives/carers/next of kin, can begin well before death has taken place. The patient and their next of kin/relatives/carers will therefore be offered appropriate psychological, emotional and pastoral support both as death approaches, and after it occurs.
• The 5 key principles of good end of life care has been developed for use within the Trust. This will further support all members of staff to identify and deliver appropriate physical, spiritual and emotional support

• Members of the Specialist Palliative Care Team host a weekly MDT meeting at which the needs of palliative patients and their families/carers are discussed. Membership of the meeting includes the Senior Nurse for Palliative Care, Consultants in Palliative Medicine, Community Nurse Specialists, Specialist Nurses from other disciplines, an Occupational Therapist, and a Pharmacist with special responsibility for Palliative Care. This meeting can provide an appropriate forum to discuss specific bereavement issues for those known to the Specialist Palliative Care team.

• Following the death of the patient the Team may contact the relatives/carers/next of kin by telephone. A condolence card may also be sent and the relatives/carers/next of kin will be facilitated in accessing further avenues of support if necessary.

• The Specialist palliative care team will also contact involved community palliative care teams to inform them of their patient’s death in order to ensure the family are also picked up by community palliative care bereavement services when on-going support is identified as a need

• The Specialist Palliative Care Team leads a regular Training Programme for members of staff. The Specialist Palliative Care team also offers specific training programmes for Medical Support Workers and Healthcare assistants. The Team also participates in the Induction Programme for new Doctors.

• The Head of Pastoral Care maintains a close working relationship with the Specialist Palliative Team. This enables those patients and families who would appear to benefit most from some additional form of spiritual support, to be identified and their needs addressed.

• The Senior Nurse for Specialist Palliative Care and Nursing team can be contacted via the Hospital Switchboard, or on extension 2312. The duty Palliative CNS carries Bleep 8867.

5. BEREAVEMENT CARE FOLLOWING THE LOSS OF A CHILD

a) Bereavement care on the Maternity Unit

The brief notes which follow should be read in conjunction with the Trust Policy: Guidelines following the Loss of a Baby after Miscarriage, Stillbirth Termination of Pregnancy for Abnormality, and Neo-Natal Death. It is the intention of this policy to inform best practice care for parents following the loss of their baby, and best practice provision for the respectful care of their baby, ensuring all needs for privacy, dignity and individual cultural observance are sensitively and accurately met.

• Mothers who attend the Labour Ward following pregnancy loss, regardless of the gestation of the baby, will be afforded appropriate and sensitive care and will be advised at every stage of the choices available to them. They, their partners, and other family members, if relevant, will be offered appropriate emotional, spiritual and psychological support. Priority will be given to addressing individual cultural needs.

• Relevant verbal and written information will be provided. Parents will be offered the opportunity, both before and after the delivery of their baby, to see a member of the Trust Pastoral and Spiritual care Team (Chaplaincy), or a religious leader of their choice (contact via the Hospital Switchboard).
• The Bereavement Support midwives/Birth Reflections Service must be informed of the death of the baby. Outside normal working hours a message must be left for them on ext. 2879.

• Bereavement packs for staff are available on the unit. Separate packs are available for STILLBIRTH (ie. post 24 week baby loss), PRE-24 WEEK LOSS, and NEO-NATAL DEATH ON THE LABOUR WARD. These packs contain all the information that midwives will need in order to complete paperwork and to offer appropriate advice/information to parents. A “flow chart/pathway” is available to support the packs and guidelines. There is a check list that should be followed and completed for all pregnancy losses. Example packs are also available

• Following delivery of the baby, parents will be offered all the time they need to spend with their child, whilst the midwife caring for the mother will also ensure that the physical care of the mother is addressed and completed.

• The individual needs of each bereaved family will be met wherever possible. The Midwife in Charge of the shift is responsible for ensuring that the baby, the parents, and the midwife looking after them, receive full support.

• The Bereavement Officer (ext 2319, Voice Mail out of hours) will be informed of the death of the baby at the earliest opportunity.

• After the mother has been discharged, one of the bereavement support midwives will be in touch with her to offer further support. This may include a home visit if the mother wishes. In some circumstances parents will be offered counselling support from the Bereavement Support Counsellor, although this is usually at a later stage.

• The Hospital Funeral service for pre-24 week babies normally takes place at Woking Crematorium on the 1st Wednesday in each month at 9am. Up to 4 babies can be included in the service, and parents will be informed of the date of the service by the Bereavement Officer.

• The Bereavement Support Midwives provide regular training opportunities for midwives and for medical staff.

• The Trust holds an annual Ceremony of Remembrance for parents bereaved of children. This is normally held on the last Saturday in June. Further details can be obtained from the Bereavement Support Midwives (ext. 2879) or the Department of Pastoral Care (ext.3324).

**Note on Maternal Death**

A “Maternal Death” is the death of a woman up to one year following pregnancy including birth and pregnancy loss such as miscarriage, ectopic pregnancy or termination of pregnancy. The death can be the result of any cause including disease such as cancer or traumatic causes including RTAs or suicide therefore could occur anywhere in the Trust. All maternal deaths must be reported to CEMACH (Confidential Enquiry for Maternal and Child Health). The Associate Director for Maternity Services (ADMS) must be informed of all maternal deaths (ext 2903) and will take responsibility for reporting these deaths to CEMACH. If the death occurs out of hours, this notification can be done on the next working day.
If a maternal death occurs anywhere in the Trust a copy of the patients notes including all
path results etc, must be taken immediately and forwarded to the ADMS in the maternity
unit.

b) Bereavement care on the Neo-natal Unit

A baby who dies following admission to the Neo-Natal Unit will be cared for in accordance
with the Guidelines to Follow in the Event of a Death on the Neo-Natal Intensive Care Unit. There is a comprehensive Checklist and Pathway included, which must be followed in all
cases.

• The individual needs of each bereaved family must be met wherever possible. The
Nurse in Charge of the shift is responsible for ensuring that the baby, the parents,
and the nurse looking after them, receive full support.

• The parents will be given the choice of being fully involved in the final care of their
baby if they wish. This will include bathing and dressing the baby, and the taking of
handprints, footprints and photographs. The parents will be given privacy in the
parents’ accommodation to spend as much time with their baby as they need and
will be helped to access the support of family or friends, the Trust Pastoral and
Spiritual Care Team and the Bereavement Support nurse.

• The Medical Certificate of Death will be handed to parents on the Unit, together with
any mementoes of their baby and written information regarding what they will need
to do following the death of their baby and how they can access further support.

• The nurse caring for the baby on the day of death is responsible for the completion
of all relevant paperwork and for informing other internal and external agencies
involved in the care of the mother and baby of the death of the baby.

• The Neonatal Unit employs a Unit Sister with designated responsibility for
bereavement care. It is her responsibility to ensure that the parents are offered a
comprehensive bereavement follow-up service. This will include a telephone call
both before and after the funeral service has taken place and the offer of additional
emotional and psychological support as required.

• Nursing Staff on the neo-Natal Unit will be provided with both informal and formal
training on bereavement related issues. They will also be given access to
counselling support if necessary and appropriate.

c) Bereavement care on the Paediatric Ward

The deceased child and his/her family will be cared for in accordance with the Trust Last
Offices Nursing Procedure. A copy of this policy, together with a copy of the Last Offices
for an Infectious Patient Policy, Early Release of the Deceased Patient Policy and the
Mortuary Viewing Policy/Procedure, are in the Last Offices “Forget Me Not” Box which is
kept on Ash Ward.

• If the death occurs in a cubicle, the child will remain there until it is time for him/her
to be transferred to the Mortuary. If the death has occurred in a ward bay, other
children and visitors will be moved from the bay, or the deceased child will be
transferred to a cubicle. Sensitivity will be shown at all times both to the bereaved
family and to other families present on the ward.

• Parents and close family will be enabled and encouraged to spend time with their
child. Appropriate mementoes (for example, photos, hand and foot prints, lock of
hair) will be offered to parents. These will depend both on the age of the child and on the wishes of the parents.

- Parents will be offered the opportunity to see a member of the Trust Pastoral and Spiritual Care Team or a religious representative of their own choice. The Head of Pastoral Care (ext.3324) should always be informed of the death of the child. The parents will be asked if they have particular religious or cultural needs and every effort will be made to ensure that such needs are met.

The Last Offices Box also contains:

Aprons and Gloves, Towel, Dressings, Nappies, a set of baby clothes, baby bath oil, hair brush, camera, Ink Pads with hand/footprint cards, Memory cards, Death Certificate Book, Notification of Death Book, Property Book, Property Bag, Last Offices Check List, Bereavement Booklet.

d) Bereavement care in Paediatric A&E

- The death of a child will always be certified in the Resuscitation Bay and not in the ambulance. The parents may be taken to the Relatives Room and supported there until one of the Paediatric Doctors is available to see them.

- The Paediatric Doctor who has been responsible for the resuscitation process will normally inform the parents of the death of their child. This must be done sensitively and with clarity. The parents should be allowed as much time as possible to talk in detail about what has happened and to ask the questions that they may need to ask at this early stage. This will be an important factor in the grieving process and should not be rushed. Wherever possible, the Consultant Paediatrician will attend for supportive and forensic input.

- The parents should sensitively be informed that the Coroner will need to be contacted regarding the sudden death of their child and that there will need to be a post-mortem examination of the child’s body.

- Out of normal working hours it may be the police that will attend the department and see the family. The parents will need to stay in the Department until the identification of their child has been confirmed by the Coroner’s Officer/Police and they have all the immediate information that they need. The Coroner’s Officer/Police will need to interview the family. This will normally take place in the Relatives Room and the family must be afforded all the privacy that they need – this must include ensuring that other members of staff know that the room is in use, and the door blinds must be closed.

- Most parents will wish to see and hold their child and to say “goodbye”. This should be gently encouraged. However, parents should not be left alone with their child until the skeletal survey has been completed by the team caring for the child. This must be handled sensitively and a named nurse designated to supervise and support parental contact.

- Once the Coroner’s Officer/Police have seen the family, confirmed identity of the child, and initial examinations/investigations have been completed the parents may be given the opportunity to wash/dress their baby/child with the help and support of the nurse or to watch whilst this is being done. Photographs, locks of hair, hand/foot prints can be taken and given to them as appropriate. If other relatives wish to visit and see the baby/child every effort will be made to keep the child in the department for the length of time needed to facilitate this.
• Parents should be offered the support of the Trust Chaplaincy Team, or help to contact their own faith leader, as appropriate. They must continue to be afforded the privacy that they may need to observe any particular religious ritual/rite of passage.

• It must be explained to the parents that the Coroner’s Office will contact them as soon as possible to advise them when their child can be released in order for funeral arrangements to be made. The death certificate will be issued by the Coroner.

• It should also be explained to the parents that an appointment will later be made for them to meet with the Consultant Paediatrician to discuss the results of the Post-Mortem examination. However, the results of the post-mortem are unlikely to be available for at least 6 weeks.

• Parents will be given the Trust information leaflet - “Help for the Bereaved – Paediatric A&E”. This booklet contains practical information regarding funeral arrangements and contact telephone numbers for external support agencies. It also contains useful information about the grieving process and how it might be experienced following the loss of a child. There are also guidelines within it about the care of other children within a family and suggestions for accessing additional support from the hospital itself.

• The member of staff caring for the family is responsible for ensuring that the GP, Health Visitor and Community Child Health Team are informed of the child’s death.

6. BEREAVEMENT CARE IN NON WARD AREAS

a) Sudden death in A&E

• The sudden death of a patient brought to the A&E Department will always be certified in A&E and not in the ambulance. A team of medical and nursing staff will assemble to receive the patient once the Department has been alerted that the ambulance is on its way. In some cases a relative may be travelling in the ambulance with the patient. In other situations relatives/next of kin/carers may be following closely behind. In each case, the care of the relatives, as well as the patient, is of paramount importance.

• The relatives must be cared for in the designated relatives’ room. A nurse should remain with them and be responsible for keeping them up to date with what is happening. On some occasions the next of kin may request to witness the resuscitation process and this must be facilitated wherever possible. A member of the resuscitation team must be given the specific responsibility of caring for the next of kin and of explaining the process as far as is possible and relevant.

• The Doctor responsible for verifying/certifying the death of the patient is also responsible for informing the relatives of the death. A nurse should also remain present. The information must be given sensitively and with clarity and time must be allowed for relatives to ask any immediate questions or to raise particular issues. The way in which this is handled is bound to inform the eventual mourning process and appropriate time should be given to it.

• The deceased will be transferred from the resuscitation area to the Body Viewing Room. In cases where there is reason to believe that the death may have been in any way suspicious, all lines and tubes must be left in place. In other circumstances it may be possible to remove lines and tubes in order more sensitively to care for relatives/next of kin/carers. However, this must be subject to the advice of the Coroner’s Office or police.
• Relatives must be kept informed of the involvement of the Coroner’s Office and of the police. Where the death is not regarded as suspicious, and where the cause of death can be identified, it should be possible to involve the Bereavement Office during normal working hours. The Office can be contacted on Ext. 2319.

• Out of hours the police will attend the Department to give further support. It is the responsibility of the nurse caring for the family to ensure that they are given the verbal and written information that they will need, including a copy of the Trust Bereavement Booklet “Caring for the Bereaved”. He/she is also responsible for offering the support of a member of the Trust Chaplaincy Team, or of a religious leader of their choice. The appropriate religious representative should be contacted and specific religious rituals/rites of passage should be facilitated as requested by the family.

• The relatives should be enabled to spend as long as they wish with the deceased patient. However, the needs of the Department and of other families must be borne in mind and under normal circumstances the deceased patient should be collected from the Department within a maximum of 3 hours. There may be exceptions to this, as when close relatives are not present and have to travel some distance to be with the deceased. In such circumstances the time available may be extended but this must always be at the discretion of the shift leader, who may need to liaise with mortuary staff (via the Bereavement Office during normal working hours) or the CSNP outside normal hours [see Appendix 1]).

• The Last Offices will be completed in accordance with the Last Offices Nursing Procedure.

b) Death in ITU

• The withdrawal of treatment from a patient being cared for in ITU will only take place following discussion and agreement with relatives/carers/next of kin. The process will follow best interests in line with the Mental Capacity Act, 2005 and adhere to the Trust’s own best interests protocol. Medical staff will spend time with relatives to describe and to reinforce the plan of care. This discussion would normally take place in the Interview room, unless occupied by another family, or in an appropriate private space. The known wishes of the patient, as well as the relatives, will be considered and taken into account wherever possible. All the members of the team caring for the patient will be involved and available to relatives to answer questions/clarify issues of particular concern. Relatives should be afforded both time and privacy and the process of withdrawal, once agreed, must be carefully explained to them so that they will have some idea of what to expect.

• The team caring for the patient must ensure that next of kin/relatives/carers are given the time and opportunity to say their goodbyes. Wherever possible, the patient should be moved to a cubicle and staff should withdraw to ensure privacy. If no cubicle is available, curtains around the bed space should be securely drawn.

• The next of kin/relatives/carers should be offered the opportunity to see a member of the Trust Chaplaincy Team or the religious leader of their choice. This may have some influence on the planned time for withdrawal since the religious leader may need to attend the Unit and there may be appropriate religious rituals/rites of passage which the relatives wish to observe.

• Following the death of the patient, the relatives will be requested to leave for a few moments to allow staff to tidy the patient/ remove tubes where it is possible to do so. Relatives should then be enabled to spend time with their loved one whilst he/she is still on the Unit, should they wish to do so.
• The nurse who has been caring for the patient will give appropriate written and verbal information to a key family member. This will include the Trust Bereavement Booklet and any other specific information that may be required, such as how to arrange to meet with a member of the medical team for further discussion.

• The Unit staff will often send a card of condolence to a bereaved family. However, each individual situation will be assessed, since such a gesture may not be appropriate in all cases.

c) Death in Theatres

The Death of a patient in Theatre may be a relatively rare event, but may occur under the following circumstances:

• Patients undergoing emergency surgery who are known to be at high risk

• Patients undergoing elective surgery, where either an additional risk of complication is already known, or where such an event occurs unexpectedly.

• Ward patients whose condition has deteriorated suddenly and who have been transferred to Theatre Recovery for specialist management.

• Patients awaiting a bed in ITU.

• Paediatric patients awaiting a Retrieval Team from another hospital. In the event of a death in these circumstances the Trust Theatres have their own local policy relating to the death of a child.

In the event of a patient dying on the operating table it will almost always be necessary for the patient to be transferred to another area if relatives/carers wish to see the deceased and spend time with them. This would normally be the Theatre Recovery area. It should be noted that conditions within this area are not ideal, since other patients will almost certainly be receiving care at the same time. Screens should be used to afford as much privacy as possible. Background noise and disruption should be kept to a minimum. Other areas which should be considered in assisting with the care of relatives are the ITU Relatives’ Room and the Children’s Waiting Area.

• Staff will follow the Last Offices Nursing Procedure in the care of the deceased and in the guidelines given for the care of relatives/carers. Relatives should always be asked if there are specific religious/cultural needs which should be followed.

• Where members of staff need additional support or advice this should be sought from the Unit Clinical Nurse Lead or out of hours the CSNP (see Appendix1), who, in any case, should always be contacted in the event of an unexpected death in Theatre. (Bleep No. 5-001 see Appendix 1). Where the patient has been transferred to Theatre from a ward or other clinical area Theatre staff should ask for support from that ward/area in the care of relatives/carers.

The Chaplaincy Team (contact via Switchboard) would always be willing to come in to offer support, both to relatives and also to staff.

Debriefing after critical incidents of this kind should be offered to staff wherever possible.

d) Death Occurring Outside the Patient’s own Ward/Clinical Area
In the event of a patient dying away from the ward/clinical unit whilst having an investigation/procedure, a senior member of the nursing team in the area where the death occurs is immediately responsible for:

- Contacting the Ward/Unit from which the patient has come
- Contacting the Bereavement Office (Ext. 2319)

  • **Certifying the Patient’s Death**

A designated nurse (see above) is responsible for ensuring that a member of the medical team certifies the death of the patient is certified and documents it in the patient’s notes. The date, time and circumstances of the death must also be recorded and it must be noted whether or not the Coroner’s Office has been informed. The name of anyone present at the time of death should also be documented.

  • **Informing the Coroner’s Office**

This is the responsibility of a senior doctor/doctor certifying the death of the patient. The Coroner’s Office can be contacted on 01483 637300. A written referral will be required, the Electronic Referral Form is available on Trustnet and in the Bereavement Office. The call will be redirected out of hours but the Doctor can still, if necessary, request to speak to the on-call Coroner’s Officer.

  • **Informing the Next of kin**

If relatives are not with the patient, or not present in the hospital, they should be contacted immediately. It may be appropriate that this is done by a senior member of the ward team from where the patient has come, particularly if the deceased has been an in-patient for any length of time. In other circumstances it may be more appropriate for this to be done by a designated nurse from the area where the patient has died, or by the area Matron or out of hours Site Co-ordinator/CSNP (see Appendix 1). In any case it is vital that the decision is made swiftly, and that there is immediate clarity around whose responsibility this should be.

  • **If the relatives are present/wish to come in**

If the relatives wish to view the deceased a decision must be made quickly as to where would be the most appropriate area. The A&E Body Viewing Room is a possibility, if not already in use. If porters are asked to move the patient from the area where the death has occurred in order for relatives to view, it is vital that they are informed that they will be moving a deceased patient.

The patient should be transferred on a bed/trolley and every effort must be made to ensure that this is done both sensitively and discreetly with appropriate consideration given to the privacy and dignity of the deceased and to the sensitivities of other patients, visitors and staff. In the case of a bariatric patient, the appropriate bed cover must be used.

In certain circumstances, particularly if a cubicle is available, it may be possible to move the patient back onto the ward. The Nurse in charge of the shift must ensure that the ward is prepared by drawing curtains around other bed spaces as necessary and by making sure that all through-ways are temporarily cleared of other patients/visitors.

If the A&E viewing room is already in use and there is no suitable space on the ward/unit from which the patient has come, then every effort must be made to find the most suitable available space within the area where the patient has died.

The relatives must be asked if there are any particular religious/cultural needs which should be met and whether they wish to see a member of the Trust Chaplaincy Team or a religious
leader of their choice. If so, the Chaplains can be contacted through the Hospital Switchboard and should also be able to offer advice on how to contact other religious leaders if required. The Trust Folder “Meeting the Patients’ Religious Needs”, a copy of which is available in most wards/clinical areas and in the Switchboard gives some guidance about Last Offices and also has a list of telephone contact numbers for religious leaders of other faiths.

The relatives must be given a copy of the Trust Bereavement Booklet (available through the Bereavement Office or on the wards/clinical areas).

- If the relatives are not present/do not wish to come in.

If the relatives do not wish to view the deceased it may be possible and preferable to move the patient directly from the area where the death has occurred to the Mortuary. The porters should be informed immediately of the patient’s death so that they can arrange a suitable time for the removal to take place. This should be done as soon as possible, allowing for appropriate last offices first to be completed.

It may be necessary to inform the relatives that they will be able to view the deceased in the mortuary during normal working hours. They must be given the telephone number of the Bereavement Office (01932 722319) and advised to ring between 9.00am – 4.00pm, Monday to Friday to arrange for the collection of the Death Certificate.

- Last Offices

Last Offices must be completed in accordance with the RMH Last Offices Nursing Procedure. If relatives have expressed any specific religious/ cultural needs these should be met.

7. BEREAVEMENT CARE IN OUTPATIENTS

- Most Outpatient areas (with some exceptions) do not normally provide hands on care to a dying patient and contact with bereaved relatives may be limited. However, the death of a patient may have a significant effect on Outpatient staff who have developed a long-standing relationship with the patient and perhaps also with their relatives/carers. This should be borne in mind when thinking about bereavement support for staff. See Section 2(e) and 2(h).

- When considering bereavement support for staff it is important for managers to bear in mind that formal debriefing does not suit everyone. It can be difficult to find a time when all members of staff affected by the bereavement are able to attend. Some people find interacting within a group setting very difficult and might prefer to talk on a one to one basis.

- When bereaved relatives/carers do attend Outpatient Departments it is important that a quiet space be found for them to speak with members of staff without interruption. The Outpatient areas at both St. Peter’s and Ashford Hospitals, including the Jasmine suite at Ashford Hospital, provide Quiet Rooms where this can be facilitated.

**Bereavement Care in the Blanche Heriot Unit**

- The Blanche Heriot Unit provides extended support for patients, their partners and their families/carers. This will sometimes include both clinical and psychological support when patients are admitted to a ward. The effect of this is to provide a seamless service of care for patients and their partners/families/carers from the point of first admission to the Unit until the patient’s death and beyond. Patients and their partners/families/carers attend the Unit both regularly and frequently.
• The relationship with Unit staff can be of essential significance to partners/relatives/carers experiencing bereavement. Contact is maintained both by telephone and face to face with those who have been bereaved. This can include home visits as well as providing an “open door” policy within the Unit. This focus of support can continue over a long period of time.

• Members of the Unit staff often attend funeral services. Issues of confidentiality can sometimes make this especially challenging and distressing for staff who have developed significant professional friendships with long-standing patients.

• Bereavement support for staff within the Unit is almost entirely on a peer support basis. This is necessitated in part by issues of confidentiality which may make it difficult to access other avenues of support. The peer support approach to staff care works well in a Unit which is relatively small and close knit. However, as Units become bigger and more fragmented it may become necessary for staff support to be addressed in a more structured way.

8. INFORMATION REGARDING POST-MORTEM

• The Trust Policy “Guidance for Doctors on Post Mortem Examinations” provides an excellent background for members of staff who are caring for relatives/carers whose loved ones may need to undergo a post-mortem examination.

• It is important to bear in mind that when a post-mortem is ordered by the Coroner it is compulsory by law. This covers a range of circumstances including those where the cause of death is unclear, suspicious or may be related to a medical procedure or treatment. The policy outlines this very clearly. Consent from the family/carers is not required but the concept of a post-mortem may be distressing to them, particularly if the reasons for it are not understood or there are religious or cultural reasons why the examination of the body after death may be particularly difficult to accept. A post-mortem will delay a funeral service and this will be particularly upsetting for members of some religious faiths. Staff need to be sensitive to such feelings and should consider involving other services, such as the Trust Pastoral and Spiritual Care Team, if relatives/carers need to be given more time to consider the implications of this.

• A Hospital Post-Mortem, which is undertaken not to establish the cause of death but to gain additional information which will be of benefit both to bereaved families and to the doctors, is not compulsory and the consent of the next of kin must be gained before the post-mortem can proceed. The Trust Policy details the process for seeking consent and it is essential that this process is followed.

• The policy states that the family of the deceased should be given time to talk and to ask questions and a reasonable amount of time to reach their decision. Members of the Trust Chaplaincy Team are always available to provide additional pastoral, emotional or spiritual support if this is appropriate. Some families may have particular religious issues relating to post-mortem. For example, in some religions, post-mortems are prohibited unless required by law and this must always be borne in mind when talking to families of a specific faith. Additional Guidance is available in the document “Meeting the Patient’s Religious Needs” which is available in hard copy on all wards/clinical areas and on the Trust intranet.

9. INFORMATION REGARDING ORGAN DONATION

As this is a situation which occurs with greater frequency in the Intensive Care Unit and Emergency Department, other staff dealing with these circumstances may find it helpful to contact the In-house Specialist Nurse – Organ Donation (based on ITU ext 2135), or outside working hours the On call Specialist Nurse-Organ Donation (pager 07659 590529,
leave name, number and message) for advice and support. The following guidelines may also be of help but it is probably more important to seek immediate local advice.

In 2006, The Department of Health commissioned a Government Taskforce (TF) to examine the barriers to Organ Donation and recommend solutions to them. In Jan 2008, all 14 recommendations made by the Taskforce were accepted and will be fully funded by the DoH.

One recommendation is that an In-house Specialist Nurse – Organ Donation is available in every Trust to raise the profile of donation, so it becomes a ‘usual not unusual event’. Each individual patient should be given the choice and opportunity to offer their organs and tissues for the purposes of transplantation after their death (if appropriate). This choice should not be denied by the assumptions of NHS staff or a lack of facilities and infrastructure.

March 2010, the Specialist Nurse-Organ Donation and Clinical Lead for Organ Donation issued ‘Offering the option of Organ Donation’ a collaborative Approach. This Guide aims:

a) To support and assist with adherence with the Human Tissue Act 2004
b) To promote a timely referral enabling the in-house SN-OD or the on call SN-OD to attend the hospital, reducing waiting time for families.
c) To ensure all families of potential organ donors have the opportunity to have an expert in organ donation present when the subject is first raised.
d) To ensure families are offered accurate and up to date information to support their decision making.

December 2011 – NICE Clinical Guideline 135 has set out clear guidance

NICE 135 would like a more effective and expedient identification of potential organ donors and a more informed and timely approach to consent for donation. This should be based primarily on identifying the wishes of the individual whenever known and however recorded.

Further information and guidance on this process can be found in the Trust Organ Donation Policy on the Trust Intranet.

The General Medical Council Guidance set out in ‘Treatment and care towards the end of life:good practice in decision making’ requires that Consultant staff who have clinical responsibility for patients who are potential donors exercise a duty to consider organ donation as part of end of life care.

All initial referrals should be made to the South East Team via Pager 07659 590529. This service will pass on Tissue only donors to Tissue Services Pager 0800 4320559.

For more information on Tissue donation consult the Trust Tissue Donation Policy – found on the Intranet.

10. THE ROLE OF THE CHAPLAINCY (PASTORAL AND SPIRITUAL CARE TEAM)

A copy of the blue Trust Folder “Meeting the Patient’s Religious Needs” is available on each ward/unit and should provide much of the information you need for meeting the specific religious requirements of the patient and his/her relatives/carers. The following notes should be read in conjunction with that folder.

a) Twenty-four hour “on call” Pastoral/Spiritual Care service
The Trust operates a 24 hour Pastoral and Spiritual Care Service. A member of the Team can always be contacted through the hospital switchboard.

b) Offering the support of a member of the Trust Pastoral and Spiritual Care Team /Other Religious Leader
It is important that the patient/relatives/carers are offered the ministry of a religious leader of their choice. If the offer is phrased sensitively, making it easy for the patient/relatives/carers to decline, some people will be very happy to accept, whether or not they belong to a particular denomination or faith. The Head of Pastoral Care or “On Call” faith leader is available to come in to offer prayer or spend time with bereaved relatives even if the patient/family has no specific religious allegiance.

c) Contacting a specific Religious/Faith Representative
For some people it will be of very great importance that relevant religious offices are observed at this significant and painful time. Some patients/relatives/carers will have a specific religious allegiance and will ask to see an appropriate religious representative. The Head of Pastoral care, or the person covering for her is responsible for all calls to Church of England or Free Church patients/families and an on call Roman Catholic Priest is also available 24/7. The folder “Meeting the Patient’s Religious Needs” has contact telephone numbers for religious leaders of other faiths. This information is also available on the Intranet or via the Hospital Switchboard. Bereaved relatives may wish to see their own religious leader. If they do not themselves have a contact telephone number the “on call” Chaplain may be able to help.

d) The response of the Pastoral Care Team in an emergency situation
When asking for a specific religious leader in an emergency situation, please tell the switchboard operator which denomination/faith representative you need. A member of the Pastoral Care Team will try, if possible, to attend an emergency situation within 1 hour. If already on site he/she may be able to attend more quickly. Out of hours it may take slightly longer for them to come in. Please give them as much notice as you can.

e) Early Release of the deceased Patient
When Early Release is requested it is often on religious/cultural grounds and it is the responsibility of the Bereavement Office, during normal working hours to facilitate this process. See Section 3(h) Outside normal working hours it is the responsibility of the CSNP (see Appendix 1) to support the Ward/Unit in implementing this policy where necessary.

11. MORTUARY VIEWING PROCEDURE

This section must be read with reference to the Trust Mortuary Viewing Policy and Procedures which document both the means of arranging viewings for relatives/carers and the availability of mortuary staff.

- The Chapels of Rest are part of the Mortuary areas. No Mortuary Viewings may be arranged by Ward Staff or by staff in other clinical areas. During normal working hours arrangements for mortuary viewings on either site can be co-ordinated only by the Bereavement Office. Under normal circumstances viewings in the Mortuary will be restricted to between 12noon and 4pm, Monday to Friday. (See Section 2(g))

- At all other times arrangements to view can only be co-ordinated by the CSNP (see Appendix 1). Viewing can only be offered in very exceptional circumstances and this must be agreed between the CSNP and the Mortuary Technician on-call before any appointment is offered to the family.
• Mortuary Staff (SPH)/Portering Staff (AH) are responsible for documenting each viewing and for presenting themselves to relatives/carers in appropriate dress. They will exercise a sensitive and compassionate manner at all times.

• It is the responsibility of the Mortuary Staff (SPH)/Portering Staff (AH), particularly if the relatives/carers have not been present at the death, to advise them before the viewing of the condition and appearance of the deceased. The Staff will be responsible for ensuring that the body of the deceased is presented in the most acceptable way possible.

• The Mortuary Chapel of Rest/Viewing rooms should be maintained in a presentable manner. Appropriate provision should be made for particular religious and cultural needs. Time allowed for viewing may sometimes have to be restricted to 30 minutes. It is therefore essential that the bereaved should be afforded quietness and privacy during that time. A member of the Mortuary Staff (SPH)/Portering Staff (AH) will always be on hand to deal with any queries or specific requests.

It is desirable that Mortuary Staff should have been given specific training in the care of the bereaved since they will encounter a wide range of emotion and expressed need. They should also themselves be offered access to emotional and psychological support where necessary.

12. FOLLOW-UP CARE

a) Verbal and written information

The Trust Bereavement Booklet, which is reviewed and updated annually and is given to bereaved relatives/carers on the Ward, or through the Bereavement Office, contains contact numbers of external agencies offering support to the bereaved. Any local information produced on ward/other clinical areas should also direct bereaved relatives/carers to external means of support. It will be explained to them that Funeral Directors are experienced in offering further support and advice at this difficult time.

b) Service of Remembrance

The Department of Pastoral Care provides a Service of Thanksgiving and Remembrance in the Hospital Chapel at St Peter’s. The service takes place every 2 months, normally on the last Sunday in the month at 4 pm. Invitations to the service, at which the deceased are mentioned by name at the request of the bereaved, are given through the Bereavement Office.

c) Emotional and psychological support (listening service)

A limited “listening” service is offered through the Department of Pastoral Care. This aims to provide basic emotional support to the bereaved and can be accessed through the Bereavement Office. It can also facilitate access by the bereaved to other agencies providing emotional and psychological support, where this is both requested and appropriate.

d) Referral to external agencies

Referral to external agencies for emotional and psychological support would not normally be made although, with the permission of the individual, it might be deemed to be appropriate in certain circumstances. Self-referral should be encouraged, again where this is considered to be appropriate. The Trust Bereavement Booklet contains a selection of relevant contact telephone numbers.
13. MEETING THE NEEDS OF STAFF: Training, reporting and de-briefing

a) Staff training for bereavement care

Both clinical and non-clinical staff offering Bereavement care should be offered training appropriate to their level of involvement. It should be the responsibility of their line manager to ensure that such training is accessible to staff. The Trust should consider including Bereavement training in its “in house” training programme. The Bereavement Officers and the Head of Pastoral Care participate in the Trust Induction programme. The Bereavement Officers also offer informal training to the medical staff in the completion of paperwork.

One of the responsibilities of the Trust “End of Life Care” Group is to explore relevant training opportunities for staff. North West Surrey CRUSE offers regular bereavement training courses for their volunteer counsellors and may be willing to offer one or two places for members of Trust staff. Other external agencies, such as SANDS, the Child Bereavement Trust and the National Association of Bereavement Services offer regular training events for NHS Staff.

b) Emotional and psychological support

Consideration should be given to the need for staff to access appropriate support following a death within their ward or clinical area. Some deaths are obviously especially hard for staff. These can include both sudden death (when staff can feel that they have not had time to build a rapport with the family so that caring for them in their bereavement has been particularly difficult) and the death of a long-term patient (when staff will have formed an important relationship both with the patient and his/her family. The death of a child or younger person can also be especially hard, and staff may be affected by a situation which is particularly close to their own personal circumstances (for example, the death of a patient who may be close in age to a family member).

The Ward/Unit Manager and the Unit Clinical Nurse Lead should try to exercise particular sensitivity and awareness in these situations. It is always possible to involve the Trust Chaplaincy Team, which operates a 24 hour “on call” service (Radio Page via Switchboard). The Specialist Palliative Care Team is also willing to offer additional support to staff. Staff themselves can be encouraged to access Occupational Health (ext 2404) or the Employee Assistance Programme. The latter is available 24 hours on 0800 282193.

c) Debriefing following critical incidents

In certain circumstances (for example following unsuccessful attempts at resuscitation, particularly in the case of an infant or child) a more formal debrief for staff may be advisable. It should be the responsibility of the Ward/Unit Manager to facilitate this. The Resuscitation Training Officers (Ext.3312) are often willing to lead a debriefing session. It might also be possible to involve the Chaplaincy/ Specialist Palliative Care Team as above.

d) Training in Communication Skills

Training in Advanced Communication Skills is no longer freely available to staff but can be accessed through NCAT and other networks. The Specialist Palliative Care Team on extension 2312 would be happy to advise.

14. MONITORING BEREAVEMENT CARE

The monitoring of effective bereavement care may be difficult since this is a sensitive and emotive area and accurate feedback may not be easily available. However, consideration can be given to the use of information from Patient Satisfaction Surveys and to more informal feedback.
Formal and informal complaints which contain specific bereavement care issues are fed back to the Trust End of Life Care Steering Group. (Anything which could identify the particular patient or family concerned will have been removed from the complaint before it is discussed by the group). It is one of the responsibilities of that Group to highlight particular concerns raised by complainants and to identify trends. The Groups can also make recommendations for action.

Informal feedback is often received within the Bereavement Office and by both groups of staff and individual staff members. It is helpful for this feedback to be retained and utilised wherever possible – for example the Complaints Department regularly records numbers of compliments, gifts and donations received by members of staff.

15. ARCHIVING ARRANGEMENTS

This is a Trust wide policy. As staff may need to apply this policy across all departments throughout the Trust, the archiving arrangements are managed by the quality department who can be contacted to request master or archived copies.

16. LINK WITH ACCESS TO MEDICAL RECORDS

This policy is not intended to retrospectively apply to conversations and documentation prior to December 2011. The Trust Policy and Procedure in respect of patient access to medical records remains unchanged and should be drawn to the attention of any patient seeking retrospective access to correspondence, or wider access to their medical records.

17. DISSEMINATION, TRAINING and SUPPORT

This policy will be disseminated via the intranet. An article in ‘Aspire’ will raise awareness of the updated policy. The Trust End of Life Care Steering Group will routinely monitor and review any complaints which address End of Life issues and this may include issues of Bereavement support.

18. EQUALITY IMPACT ASSESSMENT

See appendix III

19. REFERENCE & BIBLIOGRAPHY

1. When a Patient Dies: Advice on Developing Bereavement Services in the NHS, Department of Health (10/05).

2. Patients who die in hospital HSG(92)8.


APPENDIX 1

OUT OF HOURS CONTACT RELATED TO CARE OF THE BEREAVED

<table>
<thead>
<tr>
<th>Role</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit Clinical Nurse Lead</td>
<td>1700-2000hrs</td>
</tr>
<tr>
<td></td>
<td>Mon-Fri</td>
</tr>
<tr>
<td></td>
<td>See rota or via Switchboard</td>
</tr>
<tr>
<td>Site Co-ordinator</td>
<td>SPH: Saturday/BH</td>
</tr>
<tr>
<td></td>
<td>AH: 0800-2000hrs</td>
</tr>
<tr>
<td></td>
<td>Bleep 5001</td>
</tr>
<tr>
<td></td>
<td>Bleep 5530</td>
</tr>
<tr>
<td>Clinical Site Nurse Practitioner (CSNP)</td>
<td>2000-0800hrs</td>
</tr>
<tr>
<td></td>
<td>SPH: Bleep 5001</td>
</tr>
<tr>
<td></td>
<td>AH: Bleep 5530</td>
</tr>
<tr>
<td>Pastoral Care Team (CHAPLAINCY)</td>
<td>24/7 On Call Service</td>
</tr>
<tr>
<td></td>
<td>Via switchboard</td>
</tr>
</tbody>
</table>

NORMAL HOURS CONTACT RELATED TO CARE OF THE BEREAVED

<table>
<thead>
<tr>
<th>Role</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bereavement Office</td>
<td>Ext 2319</td>
</tr>
<tr>
<td></td>
<td>2516</td>
</tr>
<tr>
<td>Pastoral Care Team (CHAPLAINCY)</td>
<td>Ext Via switchboard</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Palliative Care Team</td>
<td>Ext 2312</td>
</tr>
<tr>
<td></td>
<td>Duty pall care CNS carries blep 8867</td>
</tr>
<tr>
<td>Occupational Health</td>
<td>Ext 2404</td>
</tr>
<tr>
<td>Employee Assistance Programme</td>
<td>PPC 0800 282193</td>
</tr>
<tr>
<td>Unit Clinical Nurse Leads</td>
<td>Surgery 3899 Bleep 8195</td>
</tr>
<tr>
<td></td>
<td>Paediatrics 3690 Bleep 8263</td>
</tr>
<tr>
<td></td>
<td>Medicine 2206/3268/Bp</td>
</tr>
<tr>
<td></td>
<td>8805/8216</td>
</tr>
<tr>
<td></td>
<td>2990 Bleep 8108</td>
</tr>
<tr>
<td></td>
<td>2934 Bleep 8213</td>
</tr>
<tr>
<td></td>
<td>Critical Care 8867</td>
</tr>
<tr>
<td></td>
<td>Orthopaedics 3868/2292</td>
</tr>
<tr>
<td></td>
<td>Maternity Bleep 8776</td>
</tr>
<tr>
<td></td>
<td>2931 Bleep 8860</td>
</tr>
<tr>
<td></td>
<td>Emergency 3441 Bleep 8251</td>
</tr>
<tr>
<td></td>
<td>Theatres/Day Surg SPH 4188 Bleep 8271</td>
</tr>
<tr>
<td></td>
<td>Theatres/Day Surg AH 3428 Bleep 8167</td>
</tr>
<tr>
<td></td>
<td>Outpatients 3231 Bleep 8939</td>
</tr>
<tr>
<td></td>
<td>Neonatal 3248 Bleep 8355</td>
</tr>
<tr>
<td></td>
<td>Ophthalmology 4434 Bleep 8947</td>
</tr>
<tr>
<td></td>
<td>AH</td>
</tr>
</tbody>
</table>
Bereavement Office
Protocol for use of small counselling room
(situated within the Bereavement Office building)

- The room will be available for use between the hours of 9am – 4pm Monday to Friday and should be booked through the Bereavement Office on Ext 2319/2516. Please note that the Office closes at 4pm and is then locked. Any request for use of the room must take this into account.

- It will be the responsibility of the person using the room to ensure that relatives are accompanied at all times

- The person using the room should also ensure it is tidy for any subsequent use

- Due to limited space within the room it would be advisable to limit the number of persons to a maximum of 4 people for comfort. In exceptional circumstances it may be possible to use the larger waiting area but this will be entirely at the discretion of the Bereavement Officer.

- There is a kitchen facility and kettle for hot drinks/water although coffee and tea cannot be provided.
### Appendix III

**EQUALITY IMPACT ASSESSMENT TOOL**

**CARE OF THE BEREAVED, GUIDELINES FOR BEST PRACTICE**

**AUGUST 2012** To be completed and attached to any policy when submitted to the appropriate committee for consideration and approval.

<table>
<thead>
<tr>
<th>1. Does the policy/guidance affect one group less or more favourably than another on the basis of:</th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race and Ethnic origin (include gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)</td>
<td>No</td>
<td>Faith leaders from a number of ethnic backgrounds have had the opportunity to review the policy.</td>
</tr>
<tr>
<td>Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)</td>
<td>No</td>
<td>Document reviewed by various departments and individuals. No issues of discrimination have been identified.</td>
</tr>
<tr>
<td>Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Culture (consider dietary requirements and individual care needs)</td>
<td>No</td>
<td>The policy makes extensive reference to the need to take relevant cultural needs into account.</td>
</tr>
<tr>
<td>Religion or belief (include dress, individual care needs and spiritual needs for consideration)</td>
<td>No</td>
<td>The policy makes extensive reference to the Trust document Meeting the Patients’ Religious Needs (reviewed July 2008), which gives clear guidelines for addressing specific religious and spiritual needs.</td>
</tr>
<tr>
<td>Sexual orientation including lesbian, gay and bisexual people (consider whether the policy/service promotes a culture of openness and takes account of individual needs)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Age (consider any barriers to accessing services or employment,</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes/No</td>
<td>Comments</td>
</tr>
<tr>
<td>---</td>
<td>--------</td>
<td>----------</td>
</tr>
<tr>
<td>2.</td>
<td>Is there any evidence that some groups are affected differently?</td>
<td>Yes</td>
</tr>
<tr>
<td>3.</td>
<td>If you have identified potential discrimination, for example, less than equal access, are any exceptions valid, legal and/or justifiable, for example a genuine occupational qualification?</td>
<td>N/A</td>
</tr>
<tr>
<td>4.</td>
<td>Is the impact of the policy/guidance likely to be negative?</td>
<td>No</td>
</tr>
<tr>
<td>5.</td>
<td>If so can the impact be avoided?</td>
<td>N/A</td>
</tr>
<tr>
<td>6.</td>
<td>What alternatives are there to achieving the policy/guidance without the impact?</td>
<td>N/A</td>
</tr>
<tr>
<td>7.</td>
<td>Can we reduce the impact by taking different action?</td>
<td>N/A</td>
</tr>
</tbody>
</table>