Care after Death Guidance
(Formerly Last Offices)
For the Adult Patient

This guidance does not override the individual responsibility of health professionals to make appropriate decisions according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

INTRODUCTION

Care after death formerly Last Offices is the term for the nursing care given to a deceased patient that demonstrates continued respect for the patient as an individual (NMC 2015). The term reflects the military and religious origins of nursing. Care After Death is now the preferred terminology as it recognises a wider range of care tasks that need to be performed, and also acknowledges our multicultural society,
(Thompson-Hill, J Mackleston, J 2012).
This procedure describes the responsibilities of the nurse in charge of the adult patient from the time of death until the patient leaves the ward.

Lead Clinician(s)

Avril Adams	Lead nurse for Palliative & EOLC
Tess Makinson	WAHT End of life Care Facilitator
Guideline approved by Clinical Governance Group on:	3rd September 2019
Review Date This is the most current document and should be used until a revised version is in place:	3rd September 2022

Key amendments to this guideline

Date	Amendment	By:
March 2010	Guideline approved by	Matrons Forum
15/09/2010	Organ/Tissue donation	S Ellson
15/09/2010	Appendix 2 – Guidelines for handling cadavers with infections	H Gentry
06/03/2012	Extended for 3 months to allow time for review	J Garside
20/04/2012	Extended for a further 3 months to allow time for review	J Garside
10/10/2012	Extended for a further 3 months to allow time for review	J Garside
07/01/2013	Republished without changes	J Garside
08/02/2013	Republished without changes	A Carey
08/08/2013	Amendments made to introduction, contact details and newly introduced Bereavement card, KGH, death outside of ward area.	T Barley
11/08/15	Amendments made throughout document in line with introduction of new National guidance around care after death (2015)	T.Makinson
09/08/16	Document extended for 12 months as per TMC paper approved on 22nd July 2015	TMC
29/03/2017	Document extended for 6 months while amendments needed owing to introduction of ICADP	High Impact Action Group: End of life
01/09/2017	Document extended for 3 months as per TMC paper approved 22nd July 2015	TMC
November 2017	Document extended whilst under review	TLG
December 2017	Sentence added in at the request of the Coroner	
March 2018	Document extended for 3 months as approved by TLG	TLG
June 2018	Document extended for 3 months as approved by TLG	TLG
March 2019	Amendments made throughout document in line with introduction and implementation of Integrated Care after Death for Adults, WR4888 Trustwide	T. Makinson

Care After Death Guidance

INTRODUCTION

Nursing care after death given to a deceased patient demonstrates continued respect for the patient as an individual (NMC 2015) and in contemporary society is focused on fulfilling religious and cultural beliefs as well as health and safety and legal requirements (Lister and Dougherty 2008).

Practices relating to care after death will vary depending on the patient's religious and cultural background. The UK today is a multicultural and multi-faith society and nursing staff need to be aware of the different religious and cultural rituals that may accompany the death of a patient.

Care following an expected death can be different to that given to a patient who has died suddenly, unexpectedly or in a critical care setting and therefore senior nursing or medical staff should be consulted before starting care after death, (Nurse Consultants, 2015.)
Factors which may need consideration include:

- Referral to coroner
- Suspicious deaths
- High risk infections
- Organ/Tissue donation

Please refer to appendix 1

If the patient has expressed a wish to be considered as an Organ/Tissue Donor in their lifetime by either carrying a donor card or registering on the Organ Donor Register or if relatives bring up the subject of donation, please contact the on call National Tissue Co-ordinator on 0800 432 0559 for Tissue donation. The Specialist Nurse in Organ Donation can be contacted via Switchboard.

Special measures should be taken when dealing with patients who have implanted radioactive materials as these will require removal prior to after death care – please contact medical staff.

Bereaved people value the support of bereavement services and the professionals that provide them and it has been shown that the experience around the time of death and afterwards can influence grieving and the longer term health of bereaved people (DOH 2011).

This procedure describes the responsibilities of the Registered nurse in charge of the patient from the time of death until the patient leaves the ward. The nurse responsible for care after death should also complete the Integrated Care Pathway for Patient Care After Death for Adults (WR4888) and 2 Notice of Death cards (WR420) which should be available on the ward.

COMPETENCIES REQUIRED

Care after death must be completed under the supervision of a registered nurse who has responsibility for this care including identification and completing all documentation.

PATIENTS COVERED

All adult patients

GUIDELINE

Equipment needed

Bowl, soap, towels, disposable wipes, gloves, and apron

Hair comb, equipment for nail care

Equipment for oral care including aids for cleaning dentures

Shroud or patient's own nightclothes

Clean sheets

Disposable body bag is routine at WRH whilst used at ALEX and KTC only if body has infection or excessive leakage.

Dressing pack, tape and occlusive dressings if wounds present

Syringe (to deflate balloon if urinary catheter present)

Continence pad and disposable pants if exuding fluid

Yellow plastic bag for clinical waste

White plastic bag for dirty linen

Patient identification bands (2)

Notice of death cards (2) WR420

Property book and property bags

Integrated Care Pathway for Patient Care After Death for Adults WR4888

(ICPPfCAD)

Procedure

Action	Rationale
Inform the medical staff and site nursing Bleep holder of the patient's death. Verification of death must be recorded in the patient's medical and nursing notes. Doctors, and registered nurses who have successfully completed training and competencies in the Trust may verify death	A registered medical practitioner who has attended the deceased person during the last illness is required to give a medical certificate of the cause of death. The certificate requires the doctor to state the last date on which he/she saw the deceased alive and whether or not he/she has seen the body after death Trust policy Verification of expected death in adults for registered nurses WAHT-CG-681

If the circumstances surrounding the death give rise to suspicion that means the death requires forensic investigation, leave all intravenous cannula and lines in situ and intravenous infusions clamped but intact (this includes syringe drivers with controlled drugs). Leave any catheter in situ with the bag and contents. Do not wash the body or begin mouth care in case it destroys evidence. Continue using universal infection measures to protect people and the scene from contamination. Mortuary staff can provide guidance on this at the time of death.	Deaths in certain circumstances must be referred to the coroner for investigation and may require a post mortem – see appendix 1 See Appendix 1
Where the death is being referred to the coroner to investigate the cause of death, but where there are no suspicious circumstances, then leave intravenous cannula and lines in situ and spigot off catheters. Infusions and medicines being administered prior to death via pumps can be taken down and disposed of, according to local policy, but must be recorded in nursing and medical documentation. The contents of catheter bags can be discarded according to local policy. Leave endotracheal (ET) tubes in situ. This is because cutting the tube deflates the balloon that holds the tube in position.	The increased mobility may enable the ET tube to become displaced during the handling of the body and any possibility of movement will lead to confusion should the coroner need to investigate this through post-mortem examination.
Sensitively inform the family that, after the coroner's involvement, ET tubes or lines will be removed and they will then be able to spend time with the deceased. They can also do this at the funeral director's premises. Personal care can then be given as per deaths without coronial involvement.	Keeping family informed.
Deaths without coronial involvement, expected adult death - See above re verification of death.	
Inform the patient's relatives/next of kin of the patient's death. Ensure that this is handled in a sensitive and appropriate manner with as much privacy as possible.	To ensure relevant individuals are aware of the patient's death.
Assemble required equipment	To prevent interruption of the procedure once commenced.

Wash hands and put on gloves and apron Carry out all personal care of the patient after death in accordance with safe manual handling and infection control policies. Adopt standard infection prevention precautions, and where indicated due to risk of infection adopt contact or respiratory precautions.	Hand washing reduces the transmission of micro-organisms. Wearing protective clothing reduces the risk of contamination with body fluids.
Lay the patient flat on their back. Straighten their limbs with their arms lying by their sides. Leave one pillow under the head.	To maintain the patient's dignity and for future management of the body as rigor mortis occurs 2-6 hours after death. The pillow will support alignment and helps the mouth to stay closed.
Wash patient. It may be important to family and carers to assist with washing, thereby continuing the care given to the patient in the period before death.	Prepare family for the changes to the body after death.
Gently close the eyes by applying light pressure for 30 seconds. If for corneal donation place saline soaked gauze to keep eyes closed and protected.	Patient will need to be in mortuary within 2 hours to best preserve eyes for donation.
Do not tape directly to the skin.	Tape may mark the face.
Apply pad and pants to all patients.	There may be further urinary leakage after death.
If expected death with no coronial involvement	
Remove mechanical aids such as syringe drivers, applying occlusive waterproof dressings to sites and document disposal of medication that remained in syringe driver.	Prevent further bodily fluid leakage after death.
Remove any cannula, endotracheal tubes. Clamp drains (remove the bottles) pad around wounds and seal with an occlusive dressing. Exuding wounds should be covered with absorbent dressing and secured with an occlusive dressing.	The dressings will absorb any leakage from the wounds and provide protection for any staff coming into contact with the body.

Cover stomas with a clean bag.	
Do not shave the person.	Shaving a deceased person when warm can cause bruising and marking which only appears days later.
Clean the mouth using a moistened, soft, small headed toothbrush and/or suction to oral cavity to remove any debris and secretions	For hygienic and aesthetic reasons
Clean any dentures and replace them in the mouth – a small pillow placed under the patient's jaw may help to keep the jaw closed and the teeth in situ. (Remove it before family view the person.) If unable to replace dentures – place in denture pot labelled with patient ID and send to the mortuary with patient.	
Tidy the hair and arrange in the preferred style.	
Put shroud on patient or leave in their own night-clothes, if requested by relatives.	Shroud sleeve ties can be tied together to keep arms in the lap to protect them further.
Remove all jewellery except wedding band in the presence of another member of staff, unless requested by the family to do otherwise and document accordingly. If rings are left on tape lightly in place.	To meet with legal requirements and relatives' wishes.
Any jewellery remaining on the body should be documented on the Notice of death cards, (WR420) accompanying the patient to the mortuary	
Record all jewellery, valuables and other property in the patient's property book	Be specific when describing jewellery, noting colour of metal, colour and number of stones for accuracy.
The registered nurse in charge of patient care is to complete identification documentation after confirming patient identification with notes, writing clearly and in capital letters.	
Label one wrist and one ankle with an identification band containing the following information: • Full Name • NHS Number • Date of Birth • Address	To ensure correct and easy identification of the body in the mortuary. Usually opposite limbs are used.

• Ward Complete 2 x Notice of death cards (WR420) one is taped to the shroud/ clothing the other is taped on the outer sheet or body bag. Complete the ward, and handover to porter sections of the ICPfPCAD (WR4888) document and give to the porter to take to the mortuary on transfer. If the patient has an implanted device such as a pacemaker – please record this fact on both patient identification cards and pathway. **Alex and KGH** Wrap the body in a sheet, ensuring that the face and feet are covered and that all limbs are held securely in position. Use tape sensitively to secure. Tape the second Notice of death card (WR420) to the outside of the sheet. If the body is at risk of infection or leakage of bodily fluids, after wrapping in a sheet place the body in a white plastic body bag and put the second identification card into the pocket of the body bag. Be sure in all cases to complete risk of infection and communicable diseases forms which are part of the (ICPPCAD, WR4888). **WRH** As all bodies are moved outside the main building to the mortuary they must, after wrapping in a sheet be placed in a white plastic body bag. Place WR420 in the pocket of the bag. Be sure in all cases to complete risk of infection and communicable diseases forms which are part of the (ICPPCAD, WR4888). If a body bag is used for health and safety purposes– please record the reason i.e. leakage or infection on the identification card on the outside of the bag. **In all cases** Ensure manual handling slide sheets are in place. Remove gloves and apron. Dispose of equipment	Implanted devices may present a hazard at cremation To avoid damage to the body during transfer. Do not bind the sheet too tight as it may cause disfigurement. For ease of identification in the mortuary Actual or potential leakage of fluid whether infectious or not poses a health and safety hazard to those handling the body. (Thompson & Mackleston, 2012) **See appendix 2** To minimize risk of cross infection and

according to local policy and wash hands. Ensure that the ward section of the (ICPPCAD, WR4888) has been fully completed and signed off. **WRH & ALEX** Request porters to attend the ward to remove the body to the mortuary. Screen off the area where removal of the body will occur. Porters must check the patient identification with the registered nurse and that details are recorded accurately and confirm that any jewellery remaining on the body is as recorded on the patient identification cards. Record all details and actions in the patient record. Porters to transfer body to concealment trolley/use X-cube with dignity and respect and in accordance with WAHT manual handling policy. Check that all actions on the Transfer to porters section of the (ICPPCAD, WR4888). have been followed and signed off. Contact bereavement office to inform them of the patients death and they will collect the notes and property (if relatives not in attendance) – out of hours leave a discrete message on their voicemail. Any property retained on the ward out of hours must be stored in a secure area and any valuables stored in the ward/hospital safe and documented on the (ICPPCAD, WR4888). . If relatives are present at the time of death, or attend the hospital shortly after, staff should ensure that they are given a Bereavement Information booklet and Bereavement card to make an appointment with Hospital Bereavement office, copies of which are to be available on each ward. If relatives are present they may take the patient's belongings providing they sign the property book.	contamination Alexandra Hospital – Contact porters via switchboard – ext 40000 Worcestershire Royal Hospital – Contact porters via the helpdesk – ext 33333 – option 3 To avoid causing unnecessary distress to other patients, relatives and staff. . See Appendix 4 The bereavement office will ensure that the patient's GP is informed of the patient's death See Appendix 3 Ask Bereavement office to supply ward stock of Worcestershire Bereavement Handbook for relatives. Order Worcestershire Bereavement Card from Service Point. Transfer of patient's property fully documented and signed for. Bereavement card to be given which has contact details of Bereavement office. Monday – Friday 09.30 – 15.30 hrs Alexandra Hospital – 01527 503030

If staff speak over the phone to Next of Kin they need to be informed as to contact number for Bereavement office and need to make an appointment, ringing after 09.30am on the next working day Relatives should be asked to contact the relevant Trust bereavement office for information on collection of property and death certification.	Ext 42083/44660 Worcestershire Royal – 01905 763333 ext. 33405
Kidderminster General Hospital. Wards have folders with all local funeral directors services and contact details for relatives to choose. Contact a funeral director according to relative's wishes. A contract has been awarded to a local funeral director to deliver services in the following situations - If the family have not made choice known and are nor contactable. -if Hospital are arranging the funeral as no identified next of kin - provide transport to WRH for PM for example. Funeral director services to be contacted if Coroner directs that the body is for removal. If property is left on the ward – staff must contact family and request collection **Death Occurring Outside of wards e.g Outpatient Department/Endoscopy/Theatres** If admitted in-patient follow care after death protocol, inform ward from which they came and ward staff may support with paperwork and care in the department. If the person is not an in-patient then they should be taken to A&E.	Open market. 9 local funeral directors within folder. They will collect from KGH and take body directly to chosen funeral directors. Contact the contracted funeral director via switchboard Providing dignity and privacy in all settings.

Viewing Arrangements once bodies have left the ward – Redditch/Worcester

If families wish to view a body once it has been transferred to the mortuary this can be organised during office hours by the Bereavement Office at the Alex and via Mortuary department at WRH.

Out of hours viewings for hospital deaths can be organised on both sites on Saturdays, Sundays and Bank Holidays by contacting the site bleep holders.

Monitoring Tool

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	Key parts- Keeping staff safe who handle body after death	Audit of Integrated Care Pathway for the Adult Patient After death WR4888	1 time a year	EOLC facilitators	Report to HIA EOLC Committee & Divisional Governance Committee	Annual report
	The body of a person who has died is cared for in a culturally sensitive and dignified manner. Nice QS 12 (13)	Recording and monitoring training attendance	Ongoing record sent to training	End of life care facilitators	Report to HIA EOLC Committee	Annual report

REFERENCES

Department of Health & NEoLCP (2011) *When a patient dies – Advice on Developing Bereavement Services in the NHS*, Department of Health London.

Dougherty, L; Lister, S (2008) *The Royal Marsden Hospital Manual of Clinical Nursing Procedures .7*th Edition Blackwell Publishing, Oxford.

Ministry of Justice Publication : *A guide to coroners and inquests* (2010)

One chance to get it right : improving people's experience of care in the last few days and hours of life. Leadership Alliance for the Care of Dying People (2014).

Guidance for staff responsible for care after death (last offices). NHS Improving Quality and Nurse Consultant group (Palliative Care, 2015)
www.hospiceuk.org

The Code : Professional standards of practice and behaviour for nurses and midwives. Nursing and Midwifery Council. (2015)
www.nmc.org.uk

Thompson-Hill,J & Mackleston,J session within e-ELCA
Introduction to Personal Care After Death 2. (2012)

APPENDIX 1

Referral to the Coroner

If the cause of death is known, is a natural cause, and a doctor has attended the deceased within 14 days prior to death, then a death certificate may be issued without referral of the death to the coroner.

The death should be referred to the coroner if:

- **the cause of death is not known**
- **there is no attending practitioner(s) or the attending practitioner(s) are unavailable within a prescribed period.**
- **the death may have been caused by violence, trauma or physical injury, whether intentional or otherwise.**
- **the death may have been caused by poisoning.**
- **the death may be the result of intentional self- harm.**
- **the death may be as a result of neglect or failure of care.**
- **the death may be related to a medical procedure or treatment.**
- **the death may be due to an injury or received in the course of employment, or industrial poisoning.**
- **the death occurred while the deceased was in custody or state detention, whatever the cause of death.**

The coroner has a judicial duty to enquire into those deaths reported to him. The coroner is concerned with:

- **The identity of the deceased**
- **When the deceased died**
- **Where the death occurred**
- **How the deceased came about their death**

Following referral to the coroner:

- **A death certificate may be issued after consultation**
- **The coroner may order a post mortem examination. If this confirms that death was due to natural causes, the coroner will issue a death certificate.**
- **If the post mortem examination reveals an unnatural cause, an inquest will be held.**

If a death is reported to the coroner and a post mortem examination is required:

- **All endo-tracheal tubes and catheters should remain in situ. Catheter bags may be removed and the catheter spigoted. Endo-tracheal tube ties should be cut and the tube may be cut short to rest within the mouth, but the cuff should remain inflated.**

- **Chest drains, surgical drains, epidural lines should also remain in situ. They can be disconnected, capped and then folded back and covered with an occlusive dressing.**

Special Consideration for suspicious deaths

If a person has died in suspicious circumstances and a police investigation is likely then the following procedure should be observed to preserve forensic evidence and minimize cross contamination:

- **The body should not be washed or cleaned, unless express permission has been given by the senior police officer in charge of the investigation or by the Coroner**
- **The body should not be touched by family and friends, unless express permission is given as above. The police will often allow supervised touching by the family.**
- **A catholic priest should be permitted to anoint the forehead and administer the sacrament of the last rights to a dying person, or the recently deceased. It would be rare for the police to refuse permission for this**
- **Clothing should only be removed after expressed permission from the police – if removed clothing and property (including cash and valuables) of the deceased should be listed as per Trust Policy, bagged and handed to the police if requested. A signature of receipt should be obtained from the police.**

Appendix 2

GUIDELINES FOR HANDLING CADAVERS NOT NOTIFIABLE INFECTIONS IN ENGLAND AND WALES

Degree of Risk	Infection	Bagging	Viewing	Embalming	Hygienic preparation
LOW	Acute encephalitis	No	Yes	Yes	Yes
	Leprosy	No	Yes	Yes	Yes
	Measles	No	Yes	Yes	Yes
	Meningitis (except meningococcal)	No	Yes	Yes	Yes
	Mumps	No	Yes	Yes	Yes
	Ophthalmia neonatorum	No	Yes	Yes	Yes
	Rubella	No	Yes	Yes	Yes
	Tetanus	No	Yes	Yes	Yes
	Whooping cough	No	Yes	Yes	Yes
MEDIUM	Relapsing fever	**Advised**	Yes	Yes	Yes
	Food poisoning	No/**Advised**	Yes	Yes	Yes
	Hepatitis A	No	Yes	Yes	Yes
	Acute poliomyelitis	No	Yes	Yes *	Yes
	Diphtheria	**Advised**	Yes	Yes	Yes
	Dysentery	**Advised**	Yes	Yes	Yes
	Leptospirosis (Weil's Disease)	No	Yes	Yes	Yes
	Malaria	No	Yes	Yes *	Yes
	Meningococcal septicaemia (with or without meningitis)	**Advised**	Yes	Yes	Yes
	Paratyphoid fever	**Advised**	Yes	Yes	Yes
	Cholera	No	Yes	Yes	Yes
	Scarlet fever	**Advised**	Yes	Yes	Yes
	Tuberculosis	**Advised**	Yes	Yes	Yes
	Typhoid fever	**Advised**	Yes	Yes	Yes
	Typhus	**Advised**	No	No	No
HIGH	Hepatitis B, C	**Yes**	Yes	No	No
HIGH (rare)	Anthrax	**Advised**	No	No	No
	Plague	**Yes**	No	No	No
	Rabies	**Yes**	No	No	No
	Smallpox	**Yes**	No	No	No
	Viral haemorrhagic fever	**Yes**	No	No	No
	Yellow fever	**Yes**	No	No	No

DEFINITIONS – See over page

GUIDELINES FOR HANDLING CADAVERS WITH INFECTIONS NOT NOTIFIABLE

IN ENGLAND AND WALES

Degree of Risk	Infection	Bagging	Viewing	Embalming	Hygienic Preparation
LOW	Chickenpox/Shingles	No	Yes	Yes	Yes
	Cryptosporidiosis	No	Yes	Yes	Yes
	Dermatophytosis	No	Yes	Yes	Yes
	Legionellosis	No	Yes	Yes	Yes
	Lyme disease	No	Yes	Yes	Yes
	Orf	No	Yes	Yes	Yes
	Psittacosis	No	Yes	Yes	Yes
	Methicillin resistant Staphylococcus aureus (MRSA)	No	Yes	Yes	Yes
	Tetanus	No	Yes	Yes	Yes
	Clostridium difficile (C diff)	No	Yes	Yes	Yes
MEDIUM	HIV/AIDS	**Advised**	Yes	No	No
	Haemorrhagic fever with renal syndrome	No	Yes	Yes	Yes
	Q fever	No	Yes	Yes	Yes
HIGH	Transmissible spongiform encephalopathies, eg Creutzfeldt–Jakob disease (CJD)	**Yes**	No **	No	No
	Invasive Group A Streptococcal infection	**Yes**	No	No	No

DEFINITIONS

* Requires particular care during embalming

** If necropsy has been carried out.

Advised = Advisable and may be required by local health regulations.

Bagging: placing the body in a plastic body bag

Viewing: allowing the bereaved to see, touch, and spend time with the body before disposal.

Embalming: injecting chemical preservatives into the body to slow the process of decay. Cosmetic work may be included.

Hygienic Preparation: cleaning and tidying the body so it presents a suitable appearance for viewing (an alternative to embalming).

Appendix 4
CARE AFTER DEATH/LAST OFFICES
ADULT FLOWCHART

CONFIRM
CORRECT IDENTITY OF PATIENT & PLACE 1st IDENTITY BAND TO WRIST AND 2ND TO ANKLE

↓

COMPLETE
THE INTEGRATED CARE PATHWAY FOR PATIENT CARE AFTER DEATH FOR ADULTS (WR4888) WARD SECTION AND GIVE CARE AFTER DEATH IN ACCORDANCE WITH THESE GUIDELINES.

↓

COMPLETE NOTICE OF DEATH CARD X 2
(Order Ref: WR420)
One card to be attached to: Shroud/patient clothing
AND
One card to be attached to: Outer layer. (a) Sheet (for AH/KTC) or (b) Body Bag (WRH)
c) Body bag if used for leakage/infection.

↓

PORTER CALLED TO WARD

↓

ON ARRIVAL, PORTER **AND** REGISTERED NURSE TO:

CHECK IDENTIFICATION ON SHEET/BODY BAG AGAINST Integrated Care Pathway for Patient Care After Death for Adults (WR4888)
CHECK JEWELLERY IN PLACE AS DOCUMENTED
REGISTERED NURSE HANDS OVER CARE TO PORTERS BOTH COMPLETE WR488 section and SIGN.

↓

ONCE THE ABOVE CHECKS HAVE TAKEN PLACE, THE PATIENT CAN BE TRANSFERRED TO THE MORTUARY AND TAKES WR4888 WITH THEM, FOR MORTUARY STAFF TO COMPLETE AND THEN BEREAVEMENT STAFF TO FETCH, COMPLETE & THEN RETURN TO PATIENT CASENOTES.

CONTRIBUTION LIST

Key individuals involved in developing the document

Name	Designation
Alison Harrison	Lead nurse for Palliative and End Care Trust End of life Care Lead
Ann Carey	Director Nursing for Medicine Division
Tess Makinson	End of life Care Facilitator
Sheryl Thomas	Mortuary manager
Tim MacCormac	Mortuary manager
Julie Webb	Matron, Surgery
Kathryn Norwood	AMBER champion and staff nurse WRH

Circulated to the following individuals for comments

Name	Designation
Lisa Miruszenko	Deputy Chief Nurse
Pauline Spenceley	PALS manager
Jackie Littlejohn	Bereavement officer
Rani Virk	Privacy & Dignity
Deborah Narburgh	Matron
Lisa Walker	Ward manager Wd 5
Avril Adams	Lead Palliative & EOLC nurse
Alice Ferguson	EOLC facilitator
Palliative & EOLC Link workers	Trust wide
Dr Mandeep Uppal	Consultant Palliative care , Quality

Circulated to the following CD's/Heads of dept for comments from their directorates / departments

Name	Directorate / Department
Ann Carey	Medicine
Sarah King	Surgery
Hospital Specialist Palliative & EOLC team	Clinical Support

Circulated to the chair of the following committee's / groups for comments

Name	Committee / group
Avril Adams	HIA EOLC Group
Tess Barley	Bereavement group membership
Tessa Mitchell	Privacy & Dignity Group
Amanda Moore	Haematology/Oncology Governance Group

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	Age	no	
	Disability	no	
	Gender reassignment	no	
	Marriage and civil partnership	no	
	Pregnancy and maternity	no	
	Race	no	
	Religion or belief	no	
	Sex	no	
	Sexual orientation	no	
2.	**Is there any evidence that some groups are affected differently?**	no	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	no	
4.	**Is the impact of the policy/guidance likely to be negative?**	no	
5.	**If so can the impact be avoided?**	n/a	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	n/a	
7.	**Can we reduce the impact by taking different action?**	n/a	

If you have identified a potential discriminatory impact of this key document, please refer it to Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	no
2.	Does the implementation of this document require additional revenue	no
3.	Does the implementation of this document require additional manpower	no
4.	Does the implementation of this document release any manpower costs through a change in practice	no
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	no
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval