POLICY UNDER REVIEW
Please note that this policy is under review. It does, however, remain current Trust policy subject to any recent legislative changes, national policy instruction (NHS or Department of Health), or Trust Board decision. For guidance, please contact the Author/Owner.

Bereavement/Care at and After Death Policy

V1.0

May 2016
Summary
Flow Chart for Care after Death at Royal Cornwall Hospital Trust (RCHT)

Ward Care: If sudden death, either involving resuscitation or not, or expected death but no family / Next of Kin (NOK) present: Follow procedures as per ward policy re e.g. drawing curtains round bed if in a bay, inform other patients / any visitors present that the person has died if they ask, and offer any support if distressed.

Then:

If expected death and family / NOK present:

NB: If any reason to require Police involvement, or need for Coroner referral requiring body not to be disturbed, or attachments (intravenous lines etc) not to be removed, follow policy and inform NOK of this, and why this needs to happen.

Communicate sensitively offering support, privacy etc. to address any emotional distress. Fulfil any cultural or religious requirements for care of the body. Offer to contact pastoral care, hospital or own support (even if out of hours) if person would have wished. Identify if NOK or other family etc. wish to come in immediately to see the person who has died, and wishes re involvement in care of body (laying out) and act as appropriate.

If Yes, keep body on ward until after visit (make presentable, await NOK if wish to be involved in laying out, or lay out as per policy. Give information re Bereavement office procedures and opening time, plus contact telephone number(s)

If no, and not visiting, give information re Bereavement office procedures and opening time, plus contact telephone number(s). Lay out as per policy; inform porters to remove body when ready.

Nurse in Charge (or Ward clerk) to contact NOK as per the instructions recorded in previous nursing notes. Ensuring two separate identifiers are used to confirm the call is to the correct family. Fulfil any cultural or religious requirements for care of the body. Offer to contact pastoral care, hospital or own support (even if out of hours) if person would have wished.

Identify if NOK or other family etc. wish to come in immediately to see the person who has died, and wishes re involvement in care of body (laying out) and act as appropriate.

If expected death and family / NOK present:
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1. **Introduction**

1.1. This document is to assist with the care and services provided to a dying or deceased patient and their next of kin (NOK), carers and close friends. The support provided to the patient at the end of their life should reflect the patient’s individual preferences, values, culture, spiritual needs and beliefs. The patient and their NOK should be afforded the greatest respect, maintaining privacy, dignity and confidentiality at all times. All staff providing care and services should feel confident that the care they are providing is appropriate and respectful.

1.2. This version supersedes any previous versions of this document.

2. **Purpose of this Policy/Procedure**

2.1. This guidance and associated protocols describe the standard of care and service that dying and deceased patients and their NOK, carers and close friends can expect at Royal Cornwall Hospitals Trust (RCHT).

3. **Scope**

3.1. This policy applies to all staff involved in the care and delivery of services to patients when they die, to NOK, carers and close friends at the time leading to and after death of a patient. The following principles should underpin the professional services offered around the time of the patients death and afterwards. They apply equally to the care and support of the patients and that of their relative, carer and close friends.

3.2. This policy applies to adult death only. Guidelines for foetuses and babies are contained within a separate policy.

4. **Definitions / Glossary**

4.1. **Laying out** - The deceased’s body is washed, stopping the natural orifices with cotton wool and cloth, and dressing the deceased. The head can be supported by a pillow, eyelids closed, the jaw supported and the arms and feet straightened. The deceased’s general appearance can be tidied, for example: false teeth put in place, hair brushed or face shaved. Arms and hands, ideally, should be elevated so they rest on top of the chest or abdomen.

4.2. **Verification of expected death** – the confirmation by a competent non-medical practitioner that a patient has died.

4.3. **Medical Confirmation of Death (MCOD)** – the examination of a body by a medically qualified professional to confirm death, following the recommendations of The Academy of Medical Royal Colleges Code of Practice for the Diagnosis and Confirmation of Death 2008 (Form CHA 3038)

4.4. **Certification** – a legal process involving the production of a medical certificate of cause of death (MCCD) and can only be undertaken by a qualified medical practitioner who attended the deceased during their last illness and who saw the deceased within 14 days of death.

4.5. **Expected death** – it has been predicted that the patient will die
4.6. Unexpected death – death has not been predicted and a post mortem may be required

4.7. Cultural - the practices associated with the person’s understanding of her/his identity which usually follow the traditions linked to the racial, national or social group with which s/he identifies or claims allegiance. (Examples: may be expressed through dress, diet or attitude to others.)

4.8. Religious - the faith framework which the person chooses to adopt and the practices which are associated with the expression of that religious framework in his/her life style and behavior. (Examples: may be expressed through dress, diet, or participation in religious rites and ceremonies.)

**Baha’i**

The family may ask for prayers to be said and the Baha’i scriptures to be read by the Spiritual Assembly of Baha’I. This may be arranged by the family or the chaplain.

Because they believe life begins at conception, a miscarriage is a great loss and the foetus should be treated with respect. Wherever possible the remains should be returned to the parents or local Baha’i community for burial.

A special ring may be placed on the patient’s finger – please do not remove. Otherwise routine last offices with the body wrapped in plain cloth or silk. At some point before interment a special prayer for the dead, the only specific requirement of a Baha’i funeral service is recited for Baha’i deceased aged 15 or over.

Baha’is treat the body of a deceased person with great respect. Baha’i Law prescribes that burial should take place at a distance of not more than one hour’s journey from the place of death. The body should not be cremated nor embalmed.

Funerals are normally arranged by the family of the deceased if available, or on occasions by the Baha’i Assembly (usually listed in the phone book).

**Post-mortems and Organ donation**

Autopsies and post mortem examinations are acceptable if necessary

**Buddhism**

The Buddhist “Path of Life” offers prescriptions for the ethical and spiritual well-being of each individual and exhorts them to have compassion for all forms of life. The Buddhist faith centres on the Buddha who is revered as an example to his followers of a way of life. Buddhahood is realised within the person through prayers, purifications, retreats and virtuous conduct.

When a child of a Buddhist family dies special prayers usually take place for a period of time before burial. This period depends on the lunar calendar and varies between three to seven days in most schools of Buddhism.
As their faith does not prevent non—Buddhists touching the body, nursing staff
do not need to take particular measures when performing Last Offices. The most
ingredient thing to do is to ensure that a Buddhist priest (preferably of the same
school of Buddhism) is contacted as early as possible and any specific requests
are ascertained from the family.

The most important consideration relates to the patient’s state of mind at the time
of death, for this will influence how they experience the intermediate or ‘bardo’
states and thereafter the character of rebirth. Nearing the time of death, the state
of mind should ideally be one of peace, so the patient may wish to meditate and
ask for a quiet place. There may be a refusal of pain relieving drugs if they impair
mental alertness.

After death, in many schools of Buddhism there is no ritual requirement and
normal hospital procedures are accepted. However, some Buddhists hold strong
views about how the body should be treated after death. It would be helpful to
ask about such views before death occurs, to avoid unnecessary distress to
relatives and friends.

After death, the main Buddhist tradition is for the family to request prayers from
the sangha (usually a monk, lama, nun, priest or order member) of the
appropriate school of Buddhism and to perform certain actions and dedicate
them to the dead person. Particularly for practitioners of Vajrayana Buddhism –
most commonly in Britain, Tibetan Buddhism – an experienced Buddhist
practitioner may perform the special Buddhist practice of Powa or ejection of
consciousness. In some cases a monk may perform chanting, however this is not
a universal practise. They may wish for a Buddha figure close by and may use a
candle or incense stick.

Some relatives may object to a post mortem due to the belief that the mind may
stay in the body for some time after the heart has stopped, and interfering with
internal organs may undermine the optimal dissolution of consciousness;
therefore the body should not be moved for 72 hours.

Buddhists can dispose of a dead body by any of the four elements (earth, air, fire
and water) – whichever is appropriate to the country and people. Traditions vary
as there are different schools of thought. However, most Buddhists are cremated
and the body should be disposed of within three to seven days.

There is no specific teaching which would favour burial over cremation, though
cremation is more usual in the country of origin of many Buddhist families.

Post Mortems and Organ donation

Post-mortems are accepted where necessary, and organ donation may be
acceptable.

Christianity

Protestants

There are no specific requirements for the Last Offices for the child of a
Protestant family, except to obtain the services of a chaplain to administer a
blessing or baptism or to pray with the family if they so wish.
Both cremation and burial are acceptable.

**Post-mortems and Organ donation**

Post-mortems are usually acceptable if requested and there is no religious objection to organ donations.

**Roman Catholics**

Infant baptism is the tradition of the Roman Catholic Church. Sacraments are extremely important to Catholics. Roman Catholic parents of a critically ill baby or child that has not been baptised would wish a Catholic priest or deacon to be called without delay. In an emergency a Christian member of staff may baptise by pouring water over the child’s head and saying, 'I baptise you in the name of the Father and of the Son and of the Holy Spirit. Amen. The Catholic chaplain should be informed in order the baptism be registered.

If the child is already baptised, prayer, a blessing or the Sacrament of the Sick may be appropriate. The Sacrament (or Anointing) of the Sick is an anointing with blessed oil and laying on of hands together with prayers for healing and strength. For this reason it is no longer referred to as Last Rites. Only a priest may give the Sacrament of the Sick. Catholics would expect a priest to be called it the event of critical illness.

The Sacraments of Baptism and of the Sick cannot be given after death. In this situation prayers and a blessing by a Catholic priest or a member of the Church may be said. The family may want to stay by the bedside to pray the Rosary.

As regards an unbaptised child who has died, the Church speaks of the great mercy of God who desires all people should be saved and of Jesus' tenderness towards children which caused him to say, 'Let the children come to me, do not hinder them'. This may help allay fears or guilt the parents may be experiencing.

An unbaptised child may receive a full Church funeral. There are Catholic funeral services both for burial and cremation.

**Post-mortems and Organ donation.**

There are no religious prohibitions to post-mortem examinations, and organ donation is generally acceptable to Catholics.

**Hinduism**

Hinduism embraces a way if life and a social system which involves the worship of numerous gods, all of them manifestations of the one Supreme Being. In Hinduism, there is no supreme church authority and no hierarchy. The priest has no pastoral functions but may come to the ward to pray with the relatives of a dying child. They often wish to give the child water from the River Ganges (Ganga) and read to them from one of the holy books of Hinduism, this is also the case with babies. They may also tie a thread around their wrist or neck, and this should not be removed. Whenever possible Hindus like to die at home but if this is not possible the following should be remembered:
Gloves should be worn by non-Hindus when touching the body. The family normally wish to perform Last Offices themselves so wrap the baby in a plain white sheet and await the arrival of relatives.

Hindu’s will appreciate being with someone, preferably of the same sex. Relatives will often wish to bring money and clothes for him or her to touch before they are given to the needy. It is preferable if all Hindu bodies can be kept together after death. A dead body should be placed with the head facing north and the feet facing south. The arms should be placed to the sides and the legs should be straightened. The face should be pointed upwards with the eyes closed and the whole body must always be covered with a white cloth. Any detached body parts must be treated with respect as if they were a complete body. Sacred objects should not be removed.

Relatives will wish to wash the body and put on new clothes before taking it from the hospital. Traditionally the eldest son of the deceased should take a leading part in this, however young he may be.

Ideally, Hindus are cremated on the day of death but the formalities required in Britain make this impractical. However many families will wish to have the death certificate issued as quickly as possible so they may take the body home or to the funeral directors on the day of death. Hindu’s believe in cremating the body so that the soul is completely free of any attachment to the past physical matter.

Children under the age of four years are not cremated but buried.

**Post-mortems and Organ donation**

Post-mortems are not generally approved of but are accepted if legally required. Hindu’s will wish all organs to be returned to the body before cremation (or burial for children under five years of age). There are no religious prohibitions against the giving of organs.

**Islam**

The word Islam means submission to the will of God and its followers are Muslims. They believe in one God (Allah) and regard the religion’s founder Mohammed as the prophet of Allah. The Koran (Quran), is Allah’s word consists of the teachings of Islam. This, along with recorded sayings of Prophet Mohammed and his acts, constitute the Islamic legal system (Sharia) – there being no distinction between religious and secular law. The mosque (masjid) is in the charge of an elected prayer leader (imam). The imam is not required to attend the death or burial of a Muslim but is usually invited to do so. Muslims believe in “life after death” and that a person is judged by Allah according to their deeds as to whether they will go to “heaven or hell”.

For the child/baby of a Muslim family it may be helpful before death to turn the foot of the cot or bed in the direction of Makkah (the Qibla). (In this country, this is in a south easterly direction), a compass is kept in the chaplaincy office. If it is not possible then the child’s head should be turned to face this direction. Family members may pray at the bedside of the dying person, whispering into their ear.
An important point that should be stressed to staff is that the Islamic faith does not prevent women from touching their babies after death. Should a baby die at or after four months of pregnancy or soon after birth, he or she will be named, washed, shrouded and buried in the usual manner. If the foetus dies before four months of pregnancy, then it should be wrapped in a clean cloth and buried.

It is customary among Pakistanis and Arabs to express their emotion freely when a relative dies. Whenever possible you should give them privacy to do so; and explain gently but firmly the need to avoid disturbing other patients by their mourning. If an Islamic woman loses her infant within this time, it is not necessary to encourage the mother to touch or hold her baby’s body if this would cause distress to the woman. Gloves should be worn when touching the child/baby’s body. The family usually wish to perform Last Offices themselves so wrap the child/baby in a plain white sheet and await the arrival of relatives.

It can give great comfort by reading to the patient verses from the Qur’an. It is an important religious duty to visit the sick and dying, so a large number of visitors may arrive at all hours.

If a Muslim is dying the face should be turned towards Makkah (the Qibla). The patient’s head should be above the rest of the body. The dying person will try and say the Shahadah prayer (the testimony of faith). Muslim dead should be placed in body-holding areas or temporary mortuaries, and ideally be kept together in a designated area (with male and female bodies separated).

The body should be laid on a clean surface and covered with a plain cloth, three pieces for a man and five for a woman. The head should be turned on the right shoulder and the face positioned towards Makkah. Detached parts should be treated with respect. Next of kin or the local Muslim community will make arrangements to prepare the body for burial.

The next of kin will want to arrange to wash the body before burial. All Muslim’s are buried as soon after death as possible (cremation is forbidden). As it is not always possible to comply strictly with Islamic rules for burial in this country, many families will embark on the bureaucratic and often distressing delays of taking their child’s body back to their country of origin.

Muslims believe in burying their dead and would never cremate a body. When possible burial takes place within 24 hours.

**Post-mortem and Organ donation.**

Post-mortem examinations are for religious reason not allowed and causes considerable distress, however they will be reluctantly accepted if legally required. It is important to the family that all organs removed are returned to the body for burial. Ideally only male Muslims should handle a male body, and female Muslims a female body.

There are no particular issues relating to blood transfusions, but although organ donation has been permitted it is a complicated issue for Muslims and will often be met with reluctance. The decision would lie with the individual and their family in consultation with their local religious leader.
**Jehovah’s Witnesses**

Jehovah’s Witnesses are members of a religious organisation that originated in the U.S.A. in 1872. They attach great importance to Christ’s second coming with the ensuing Armageddon and Last Judgement entailing the destruction of all but the faithful.

Many of their inherent strict beliefs involve the rejection of established authoritarian rulings. Their religion forbids them from accepting many forms of medical treatment including blood transfusion,

They refer to death as “passing over” and having led a blameless life, have nothing to fear from it. This means they may not demonstrate the emotions our society usually expects.

There are no specific rituals to perform for those who are dying, nor last rites to be administered to those in extremis. However, Spiritual care will be provided by local Witnesses (friends, family and elders).

A child or adult may be either buried or cremated according to the family’s preference.

**Post-mortems and Organ donation.**

Post-mortems are not freely consented to, and organ donation is unusual

**Judaism**

Judaism is based on the belief in one God. The love of God and the wish to carry out the Ten Commandments as given in the Torah (the first five books of the Old Testament). Religion and culture are inextricably mixed.

The Jewish Sabbath begins before nightfall on Friday and ends with the first sighting of three stars on Saturday night (i.e. sunset to sunset). The exact time that the Sabbath ends is indicated on Jewish calendars. During this time strictly Orthodox Jews will not work,, travel, write, cook or switch on electrical appliances.

A point that staff should remember is that if a child dies during the Jewish Sabbath an orthodox family may not be contactable or able to come to the hospital until after the Sabbath.

For the child/baby of a Jewish family, staff should wear gloves when handling the child’s body, wrap the child in a plain white sheet and await the arrival of relatives to perform Tahara (the preparation of the body). In Judaism, it is a member of the same sex as the deceased who will undertake the rituals required, usually accompanied by three members of their community.

Jewish law requires the burial of miscarried foetuses, which should be delivered to the family or burial society.

It is usual for a companion to remain with a dying Jewish person until death, reading scripture or saying prayers.
Jewish law forbids Jews to do anything to hasten a person's death and at the same time requires everything possible to be done to comfort the dying. Some Jews would not touch a dying person for fear that the slightest touch might hasten their death. So the range of what you can or cannot do for a dying person may vary and if time allows you should consult a trusted rabbi acceptable to the family. Prompt and accurate identification of the dead is particularly important for the position of a widow in Jewish law. Immediately after death, close relatives may make a tear in one of their garments.

It is Jewish tradition that when a Jewish person dies, a Wach’a (Watcher) may stay with the body from the time of death until the burial, which is usually within 24hrs of the death. This practice should be respected and provision made for the person even when the body is taken to the mortuary. Psalms may be recited during this time.

There are specific Jewish laws and customs for dealing with the dead. It is important to contact the family and the appropriate Burial Society as soon as possible. If a child dies, the body should be treated in the same way as an adult.

When a Jewish person dies, the following guidelines apply:

- Do not touch the body until 20 minutes after death.
- Do not wash the body (clean crevices if required to preserve the dignity of the deceased).
- Do not remove false teeth or other prostheses.
- Close the eyes.
- Straighten the body out, laying it flat with the feet together and arms by the side. Fingers should be straight.
- Cover the body with a plain white sheet without emblems.
- The body should be placed with the feet towards the doorway.

For men a prayer shawl, tallit, is placed around the body and the fringes on the four corners cut off.

The family will usually wish to burn a candle, this should be made possible but bear in mind safety precautions.

The Chevra Kadisha (Holy Brotherhood) should be notified immediately after death. They will arrange the funeral, if possible before sunset on the day of death, but will not move the body on the Sabbath.

Jewish burials should take place within 24hrs after death and the family will require the death certificate as soon as possible.

While Orthodox Jews are buried, not cremated, Reform and Liberal Jews may choose either method of disposal of the body.

**Post-mortems and Organ donation**

No mutilation of the body is allowed unless there is a legal requirement for a post mortem.

Any organs removed from the body for examination should be returned for burial. Organ donation may be acceptable if requested.
Sikhism

The word Sikh means disciple or follower, and they believe in one God whose message is revealed by Guru Nanak, the 16th Century founder of the religion. There are no ordained priests in Sikhism. The temple (Gurdwara) is in the care of a reader (granthi) who is appointed and supported by the community.

Whilst they have no objections to non-Sikhs touching the child’s body, most Sikhs are cremated although babies who are stillborn or die around the time of birth may be buried, and the body of a stillborn baby should be given to the parents to perform the funeral rites. The child should simply be wrapped in a plain white sheet to await the arrival of a relative who will perform the Last Offices.

When a Sikh is dying, the family sometimes accompanied by the granthi (priest), pray and read from the holy book (the Guru Granth Sahib) at the person’s bedside. After death and identification, the body or parts of the body should be covered with a plain white sheet or shroud. If the condition of the body permits, the eyes and mouth should be closed and limbs straightened with arms placed straight beside the body.

It is vital for nursing staff to ensure that none of the five symbols of Sikhism are disturbed. It is also important not to trim the hair or beard, and the hair on the head should be kept covered.

These symbols are:

1. KESH – uncut hair (and beard)
2. KANGHA – a semi-circular comb fixing the hair in a bun.
3. KARA – a steel or gold bangle worn on the right wrist.
4. KIRPAN – a symbolic dagger.
5. KACHI – shorts/underpants.

The five Ks should be left on the dead body, which should if possible be cleaned and clothed in clean garments before being placed in a coffin or on a bier.

According to Sikh etiquette comforting a member of the opposite sex by physical contact should be avoided unless those involved are closely related.

Deliberate expressions of grief or mourning by bereaved relatives are discouraged, though the bereaved will want to seek comfort from the Sikh scriptures. Cremation should take place as soon as possible after death, and friends and relatives will prepare the body the night before the cremation at the funeral parlour.

All Sikhs (except infants dying within a few days of birth) are cremated, with a close relative lighting the funeral pyre or operating the machinery. This may be carried out at a convenient time.

The ashes of the deceased may be disposed of through immersion in flowing water or dispersal.
Post-mortems and Organ donation

Sikhs do not like the idea of a post mortem but will accept it if it is legally unavoidable. Organ donation is generally acceptable to Sikhs.

Humanists and Atheists

Whilst these families have no religious requirements at the time of death, they nonetheless often have very firm ideas of what they would like for their child/baby, and these should be respected.

Many humanists will want to have a caring individual with them if they are dying.

Humanists may refuse treatment that they see simply as prolonging suffering. Some may strongly resent prayers being said for them or any reassurances based on belief in God or an afterlife. The choice between cremation and burial is a personal one, although cremation is more common. Most will want a humanist funeral, however, since many humanists believe that when someone dies the needs of the bereaved are more important than their own beliefs, some may wish decisions about their funeral and related matters to be left to their closest relatives.

Pagan

Patients may ask for prayers to be said by their Spiritual adviser- please contact chaplaincy for pagan chaplain to be called. Individuals should be listened to for requirements.

Pagans believe in reincarnation. Most pagans believe in some form of reincarnation, viewing death as a transition within a continuing process of existence. Pagans accept death as a natural part of life and will wish to know when they are dying so that they may consciously prepare for it. The emphasis in funerals is on the joyfulness for the departed in passing on to a new life, but also consolation for relatives and friends that the person will be reborn.

Cremation is acceptable but burial is usually preferred. Funeral services will take place in crematorium chapels, at the graveside or at the deceased’s home.

In some traditions, any religious items of significance to the deceased must be buried or burned with the body.

A wake (mourning ceremony) carried out around the body by friends and relatives is common in some traditions.

Post-mortems and Organ donation

No religious objections to post-mortem. Most Pagans would donate for transplant.

4.9. Spiritual - the essence of every human person which makes him or her unique and different from all other biological entities. The sense of “self” which relies on being part of a community and being valued as a person by others. It requires interaction with others and can be damaged by rejection by others. The recognition of “otherness” in the world around, often expressed in an appreciation of colour, shape, music or the natural world
4.10. The following principles should underpin the development of services and professional practice around the time of the patients death and afterwards. They apply equally to the care and support of the patient and that of their relative, carer and close friends.

**Respect for the individual** - When a patient dies, confidentiality must be maintained and individual preferences values, cultures and beliefs honored to the best of the care givers’ ability

**Choice** - Professionals involved in caring for and supporting people who are dying or bereaved should offer choice, providing information, time and support to people to enable that choice to be informed.

**Communication** - Communication with people around the time of death and afterwards should be clear, sensitive and honest.

**Information** - People who are dying, and those who are bereaved, need accurate information, appropriate to their needs, communicated clearly, sensitively and at the appropriate time.

**Involvement** Services when a patient dies should be responsive to the experiences of the patients and people who are bereaved. Information from patients and families should inform both service development and care provision. Professionals must be prepared, and sufficiently skilled, to involve patients and their families, enabling them to express their needs and preferences.

**Recognising and acknowledging loss** People who are bereaved need others to recognise and acknowledge their loss. Staff caring for the bereaved need to recognise their needs and have these needs acknowledged.

**Time and timing** Professionals should be aware of the importance of time and should try to work at a pace dictated by peoples’ need.

**Environment and facilities** Staff will do their best to maximize privacy and comfort at the time leading to and at death

**Equality of provision** All patients and the bereaved are entitled to a service that responds to and respects their basic needs

**Informed staff** All those staff involved in the care of bereaved people should be well informed and confident about the care and support they give.

**Staff training and development** Staff caring for people who are dying and for bereaved people will have opportunities to develop their knowledge, understanding, self-awareness and skills.

**Staff Support** Staff caring for dying patients and for the recently bereaved, particularly managing unexpected deaths, will have access to support

RCHT: Royal Cornwall Hospital Trust
NOK: Next of Kin
COD: Cause of Death
FD: Funeral Director
MCCD: Medical Certificate of Cause of Death
5. **Ownership and Responsibilities**

5.1. **Role of the Managers**

Line managers are responsible for:

- Ensuring that all relevant staff are aware of this policy
- Ensuring that any corrective actions arising from audits or incident investigations are implemented

5.2. **Role of the end of life group**

The end of life group:

- Is responsible for the development, approval and communication of this policy and monitoring compliance with it.

5.3. **Role of Individual Staff**

All staff members are responsible for:

- Ensuring that they are aware of this policy
- Ensure that they follow the policy

- All staff: All members of staff of the Trust who are involved in the care of the deceased patients will treat them with respect and dignity at all times. All staff involved should be aware of the RCHT End of Life Care Strategy 2014.

- Nursing Staff will ensure that the support provided to the patient at the end of their life should reflect the patient’s individual preferences, values, culture, spiritual needs and beliefs. Personal property belonging to the deceased not collected at the time of death by next of kin should be itemised and securely stored on the ward for later collection in accordance with RCHT patient’s property policy. Cash and valuables should be dealt with in accordance with RCHT cash and valuables policy.
6. Standards and Practice
6.1 Procedure for when a patient dies

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inform member of medical staff to confirm death. Ensure confirmation of death is documented in patient’s notes (by completing ‘Medical Confirmation of Death’ form CHA 3038), alongside medical staff contact details. Form available to order via Design &amp; Publications department or available from the Bereavement office.</td>
<td>Legal requirement</td>
</tr>
<tr>
<td>Ensure next of kin; carers; and close friends are informed of the patient’s death as agreed and documented in patient’s notes.</td>
<td>To ensure all are aware of patient’s death and record of communication provided</td>
</tr>
<tr>
<td>If next of kin not present at time of death, establish if they would wish to visit ward to view deceased. If so attendance time should be limited to ensure ward activity is not disrupted. In each individual case, ward staff should attempt to identify to these individuals how long the deceased’s body will remain on the ward. It is anticipated that there should be flexibility to meet next of kin’s wishes to view a body on the ward within reasonable time limits.</td>
<td>Grief Pathway</td>
</tr>
<tr>
<td>If next of kin wish to view deceased in the viewing room then: Inside working hours (09:00 -16:00 hrs Monday to Friday) contact the Bereavement office on ext 2713 who will make the necessary arrangements. Outside of working hours contact the on call Mortuary technician via switchboard who will decide if a viewing is appropriate based on the case history and circumstances of death and will liaise with the next of kin to make the necessary arrangements.</td>
<td>HM Coroners legislation</td>
</tr>
<tr>
<td>Check with next of kin and patient notes for specific requests, religious or cultural requests related to patient’s death.</td>
<td>To ensure specified and specific needs are met</td>
</tr>
<tr>
<td>If next of kin visit patient on ward after death, provide them with RCHT Bereavement booklet and advise them to make an appointment the Bereavement Officer on ext 2713.</td>
<td>To provide practical advice to bereaved and ensure they understand appointment system is in place</td>
</tr>
</tbody>
</table>

6.2 Preparation of the deceased patient
In most situations the following actions will be taken however in the event of a death as a result of a category 3 infection e.g Viral Haemorrhagic Fever the body must be double bagged in leak proof cadaver bags with absorbent padding placed between the two bags. The outer bag must be disinfected with 1,000 ppm available chlorine. The staff involved must wear appropriate PPE:

- Mortuary Scrubs
- Disposable gown
- Disposable apron
- FFP3 facemask
- Eye protection
- Surgical cap
- Gloves (double gloves)
<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curtains Should be drawn fully around the bed space, once death is established.</td>
<td>To promote privacy and dignity</td>
</tr>
<tr>
<td>Put on apron and gloves</td>
<td>To reduce the risk of contamination with body fluids and to reduce the risk of cross infection.</td>
</tr>
<tr>
<td>Patients to be laid flat, with one pillow, eyes closed, arms by their sides and dentures in place (if appropriate). The jaw should be supported by a rolled towel or pillow.</td>
<td>To ensure appropriate positioning prior to onset of rigor mortis</td>
</tr>
<tr>
<td>If there is an item of religious significance which the deceased’s relatives insist remains with the deceased, then it should be made clear that the responsibility for that lies with the relatives rather than hospital staff.</td>
<td></td>
</tr>
<tr>
<td>All jewellery should be removed if possible, in the presence of another member of staff, and handed back to the family if present. If family not present all jewellery should be dealt with in accordance with RCHT cash and valuables policy.</td>
<td>To ensure safety of patients valuables</td>
</tr>
<tr>
<td>If it is not possible to remove all jewellery, or the family insist on the jewellery remaining on the deceased, it should be taped in place and recorded on the deceased care record and signed by two members of staff.</td>
<td>See patient property policy</td>
</tr>
<tr>
<td>Patient belongings should be handed back to the family if present. If family not present then the belongings should securely stored on the ward for later collection by the family.</td>
<td>See patient property policy</td>
</tr>
<tr>
<td>Remove all tubes and lines and double bandage all cannula sites, except in Coroner cases where are tubes and lines should remain in situ.</td>
<td>Relieves distress to relatives or fulfils legal requirement</td>
</tr>
<tr>
<td>Wash patient as required (NB. some relatives may have made specific requests to be involved in this aspect of care and religious issues must be considered).</td>
<td>Meeting Religious requirements after death document</td>
</tr>
<tr>
<td>Packing of orifices is not usually undertaken. Due consideration must be given to ensuring deceased patients retain their dignity and alternate methods such as using pads or dressings should be used as the first line of action. Leaking wounds should be covered with a dressing and waterproof covering. If in doubt, contact the mortuary staff for advice on ext 2555.</td>
<td>To ensure risk of contamination from body fluids is reduced and dignity of deceased patients is maintained</td>
</tr>
<tr>
<td>Dress the patient in a hospital shroud.</td>
<td></td>
</tr>
<tr>
<td>Ensure written or printed ID bracelet, with three unique identifiers remains in place.</td>
<td>To ensure ease of identification</td>
</tr>
<tr>
<td>Wrap the deceased in a sheet, ensuring that the face and feet are covered and all limbs are held securely in position without using excessive pressure.</td>
<td>To avoid potential injury to deceased patient during transfer</td>
</tr>
<tr>
<td>If deceased falls into a high risk category or leakage is a cause for concern, place the deceased patient in a white zipped body bag and annotate concern on deceased care record.</td>
<td>To minimise risk of contamination</td>
</tr>
<tr>
<td>Remove apron and gloves. Dispose of equipment as per Waste guidelines and wash hands with soap and water.</td>
<td>To minimise the risk of cross-infection and contamination</td>
</tr>
<tr>
<td>When dealing with a deceased patient of bariatric proportions, consideration must be given to manual handling restrictions and the use of specialised equipment may be required to aid moving and transferring of the deceased. Seek advice from mortuary staff.</td>
<td></td>
</tr>
<tr>
<td>Deceased care record and Bereavement notification of death forms to be handwritten and completed in full.</td>
<td></td>
</tr>
</tbody>
</table>
6.3 Transfer of deceased patients by portering staff

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>The deceased patient is treated with the same respect and dignity afforded in life</td>
<td></td>
</tr>
<tr>
<td>The concealment trolley with two porters is used to transport deceased patients from the wards/units to the mortuary across both RCHT &amp; WCH</td>
<td></td>
</tr>
<tr>
<td>The concealment trolley and body bags if required are available from the porters on ext 3700</td>
<td></td>
</tr>
<tr>
<td>Ward staff are advised of the trolley arrival in the ward to ensure curtains are drawn to ensure dignity and sensitivity.</td>
<td></td>
</tr>
<tr>
<td>The deceased patient is transferred with care onto the trolley with appropriate lifting/moving aids if necessary</td>
<td></td>
</tr>
<tr>
<td>The porters transfer the deceased to the mortuary with the deceased care record bereavement notification of death form along with the Hospital Notes</td>
<td>Accurate identification of deceased patients is imperative when transferring patients to the mortuary</td>
</tr>
<tr>
<td>On arrival in the Mortuary the porters transfer the deceased onto an appropriate Mortuary tray and write the deceased details on the corresponding board on the fridge door, The completed deceased care record and bereavement notification of death should be left in the corresponding trays.</td>
<td></td>
</tr>
<tr>
<td>The transfer to the Mortuary should be conducted within reasonable time limits.</td>
<td>Maintain patient dignity</td>
</tr>
</tbody>
</table>

6.4 Transfer of deceased patients from the community

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>All deceased community patients are admitted to RCHT via contracted Funeral Director</td>
<td>To ensure continuity of care</td>
</tr>
<tr>
<td>Deceased placed in appropriate fridge space</td>
<td>To maintain respect and dignity</td>
</tr>
<tr>
<td>All relevant paperwork left in secure box in vestibule</td>
<td>To maintain confidently</td>
</tr>
</tbody>
</table>

6.5 Burial certification procedures

6.5.1 Doctor completes the Medical Certificate of Cause of Death (MCCD) and on completion this is handed to the Bereavement Support Services department who, in turn, hand this to the NOK (known as the ‘informant’) as a statutory notice of Cause of Death (COD).

6.5.2 The informant has the responsibility to give this to the Registrar at the Register Office within five working days.

6.5.3 The Register Office issues the ‘Certificate for Disposal’ (green in colour and referred to as the “the Green Certificate” by funeral directors). The funeral director requires the green form to finalise funeral arrangements.

6.6 Cremation certification procedures
6.6.1 The MCCD is completed by the Doctor (normally in conjunction with Form B of the Cremation certificate). The MCCD is handed to the Bereavement Staff, who in turn hand this to the NOK (known as the ‘informant’) as a statutory notice of COD.

6.6.2 The informant has the responsibility to give this to the Registrar at the Register Office within five working days.

6.6.3 The Register Office issues the 'Certificate for Disposal' (green in colour and referred to as the "the Green Certificate" by funeral directors). The funeral director requires the green form to finalise funeral arrangements – provided that the Forms B and C have been completed.

**Note**: Should the Coroner hold a Post-Mortem examination, there will be no MCCD or Cremation Certificate issued from the Hospital. If a Hospital Post-Mortem examination is carried out with NOK consent, then an MCCD or Cremation Certificate may still be issued.

**6.7 Cremation certificates**

6.7.1 When a person dies and the NOK/executor request disposal by cremation, a statutory procedure has to be followed which assures the Crematorium Authority, and beyond them the Home Office, Coroner and Registrar General for Births, Marriages and Deaths in England and Wales, that the cause of death is as stated on the Death Certificate.
6.7.2 The procedure is as follows:-

Application for cremation of a body is made by the informant (NOK/executor) at an initial meeting with their preferred Funeral Director where a prescribed form (known as Form A – Application for Cremation) is completed.

Form B - Cremation Certificate of Medical Attendant (Doctor who attended the deceased). This is usually completed at the same time as the MCCD. The completed ‘Form B’ of the Cremation Certificate is handed to the Bereavement Office who will arrange for a suitably qualified Doctor to take on the work necessary to complete the Form C.

Form C – Confirmatory Cremation Certificate, signed by a suitably qualified Doctor. Form C is completed in the mortuary and is handed to the Funeral Director (FD) when they collect the deceased. (This process requires external examination of the deceased and due enquiry of the doctor who signed the Form B, and either other medical personnel or relative of the deceased – all as detailed on the Form C and in accordance with Home Office Guidelines (as published on their Website: www.dca.gov.uk/corbur/cremation-forms-guidance.pdf).

Form F – Authority to Cremate (signed by the Crematorium Referee who is satisfied all procedures in Form E and C have been correctly followed).
6.8 Duties and responsibilities regarding cremation certification

6.8.1 The process which follows will be carefully adhered to. It is designed to be robust. The doctor signing the Form C (also known as “Part 2”) Cremation Certificate fulfils a vital public safety role in ensuring to the satisfaction of the Crematorium Referee, the Coroner and Registrar General that the cause of death is as stated by the doctor who has had charge of the patient and has signed the Form B Cremation Certificate.

6.8.2 Equitable - A fee is payable by the FD to the doctor signing Form B & C. It will be equitable that all doctors wishing to partake of this work have an equal chance to do so.

6.8.3 Efficient - The prompt signing of the Form B & C is essential to the swift processing of documentation to enable the body to be released to the FD for cremation. Delays in the process can cause distress to next of kin and complaints to the Trust.

6.8.4 Bereavement Services - The Mortuary and Bereavement Services manager together with the senior Bereavement officer shall be responsible for the day-to-day facilitation of this service.

6.8.5 Medical Staff - All doctors completing Form B and Form C of the Cremation Certificates are fully responsible and accountable for accuracy, content and fulfilling the requirements as set out in the Cremation Certificate and in accordance with Home Office Guidelines (as published on their Website: [www.dca.gov.uk/corbur/cremation-forms-guidance.pdf](http://www.dca.gov.uk/corbur/cremation-forms-guidance.pdf)). Doctors will agree to fulfil these duties in accordance with the above guidance and in a timely manner.

6.8.6 HM Coroner - In some cases the death has to be referred to the Coroner for discussion. This is a legal requirement. Listed below are examples (this is not an exhaustive list):

- Died within 24 hours of admission
- Operation within the last 12 months
- Died during or shortly after surgery
- Fall resulting in a fracture

6.8.7 If the Coroner decides a Post Mortem has to be performed then all the relevant paperwork is issued from the Coroner’s Office. However if the Coroner decides a Post Mortem need not be performed then the MCCD and Cremation Certification can be issued – this process is called a Coroner’s Clearance. The Coroner then signs a Coroner’s Part A Form which is then faxed to the Register Office. This paperwork must arrive at the Register Office before the next of kin are able to register with the MCCD.

6.9 RCHT funded funeral arrangements

6.9.1 RCHT has a duty of care to make funeral arrangements for any patient who has died at RCHT and where it appears to the RCHT that no suitable arrangements have been or are being made for the disposal of the body. This includes if there is no NOK or the NOK hand over responsibility for funeral arrangements to RCHT.

6.9.2 RCHT provides a public health funeral by using the services of Cornwall Council contracted FD.
As a result of this the service provides the following:

- Cremation only
- Crematorium fees
- A basic coffin
- One suitable vehicle to transport the deceased
- A basic service at the crematorium

Unfortunately, we are not able to provide:

- Flowers
- A church service
- Music choices
- The opportunity for speeches
- The release of ashes (these will be scattered at the crematorium)
- A vicar or minister for the service
- A choice of times/location for the service to be held

Where Cornwall Council makes arrangements for a public health funeral there is a set charge, currently £3,250 (no VAT), plus undertaker fees at cost + any additional costs incurred. The Council has a legal right to reclaim funeral costs and will seek to recover these from the estate of the deceased.

6.10 Funding a funeral

6.10.1 If you are unable to pay for a funeral you may be eligible for financial assistance towards the costs.

6.10.2 There are two main types of financial assistance available for people who are unable to pay for a funeral in way of a funeral payment or a bereavement payment.

6.10.3 Applicants who claim benefits are advised to contact the Welfare Team at Cornwall Council prior to requesting a RCHT funded Funeral. This is to discuss their eligibility for financial assistance towards the costs of a funeral service. The Welfare Team can be contacted on 0300 1234 131

6.10.4 The Bereavement staff will referral all requests for a Public Health Funeral to Cornwall council who will be the point of contact for Public Health funded funerals who will make all necessary arrangements and seek to recover the costs

6.11 Organ Donation

6.11.1 Organ and tissue donation is supported by the Royal Cornwall Hospital and should be considered with all patients who die within the Hospital. Non Beating donor Tissue / Organ’s can be donated up to twenty fours following death all staff should be aware of the potential for organ and tissue donation. RCHT has a dedicated specialist nurse for Organ/Tissue can be contacted via Critical care on ext 3152 or on mobile 07590 353023

6.12 Out of hours Guidance

6.12.1 Bereavement advice and guidance can be obtained outside of core working hours from the on call Mortuary technician, available via the Hospital Switchboard from 16.00-07.30 weekdays and 10:00-20:00 weekends and bank holidays, The Mortuary on call provision supports the following roles at the discretion of the on call technician, viewings
and identifications, bereavement support/guidance for next of kin, organ/tissue retrieval for UKBT, fridge management for capacity/failure issues, Post Mortem services for Devon & Cornwall Constabulary and major incident support. All requests for Bereavement support and advice outside of core working hours should be directed to the on call Mortuary technician to ensure accuracy of information and continuity of care

7. Dissemination and Implementation

7.1 This policy is to be implemented and disseminated through the organisation immediately following ratification and will be published on the organisations intranet site document library. Access to this document is open to all via: RCHT One and All Daily Bulletin Presentation at the CSSC Divisional Board Meeting and the RCHT End of Life Care Group

8. Monitoring compliance and effectiveness

8.1 Training will be facilitated by the Learning and Development and be accessible to all employees handling deceased patients.

8.2 All training must be formally recorded with refresher training undertaken periodically.

8.3 Once consultation has been undertaken the final published document will be held centrally within the online Document Library and be available to staff.

8.4 Upon publication, awareness to all staff will be raised by notification within the Trust “Daily Bulletin” and through Health and Safety Committee feedback from both management and staff representatives.

8.5 Divisional General Managers will ensure that the contents of this document are highlighted to staff though regular divisional meetings.

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Correct pathway followed from point of death to completion of statutory or non-statutory paperwork</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>End of life Lead</td>
</tr>
<tr>
<td>Tool</td>
<td>Audit documentation</td>
</tr>
<tr>
<td>Frequency</td>
<td>Annually</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>Report it to End of life lead. The department Quality Group and Divisional Governance Management Board</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>End of life group</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice will be identified and actioned within 3 months. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders</td>
</tr>
</tbody>
</table>
9 Updating and Review
9.1 This document will be reviewed bi-annually and/or in the event of any significant change with the organisational structure/management arrangements and subject to consultation via the End of life Committee.

9.2 Where the revisions are minor, e.g. amended job titles or changes in the organisational structure, approval can be sought from the Medical Director responsible for signatory approval, and can be re-published accordingly without having gone through the full consultation and ratification process.

9.3 Any revision activity is to be recorded in the Version Control Table as part of the document control process.

10 Equality and Diversity

This document complies with the RCHT NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

10.1 Equality Impact Assessment

10.2 The Initial Equality Impact Assessment Screening Form is at Appendix 2.
### Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Bereavement/Care at and after death policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>May 2016</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>May 2016</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>May 2018</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Kevin Hammett, Mortuary Manager</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01827 252555</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>This policy and procedure sets out the pathway for deceased patients at RCHT</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Bereavement, Mortuary, End of life, After Death</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>Not Required</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Not Required</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>End of life Care group</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes:</td>
<td>Bryson Pottinger, Clinical Director CSCS</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories:</td>
<td>Associate Director CSCS Karen Jarvill</td>
</tr>
<tr>
<td>Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings:</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Name: Janet Gardner, Governance Lead CSSC</td>
<td></td>
</tr>
<tr>
<td>Signature of Executive Director giving approval:</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet</td>
</tr>
<tr>
<td>Document Library Folder/Sub Folder:</td>
<td>Clinical / End of Life</td>
</tr>
<tr>
<td>Links to key external standards:</td>
<td>Not Required</td>
</tr>
<tr>
<td>Related Documents:</td>
<td>Not Required</td>
</tr>
<tr>
<td>Training Need Identified?:</td>
<td>No</td>
</tr>
</tbody>
</table>
## Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2016</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Kevin Hammett, Mortuary Manager</td>
</tr>
</tbody>
</table>

---

**All or part of this document can be released under the Freedom of Information Act 2000**

**This document is to be retained for 10 years from the date of expiry.**

**This document is only valid on the day of printing**

**Controlled Document**

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
### Appendix 2. Initial Equality Impact Assessment Form

| Name of Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as *policy*) (Provide brief description): Bereavement/Care at and after death policy | Directorate and service area: RCHT | Is this a new or existing Policy? New |
| Name of individual completing assessment: Kevin Hammett | Telephone: 01872 252555 |
| 1. Policy Aim* Who is the strategy / policy / proposal / service function aimed at? | To provide guidance on the care of deceased patients at RCHT |
| 2. Policy Objectives* | To provide guidelines on the handling of deceased patients in RCHT |
| 3. Policy – intended Outcomes* | Effective procedure of dealing with deceased patients |
| 4. *How will you measure the outcome? | Monitor rate and subject matter of Complaints, Datix incident reports, and PALS contacts relevant to end of life care delivery within RCHT. |
| 5. Who is intended to benefit from the policy? | All RCHT staff, visitors and patients |
| 6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy? | Yes |
| b) If yes, have these *groups been consulted? | Yes |
| C). Please list any groups who have been consulted about this procedure. | RCHT End of Life Care Group, Clinical Support Services and Cancer Divisional Governance Board, Trust Management Committee (Governance) |
7. The Impact
Please complete the following table.

Are there concerns that the policy could have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>X</td>
<td></td>
<td>It is expected that any one working in a health care situation is of employment age</td>
</tr>
<tr>
<td>Sex (male, female, transgender / gender reassignment)</td>
<td>X</td>
<td></td>
<td>The policy does not make any reference to gender</td>
</tr>
<tr>
<td>Race / Ethnic communities / groups</td>
<td>X</td>
<td></td>
<td>The policy does not make any reference to race or ethnic groups</td>
</tr>
<tr>
<td>Disability - Learning disability, physical disability, sensory impairment and mental health problems</td>
<td>X</td>
<td></td>
<td>The policy does not make any reference to user disabilities</td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>X</td>
<td></td>
<td>The policy does not make any reference to relationship status</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>X</td>
<td></td>
<td>This procedure will not cause damage to the unborn child or mother</td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td>X</td>
<td></td>
<td>This policy does not make any reference to sexual orientation</td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended. No

9. If you are not recommending a Full Impact assessment please explain why.

No impact assessment identified

Signature of policy developer / lead manager / director

Date of completion and submission

Names and signatures of members carrying out the Screening

1.  
2.  

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed

Date