POLICY DOCUMENT CONTROL SHEET

Reference Number	*POL/N&Q/0047*						
Title	Care After Death Policy						
Version number	5.0						
Document Type	Policy	**X**	Trust Procedure		Clinical Guideline		
Approval level (Clinical Guidelines)	Local		Trust-wide	x	N/A (not a guideline)		
Original policy date	December 2006						
Reviewing Committee	End of Life Steering Group						
Approving Committee	Integrated Quality Assurance Committee						
Approval Date	11th December 2018						
Next review date	11th December 2021						
Originating Directorate & Care Group (where applicable)	Pathology						
Document Owner	Jen Siddal						
Lead Director or Associate Director	Associate Director of Operations, CSS						
Scope	Trustwide						
Equality Impact Assessment completed on	2014						
Status	Approved						
Confidentiality	Unrestricted						
Keywords	Certification, cultural, expected death, next of kin, verification of expected death, religious, unexpected death						

Final approval

Chairman or Executive Sponsor's Signature	
Date Approved	11th December 2018
Name & Job title of Chairman or Executive Sponsor	Jeremy Cundall, Executive Medical Director
Approving Committee	Integrated Quality Assurance Committee
Signed master copy held at:	Corporate Records Office, Trust Headquarters, Darlington Memorial Hospital

VERSION CONTROL TABLE

Date of Issue	Version Number	Status
December 2006	1.0	Superseded
August 2014	2.0	Superseded
June 2016	3.0	Superseded
August 2017	4.0	Superseded
December 2018	5.0	Approved

TABLE OF REVISIONS

Date	Section	Revision	Author
04/08/2014	All	Full policy review to compliment Marsden Manual of Nursing Procedures	Joanne Todd
01/06/2016	All	Full policy review to reflect all care groups.	Delcy Wells
06/03/17	5.4 and 5.17	Harmonize care after death section and remove section around expected death in community as this belongs in Verification of Death policy	Suzanne Vickers
27/06/17	Appendix D	Updated Mortuary Identification Form.	Nicola Sherriff
25/08/17	Appendix D	Updated Mortuary Identification Form.	Stephen Hopper
01/06/18	All	Full policy review to reflect updated practice, updated mortuary identification form	Jen Siddall

CONTENTS

1 INTRODUCTION

Care after death, or last offices, is the term for the nursing care given to a deceased person which demonstrates continued respect for the person as an individual after death. Care after death is a nursing routine which does not have a large amount of research based evidence. Many parts of this policy are based on the general principles of infection prevention and control, and safe working. The process of care after death for a patient is, however of upmost importance. Nurses and midwives carrying out this care with compassion allow families to see that their family member was cared for and respected, even after death.

Care after death includes

- Honoring the spiritual or cultural wishes of the deceased person and their family/carers while ensuring legal obligations are met
- Preparing the body for transfer to the mortuary
- Offering family and carers present the opportunity to participate in the process and supporting them to do so
- Ensuring that the privacy and dignity of the deceased person is maintained and respected
- Ensuring that the health and safety of everyone who comes into contact with the body is protected
- Ensuring that all due policies and procedures are followed

This policy relates to all acute hospital services and community services.

2 PURPOSE

This policy describes the standard of care and service that the deceased and their next-of-kin can expect, from before death (chaplain support) to when the deceased is released from County Durham & Darlington NHS Foundation Trust (the Trust), facilitating the Trust's compliance with legislative requirements.

2.1 Objectives

This policy aims to ensure that the deceased patient is cared for with:

- Compassion
- Confidentiality
- Privacy
- Dignity
- Respect

And will be ready for

- Viewing by their friends/relatives
- Transfer to the mortuary
- Possible post mortem

3 SCOPE

This policy applies to all staff involved in the care and delivery of services to the deceased and next-of-kin/family/significant others at the time leading to and after death. The following principles should underpin the professional services offered around the time of the death and afterwards. They apply equally to the care and support of the patients and that of their next-of-kin/family/significant others.

4 DUTIES

Healthcare organisations have an obligation to provide care after death in line with the patient's wishes, where these are known

All staff involved in the care of deceased patients are required to be familiar with the content of this Policy and to comply with it. Failure to do so may result in disciplinary action.

4.1 Quality and Health Care Governance Committee (QHCGC)

The Quality and Healthcare Governance Committee will be the approving body for this policy and will ensure that the policy is reviewed fully and approved on behalf of the Trust Board.

4.2 Care Group Senior Leaders

The Care Group senior leaders include Sister/Charge Nurses, Midwives, Matrons, lead nurses, Associate Chief Operating Officers and Care Group Clinical Directors.

They are responsible for ensuring that the requirements of this policy are managed effectively within their Care Group and that staff are aware of, and implement, its requirements.

4.3 Line Managers, Professional Leads and Service Leads

Line Managers, Professional Leads and Service Leads are responsible for ensuring policy implementation and compliance in their area(s). This includes ensuring that all staff are aware of this policy as part of their Induction to the Trust.

4.4 Clinical Staff

All clinical and clinical support staff are responsible for complying with policy.

5 MAIN CONTENT OF POLICY

5.1 Religious and Cultural Beliefs

County Durham & Darlington NHS Foundation Trust cares for patients from a variety of ethnic and religious backgrounds. Staff should, as far as possible, comply with the requirements of the individual's religious or cultural beliefs, where these are known. When a patient's death is imminent and where possible, advice should be sought from the patient or the family as to what religious or cultural practices should be considered. It is essential that any specific religious or

cultural requirements are recorded in the patient's notes and drawn to the attention of all staff caring for the patient both before and after death. Failure to do this may result in added distress to the patient's family, friends and loved ones. Appendix C provides staff with guidance on the practices to be followed for different religions and cultures in the event of a death; however this does not negate the need to speak directly to the patient and their family/significant others about their specific requirements, where possible.

The availability of chaplaincy support should also be made known and, as is outlined in the "Chaplaincy: End of Life care Policy," the chaplains should be advised either through an alert placed on Nervecentre (patient selected as end of life) or by contacting the on-call chaplain through switchboard. A chaplain will be available to attend on the patient and/or their family to offer spiritual, pastoral and (where requested) religious support.

The Chaplaincy team also hold a list of faith leaders and advisors who can be contacted for specific religions.

Consideration should also be given to tissue or organ donation if appropriate.

5.2 Verification & Notification of Death

The Checklist for Care after Death (See Appendix A) should be commenced and once completed filed in the deceased patient's medical notes.

The nurse in charge of the ward/area should be informed as soon as the patient has died. Verification of death should be made either by the medical staff or by a registered nurse who has been trained and assessed as competent to verify death. See Policy for the Verification of Death by a Registered Health Professional (POL/NQ/47). Care should be taken to ensure that this is documented fully and clearly. This should include ensuring all dates and times are as accurate as possible and that signatures/ designations are clear.

Confirmation of the patient's death should be recorded in the patient's medical and nursing notes on Verification of Death by a Registered Health Professional proforma which can be found in The Verification of Death by a Registered Health Professional Policy (POL/NQ/47)

The patient's next of kin and/or relatives should be informed and supported. Extra support can be offered through the Hospital Chaplains and Bereavement support officers. The Hospital Chaplains can be contacted during normal working hours, between 8am - 5pm Sunday-Friday, via the hospital switchboard. Out of hours (that is between 5pm – 8am Sundays to Fridays, all day/night on a Saturday and all day/night on a bank holiday) one chaplain is available trust-wide. Hospital switchboard staff have a rota which identifies the chaplain who is on call. The religious denomination of that chaplain will vary, but each of these is able to source the required support from other religion/faith personnel as required. Bereavement support officers can be contacted Monday to Friday 8.30am to 4pm, via the hospital switchboard.

5.3 Viewing the Patient after Death

Patients who die on a ward can be viewed by family/ friends immediately after death. Those wishing to view should not be rushed and nurses/midwives should not have the patient moved to the Mortuary unreasonably quickly. Notwithstanding this, staff should normally arrange for transfer within two hours of

death to maintain the appearance, condition and dignity of the body, and to prevent distress to surrounding patients.

Care of the patient after death should not be undertaken until it has been ascertained whether the family wishes to have a viewing. If a viewing is to take place, the deceased should be presented as peacefully as possible. This includes ensuring that the bed area is cleared of excess equipment and is clean and tidy.

5.4 Care of the Patient after Death

The relatives of the deceased may wish to stay in the room during care after death, or indeed may wish to participate in washing the body themselves. This should be facilitated where possible.

Following verification of death and, in the absence of any cultural or religious instructions, or coronial investigation, the following must be carried out: (See Appendix A for checklist version).

Registered nurses/midwives must always supervise care after death. It is not acceptable for unregistered staff to be left to carry out care after death without input and supervision from a registered member of staff.

Personal protective equipment (PPE), for example gloves and aprons must be worn when delivering care after death.

Clean the patient's mouth (unless the death requires coronial investigation). Dentures should be cleaned and replaced wherever possible as it is difficult to fit them at a later date. If this is not possible the dentures should be placed in a labelled pot/bag and accompany the deceased, for the funeral director to fit. This must be documented and recorded clearly and fully in the patient's record and mortuary ID sheet.

Under no circumstances should dentures be placed with the deceased's personal possessions eg. clothing. Family should be informed that the patient's dentures have accompanied them to the mortuary.

Lay the patient on their back and remove all but one pillow. Support the jaw by placing a pillow or rolled up towel underneath (remove it before the family view the person).

Close the eyes by applying light pressure for 30 seconds. If this fails then explain sensitively to the family that the funeral director will resolve the issue. If corneal or eye donation is to take place close the eyes with gauze (moistened with normal saline) to prevent them drying out. In normal circumstances do not use any tape over the eyes as it will mark the patient's face, contact the mortuary for further advice if you are having difficulty.

Remove any external medical devices such as syringe drivers but leave in place everything that enters the body, including: cannula, tubes; nasogastric or endotracheal, and/or catheters (without the bag). These should be capped to prevent leakage of bodily fluids. Subcutaneous needles should remain in place.

All items that are left in the body must be documented fully and clearly on the mortuary ID form for the safety of porters, mortuary staff and funeral directors (see Appendix D form).

Endotracheal ties across the patient's face can be disfiguring to the patient after death. The ties need to remain in order to hold the tube in the correct location, as instructed by the Coroner. This should be explained to relatives if they view the deceased.

Exuding wounds should be covered with a clean absorbent dressing and secured with an occlusive dressing.

Wash the patient, unless requested not to do so for religious or cultural reasons, or if the death requires coronial investigation. Muslim patients should not be washed if they are not having a post mortem. They should also remain in the clothing they died in if it is not soiled.

Shaving a deceased person when they are still warm can cause bruising and marking which only appears days later. Usually the funeral director will do this.

A discussion should be had with the next of kin to determine whether all jewellery should be removed or whether any specific jewellery item should be left on the deceased.

If the next of kin request that the jewellery be removed, place it in an envelope, then seal it and store securely until it can be handed to the next of kin. All jewellery removed and stored should be listed in the clinical care record/nursing notes.

In the Hospital Setting only:

- Place TWO PATIENT IDENTITY BANDS on the patient, one on the wrist and one on the opposite ankle (where possible). Ideally, left wrist and right ankle. Make sure they are visible. If there is significant low limb oedema, ensure second band is applied to the other wrist. If patient has had amputation, ensure identity bracelets are placed on both wrists and/ or both ankles.
- Dress the patient in a hospital shroud or, if the family requests, their own nightwear. The patient should not be transported naked or partly clothed.
- Place the patient on an absorbent pad and use continence pants to absorb any possible leakage. Mortuary staff to change these if leakage occurs.
- It is important to lie the patient as straight as possible after death. Lay the body with the hands parallel to the thighs.
- Provided there is no notifiable disease present, the deceased can be wrapped in a sheet and taped lightly, ensuring that the face and feet are covered and that all limbs are held securely in place. Do not bind the sheet too tightly around the face as this can cause disfigurement. Secure the sheet with a small amount of adhesive tape, not over the face.
- A body bag should be used for any obvious leakage after death. Wards to supply their own bags. No sheet is required. Pads and pants must be used to absorb any leakage of fluid from the urethra, vagina or rectum. If the body is leaking profusely then take time, pre transfer to the mortuary, to address the problem. Ensure mortuary staff are informed of any potential for profuse leakage to enable appropriate positioning of the deceased in the refrigeration areas. It is the role of mortuary staff to pack orifices not the nurse. Contact a member of the mortuary staff for further advice if necessary.
- A body bag should be used for an infectious body (without a sheet). This must be clearly labelled on the bag and on the mortuary ID form.

In the Community Setting only:

- After washing the deceased dress the patient in their nightwear or, if the family requests, their own clothing. Lie the patient on a pad and use continence pants.

5.4.1 Transfer of the deceased:

In the Hospital Setting only:

- Any implants or battery operated prostheses (pacemaker, hearing aid etc) must be noted on the mortuary ID form and documented clearly in the patient records.
- Request the portering staff to remove the body from the ward and transport to the mortuary. Ward staff must specify the size of the concealment trolley (regular or bariatric) or burgundy baby carrier.
- When the porters arrive, screen off the area where the removal of the body will occur. Ward staff and porters must ensure that bodies are always removed with care and dignity and respect. The body should have a full length slide sheet and bed sheet under the body. A lateral transfer should be executed using a minimum of three people using a lateral transfer board (Pat slide) and slide sheet. If required a Hovermatt transfer should be considered in event of bariatric patient. Care must be taken to ensure privacy when the deceased is placed on the mortuary trolley. Bodies should not be removed from the ward during meal times. Care and consideration for other patients, relatives and visitors must be taken into account. Bodies must NEVER be transported to the mortuary on a hospital bed, buggy or moses basket.
- The Mortuary Identification Form (Appendix D) MUST accompany the deceased to the Mortuary.
- All other property belonging to the patient must be gathered together, and be placed neatly in a bereavement bag for the family to take away (medications will be disposed of by the hospital).
- If a garment belonging to the patient is particularly badly soiled, ask the family/next of kin, whether they would rather you disposed of the garment for them. If relatives want soiled clothing to be returned to them or are not available to state a preference, the soiled clothes should be placed in a separate, clearly labeled, sealed bag.
- Clear instructions should be given to the relatives regarding collection of personal effects, valuables and the medical certificate of death, by the ward staff, before they leave the hospital. The Trusts ‘Information and Advice for the Bereaved’ booklet should be given to the relatives (See Appendix B).

In the Community Setting:

- Family members should be advised to contact their chosen Funeral Directors to remove the deceased

5.5 Cases of Communicable Disease

For patients who, at death, were suffering from a notifiable infectious disease e.g. Hepatitis, TB, HIV/AIDS, Streptococcal Septicaemia, Variant Creutzfeldt Jakob Disease (VCJD), staff should:

Wear PPE in accordance with Standard Infection Control Precautions in order to best protect themselves.

Seal all leaking wounds/orifices with occlusive dressings, continence pants.

Minimise unnecessary handling. Wash only the parts of the body that are grossly soiled.

Close eyes and mouth, straighten body and apply shroud. Attach ID bracelets to ankle and wrist, as per normal procedure.

Place body in a body bag and arrange for collection. Body bags to be supplied by Ward.

A 'danger of infection' label should be secured to the outside of the body bag and the Mortuary staff should be made aware of the Communicable Disease.

5.6 Accident and Emergency (A & E) and Deaths in Non Clinical Areas

Patients should be transferred directly to the mortuary. As these deaths are often classed as 'sudden deaths' they will be subject to coronial investigation. The patient should not be washed or clothing changed.

All lines (cannula) MUST remain in situ, especially as the patient may be subject to a post mortem/ referral to Her Majesty's Coroner.

In the event of the patient's name not being known then a patient number should be allocated by the A& E dept.

Children under 16 years of age and babies must NOT be taken directly to the Mortuary. They must always be taken into the Emergency Department even if active resuscitation is not being undertaken.

5.7 Patients Brought In Who Are Already Deceased

If the patient is confirmed dead on arrival and has been identified formally they can be transferred directly to the mortuary once they have been issued with an A&E number. Ensure completion of identity bracelets.

If the patient is confirmed dead on arrival and has not been identified formally they can still be transferred directly to the Mortuary following issue of an unidentified patient number. Ensure completion of identity bracelets is undertaken with care.

If the patient has died and has been transferred directly to the mortuary, A&E will receive any relatives who may be coming to the hospital.

If the patient is being actively resuscitated in the ambulance they should be transferred to the resuscitation bay within the Emergency Department when it is safe and appropriate to do so. If the patient subsequently dies standard last offices should be performed.

If the identity or next of kin is not known, the Police may be asked to trace relatives/next of kin.

If, however, the Police arrive without an appointment and wish to view a body in the mortuary during normal working hours and no relatives are present, the mortuary technician and Coroner's officer should be contacted to arrange a

viewing. (All Coroners officers are based at Crook, Co. Durham and can be contacted on: 03000 267649).

Outside normal working hours, the on- call mortuary technician should be called (via switchboard) and requested to prepare the body for viewing by the Police. (Sufficient travel time should be allowed for the on-call mortuary technician to arrive and prepare the body).

5.8 Deaths Thought To Have Been As A Result Of Crime

The patient should not be washed following confirmation of death until the Police officers have seen and photographed the body.

Any clothing removed from the patient during or following the resuscitation attempt must be placed in individual brown paper bags. The Police will collect and sign for these.

All further instructions are taken from the Senior CID officer.

5.9 Death in Theatre

Whenever a patient dies suddenly or unexpectedly in the perioperative environment there may be a legal requirement to establish the cause of death by a post mortem. The theatre staff may also be expected to care for deceased patients following organ retrieval. Where possible, the requirement of different faiths or religions must be taken into consideration, after negotiation of the overriding clinical and legal considerations, and the duty of care to other patients in the department.

If a death occurs, the Theatre Manager or the senior staff member in charge must be informed as soon as possible.

It is the responsibility of the medical staff to inform their colleagues as appropriate.

The duty Chaplain can be contacted to provide a link to local religious representatives for deceased patients who do not have or cannot contact any relatives for help and advice regarding procedures at death.

Support for staff can be provided by the Chaplaincy where necessary.

The Coroner will need to be informed of the death (All Coroners officers are based at Crook, Co. Durham and can be contacted on: 03000 267649.) This will be determined by the medical staff in charge of the deceased's care. Please link to policy on Consent for Post Mortem Examination and Retention and Use of Organs.

A Safeguard (incident report) should be submitted by the anesthetist or surgeon and graded appropriately.

5.10 Removal of the Deceased from the Trust within 24 Hours of Death

To comply with certain religious and cultural beliefs it may be necessary to remove the body from the Trust within 24 hours of death. In such cases the following should be carried out:

5.11 Non Coroner Cases

If the death occurs within working hours contact the Service Manager as a priority. If the death occurs out of hours contact the Duty Manager. They will inform you of the availability of the local registrar.

Please note that this service is not for relatives who wish to arrange a cremation

Medical Certificates of Cause of Death can only be signed by a doctor who knows the patient, i.e. has seen the patient in the previous fourteen days.

Since the team on duty over a weekend or bank holiday may not know the patient, it would be advisable that a pre-weekend hand over to the on-call team identifies patients who may die, so that a member of the on-call team can review the patient in anticipation, whilst still alive.

Muslim patients who are being removed from the hospital by relatives MUST be taken through the mortuary prior to release. The body should only be released by mortuary staff (and not via any other means).

5.12 Viewing in Mortuary (Viewing Room)

Once the deceased has been taken to the mortuary, family and friends of the deceased may wish to have a further viewing. Ideally this should occur at the funeral directors. However, next of kin should be made aware that a viewing of the deceased may be possible in the viewing room of the mortuary.

The family must make the necessary arrangements for a viewing, by liaising with the Mortuary (during normal working hours) (DMH: 01325 743594, UHND 0191 3332300) or via switchboard outside working hours.

Viewing appointments are available 7 days a week.

An appointment to view patients who are brought in dead should also be made via switchboard. No family members should attend the mortuary for a viewing without an appointment.

The mortuary technician should check that the deceased is the correct patient, and has been suitably prepared and cleaned for viewing before taking relatives in to view.

5.13 Support for Family and Friends

It is desirable that ALL staff dealing with the recently bereaved receive updates with regard to both the practical procedures and the provision of emotional support for the dying and the bereaved. The bereavement support officers can assist.

Where possible, private facilities should be made available for the bereaved, which are suitable for children, if necessary. Refreshments should be provided.

If there are strong indications that bereaved relatives are in particular distress, and if they give permission for a referral to the Chaplaincy, the duty chaplain can be contacted at any time, via switchboard.

Copies of the Trust ‘Coping with Grief, Loss & Bereavement’ Leaflet (Appendix B) are held on each ward or department and should be made available to the

relatives/next of kin of the deceased. All deceased families should be given the Bereavement booklet 'Information and Advice for the Bereaved'.

5.14 Completion of the Medical Certificate of Death or Coroner Referral

Every deceased patient must have a Medical Certificate of Cause of Death, completed by the medical officer as soon as possible and at the latest on the next working day, provided the doctor has seen the patient within 14 days prior to death. If the death needs referring to the coroner for any reason the Referral to coroner form can be found on the Trust Intranet POL/NUR/0002 (Reporting Death to the Coroner Policy). Referral should be completed and emailed to the coroner's office as soon as possible / within 24 hours and a copy placed on the front of the notes.

A Notification of Death form should be attached to the Medical Notes, stating the patient's name, date and time of death, ward and patient's consultant. The form remains on the front of the medical notes.

When a death occurs during the day, doctors should complete the Medical Certificate of Cause of Death and Cremation Form with the minimum of delay. The Cremation Form should then be delivered by hand by the Doctor to the Mortuary. This allows the doctor to view the deceased for identification purposes, a legal requirement of the cremation process, and also to check for the presence of any implanted devices. Every effort should be made to ensure that the Medical Certificate is completed before the relatives arrive to collect it. If the house officer is not available, another member of the medical team should be approached.

5.15 Hospital Post Mortem

Where further information about the patient's condition is required/requested, including for teaching and research purposes, then a hospital post-mortem examination may be performed, but only after receipt of written consent. Post-mortem requests are made to the relatives by the medical staff or may be made by the family. Medical staff are to contact the Pathologist on duty prior to consent to determine implications that need to be discussed. It is recommended that a third party (such as a senior trained nurse, chaplain or bereavement officer) be present.

If the next of kin agrees, the necessary consent form is completed and witnessed by the consenting medical officer. A copy of this consent form is placed in the medical case notes, and agreement or refusal is recorded in the patient's case notes. Relatives must be advised that if a hospital post mortem is to go ahead then the funeral may be delayed.

Cultural or religious beliefs may affect the relatives' decision, and both awareness and acknowledgement of these may be of help to grieving relatives.

See Appendix C – Care after Death for Different Faiths

If a death is to be reported to the Coroner, there is no need to ask for the relatives' permission for post-mortem. This is the Coroner's prerogative and his officer will speak to the relatives about this. (All Coroners officers are based at Crook, Co. Durham and can be contacted on: 03000 267649)

Under no circumstances may a ward/department doctor sign the Medical Certificate of Cause of Death conditionally upon permission being granted for a post mortem examination.

In cases of cremation, it is necessary for the Medical staff to complete the Cremation Certificate when they complete the MCCD.

5.16 The Coroner

(All Coroners officers are based at Crook, Co. Durham and can be contacted on: 03000 267649).

The Coroner is required by law to inquire into violent or unnatural death of which the cause is unknown.

Only the Coroner may authorise a Certificate of Death after a Coroner's post-mortem examination. The Coroner will also deal with all the paperwork, including the Certificate for burial/cremation.

To contact the Coroner call 03000 267649

The following points indicate the circumstances in which a report to the Coroner should be made:

Abortions: Death after natural spontaneous abortion must always be reported.

Accidents: Death following an accident – whether it occurred at home, at work, while travelling or during sport – must always be reported. NB The most common accidental cause of death is fracture of the neck of the femur in elderly persons.

Anaesthetics: Deaths apparently solely due to the anaesthetic must be reported to the Coroner.

No Cause of Death: most common reason for calling the Coroner

Cot death: The Coroner must be informed in the case of a cot death, which would be considered to be a sudden death; the cause of which is unknown.

Drugs Death: from drugs taken for any reason (in therapy, in addiction or suicidally) must be reported. Bone marrow aplasia or liver necrosis suspected to be due to drugs should form the basis of a report to the Coroner. Accidental overdose of drugs is rare, but must be reported.

Industrial Death: Due to any industrial disease, poisoning or accident must be referred to the Coroner.

Medical Mishaps: Death caused by an operative error, whether the death occurs on the operating table or in the ward afterwards, must always be reported. Most post-operative deaths are cleared by the Coroner without an inquest, unless there is evidence of error. Complaints by relatives that there has been negligence in treatment should always be referred to the Coroner if death ensues. Usually this is protection for the doctor.

Poisonings: Deaths from poisoning - accidental, suicidal, homicidal or in industry - should be reported.

Prisoners: If a person serving a prison sentence has been transferred to hospital for treatment, his death – even if from natural causes – should be referred to the Coroner

Suicide: Death from suicide by any means should be reported to the Coroner.

6 DEFINITIONS

Certification – a legal process involving the completion of paperwork that can only be undertaken by a doctor who attended the deceased during their last illness.

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.)

Expected Death – it has been predicted that the patient will die and the patient has a fully completed valid Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Decision recorded.

Next-of-Kin: This term is used to cover relatives, friends and carers of the deceased

Verification of Expected Death – the formal confirmation, by a competent medical or non-medical practitioner, that a patient has died.

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.)

Unexpected Death – death has not been predicted and a post mortem may be required.

7 DISSEMINATION ARRANGEMENTS

This Policy is for the attention of all clinical staff who may be expected to carry out Care after Death duties.

8 MONITORING

Monitoring Criterion	Use of checklist for care after death
Who will perform the monitoring?	Senior Nurse/Heads of Service and Matrons/Team Leads
What are you monitoring?	Any rise in incident reporting with an identified adverse outcome in agreed process.
When will you be monitoring?	All of the above issues will be subject to on-going monitoring
How are you going to monitor?	Maintain a record any untoward incidents
What will happen if any shortfalls are identified?	If deficiencies are identified the Care Groups risk management and audit forums will receive a report and action plan from the Senior Nurses identifying the process for improvement action
Where will the results of the monitoring be reported	The Care Groups risk management and audit forums will receive assurance from the

	Senior Nurses that appropriate action has been taken.
How will the resulting action plan be progressed and monitored?	The Matrons/Team Leads will implement action plans. Progress will be monitored at the Care Groups risk management and audit forums
How will learning take place?	The action plan will be monitored by the Care Groups risk management and audit forums with updates provided to the Clinical Standards and Therapeutics Committee

9 REFERENCES

This Policy refers to the following CDDFT Trust policies and procedures:

- Chaplaincy Policy POL/CHAPS/0004
- The Verification of Death by a Registered Health Professional POL/NQ/0047

This Policy refers to the following guidance, including national and international standards:

- National End of Life Care Programme & Royal College of Nursing (2012) Guidance for staff responsible for care after death
- Department of Health (2006) Care and Respect in Death: Good Practice Guidance for NHS Mortuary Staff. HMSO

10 APPENDICES

Appendix A – Trust Care After Death Checklist
Appendix B - Trust Coping with Grief, Loss & Bereavement
Appendix C: Final Care for Different Faiths and Beliefs
Appendix D: Mortuary Identification Form
Appendix E: CQC Statutory notification about the death of a person detained or liable to be detained under the Mental Health Act 1983
Appendix F: Equality Impact Assessment

10.1 Appendix A: Trust Care after Death Checklist

CHECKLIST FOR CARE AFTER DEATH

Action	Completed √ or X	Signature	Designation	Date
Inform Medical Staff or Nurse trained to verify death				
Inform Next of Kin				
Close deceased patients eyes DO NOT USE TAPE (cover with saline soaked cotton pads for corneal / eye donation)				
Replace dentures if possible, if not send to Mortuary in labelled pot.				
Remove jewellery if requested by family and record on property form. Secure any specific jewellery item left on deceased with tape and document on mortuary ID form.				
Pack deceased patients belongings neatly into a bereavement bag. Place any dirty/soiled belongings into a red bag first, tie off and place in a further green bag. Label bag with the patients details				
Wash the deceased patient (unless for coronial investigation)				
Action	**Completed** **√ or X**	**Signature**	**Designation**	**Date**

Apply identification bands x 2. • Wrist • Ankle Make sure ID band is visible around wrist. If there is significant lower limb oedema or in cases of amputation place ID bands on both wrists or ankles				
Dress patient in shroud or own clothes if family have requested it. (Do not change patient's clothes if the death requires coronial investigation)				
Place continence pants onto the patient and lie patient on absorbent pad				
Place deceased patients in a clean sheet for transfer				
Complete the mortuary identification form ensuring that it is given to the porters collecting the deceased to place in the plastic wallet				
If patient is high infection risk, place in body bag and label route of infection clearly (A sheet is not required if a body bag is to be used)				
If patient is leaking after death place in a body bag with absorbent pads in the base of the bag and continence pants on the patient				
Complete all nursing documentation				
Request removal of patient to Mortuary				

10.2 Appendix B: Trust Coping with Grief, Loss & Bereavement

COPING WITH GRIEF, LOSS AND BEREAVEMENT

Coping with the news that someone we know is dying or the death of someone close to us is a very personal experience, no two people will experience the same feelings and there are no right or wrong ways to cope.

Grieving following a loss is a natural process, it's a normal and often painful journey, which allows us to adapt to life without the person.

What reactions might I experience/ feel and how can I cope with them?

There are many different reactions you could experience. We will try and explain some of the more common reactions so if whilst reading this, you realise that you have felt, or are feeling some or all of these, be reassured that this is normal.

Numbness, shock and disbelief even though the death was perhaps expected it will still come as a shock to you when it happens.

You may feel that it hasn't really happened; you may find yourself either not being able to cry and /or 'throwing yourself' into the practicalities following the death, or you may find yourself crying uncontrollably and/or reliving the last few months, days or hours leading to the death.

These are all normal reactions and how you cope with them is right for you, but remember ***you are not on your own*** so use the support and help of those closest to you, as it will also help them through this difficult time.

Anger, guilt and fear - You may find that you have strong feelings of anger because you have been left on your own, or because you didn't get a chance to say how you really felt, or perhaps to say goodbye.

You may feel guilty as it may be a relief to you and those around you that the person has died; or because you may feel you should have said / done something but didn't and now cannot.

You may experience fear of the unknown: 'How am I going to manage and cope on my own?' 'What do I do now?' Doing things and going places for the first time on your own are some of the hardest things you'll do. Give yourself time and remember the support you have around you. During the first year significant dates and events may also be difficult times for you.

Loneliness–Nobody but you truly understands how you are feeling at this moment in time. You do need time on your own to work through your feelings and emotions, but remember that those closest to you and to the person who died will also be experiencing similar feelings in their own way. Talking together about the person who has died and how you are feeling can help you all.

Crying and talking – are two of our natural ways of coping with emotional, physical and psychological issues that we encounter in life. It cannot be underestimated how these can help you work through the grieving process. There is no shame in crying when you have lost someone close to you.

Help and Support – Many people find that, with the help and support of friends and family, they can cope with their emotions.

However, sometimes you can feel so distressed, either through depression or anxiety or both, that more help is required.

There are lots of avenues of help.

Never feel shy about discussing your feelings with your GP who, if appropriate, can refer you onto a counselling service or can provide you with information on bereavement services.

Your local priest, vicar, minister, or faith leader would also be available for you to talk through your feelings, particularly if you made contact with them at the time of the funeral.

There are other organisations that can also provide you with support, their contact details numbers are listed below.

Age Concern 0800 009966

British organ Donor Society 01223 893636

(Self help group for families of organ donors and for those who have received organs)

BACUP 0800 8001234
(British Association of Cancer United Patients)

Child Death Helpline 0800 282986

Citizens Advice Bureau

Darlington 01325 254848

Bishop Auckland 01388 606661

Durham 0191 384 2638

CRUSE 01429 824141

SOBS Survivors of Bereavement by Suicide 0300 111 5065

Macmillan Information and Support Centres

0191 333 2815

01207 594660

0191 3876303

Samaritans 0845 7909090

Reviewed and reformatted: June 2013
Review date: October 2016
Responsibility for review: Chaplaincy UHND/ Macmillan information and support centre
Leaflet reference: PIL/CG/0095
Version: 2.0

10.3 Appendix C: Final Care for Different Faiths and Beliefs

Final Care for Different Faiths and Beliefs

Bahai

The body of the deceased should be treated with respect. Bahai relatives may wish to say prayers for the deceased person, but normal final care performed by nursing staff is quite acceptable.

Bahai adherents may not be cremated or embalmed, nor may they be buried more than an hour's journey from the place of death. A special ring will be placed on the finger of the patient and should not be removed. Bahais have no objection to post-mortem examination and may leave their bodies to scientific research or donate organs if they wish.

Buddhism

There is no prescribed ritual for the handling of the corpse of a Buddhist person, so customary laying out is appropriate. However, a request may be made for a Buddhist monk or nun to be present.

As there are a number of different schools of Buddhism, relatives should be contacted for advice as some sects have strong views on how the body should be treated. When the patient dies, inform the monk or nun if required (the patient's relatives often take this step). The body should not be moved for at least one hour if prayers are to be said. There are unlikely to be objections to post-mortem examination and organ donation, although some Far Eastern Buddhists may object to this. The patient's body should be wrapped in an unmarked sheet. Cremation is preferred.

Christianity

There are many denominations and degrees of adherence within the Christian faith.

In most cases customary final care is acceptable. Relatives may wish staff to call the hospital chaplain, or minister or priest from their own church to either perform last rites or say prayers. Some Roman Catholic families may wish to place a rosary in the deceased patient's hands and/or a crucifix at the patient's head. Some orthodox families may wish to place an icon (holy picture) at either side of the patient's head.

Hinduism

If required by relatives, inform the family priest or one from the local temple. If unavailable, relatives may wish to read from the Bhagavad Gita or make a request that staff read extracts during final care. The family may wish to carry out or assist with final care and may request that the patient is dressed in his or her own clothes. If possible, the eldest son should be present.

A Hindu may like to have leaves of the sacred Tulsi plant and Ganges water placed in his/her mouth by relatives before death. It is therefore imperative that relatives are warned that the patient's death is imminent. Relatives of the same sex as the patient may wish to wash his or

her body, preferably in water mixed with water from the River Ganges. If no relatives are present, nursing staff of the same sex as the patient should wear gloves and apron and then straighten the body, close the eyes and support the jaw before wrapping in a sheet. The body should not be washed. Do not remove sacred threads or jewellery. The patient's family may request that the patient be placed on the floor and they may wish to burn incense, therefore arrangements should be made for this to happen if requested. The patient is usually cremated as soon as possible after death. Post-mortems are viewed as disrespectful to the deceased person, so are only carried out when strictly necessary. Consult the wishes of the family before touching the body.

Jehovah's Witness

Routine final care is appropriate. Relatives may wish to be present during final care, either to pray or to read from the Bible. The family will inform staff should there be any special requirements, which may vary according to the patient's country of origin. Jehovah's Witnesses usually refuse post-mortem unless absolutely necessary. Organ donation may be acceptable.

Jainism

The relatives of a Jainist patient may wish to contact their priest to recite prayers with the patient and family. The family may wish to be present during final care and also to assist with washing. Not all families will want to perform this task however. The family may ask for the patient to be clothed in a plain white gown or shroud with no pattern or ornament and then wrapped in a plain white sheet. They may provide the gown themselves. Post-mortems may be seen as disrespectful, depending on the degree of orthodoxy of the patient. Organ donation is acceptable. Cremation is arranged whenever possible within 24 hours of death.

Orthodox Jains may have chosen the path of Sallekhana, that is, death by ritual fasting. Sallekhana is rarely practised today although it may still have an influence on the Jain attitude to death.

Judaism

The family will contact their own Rabbi if they have one. If not, the hospital chaplaincy will advise. Prayers are recited by those present. Traditionally the body is left for about 8 minutes before being moved while a feather is placed across the lips and nose to detect any signs of breath. Usually close relatives will straighten the body, but nursing staff are permitted to perform any procedure for preserving dignity and honour. Wearing gloves, the body should be handled as little as possible but nurses may:

a. Close the eyes
b. Close the jaw
c. Put the arms parallel and close to the sides of the body leaving the hands open. Straighten the patient's legs
d. Remove tubes unless contraindicated

Patients must not be washed and should remain in the clothes in which they died. The body will be washed by a nominated group, the Holy Assembly, which performs a ritual

purification. Watchers stay with the body until burial (normally completed within 24 hours of death). In the period before burial a separate non-denominational room is appreciated, where the body can be placed with its feet towards the door. It is not possible for funerals to take place on the Sabbath (between sunset on Friday and sunset on Saturday). If death occurs during the Sabbath, the body will remain with the watchers until the end of the Sabbath. Advice should be sought from the relatives. In some areas, the Registrar's office will arrange to open on Sundays and Bank Holidays to allow for the registration of death where speedy burial is required for religious reasons. The Jewish Burial Society will know whether this service is offered in the local area. Post-mortems are permitted only if required by law. Organ donation is sometimes permitted. Cremation is unlikely but some non-orthodox Jews are now accepting this in preference to burial.

Mormon (Church of Jesus Christ of the Latter Day Saints)

There are no special requirements, but relatives may wish to be present during final care. Relatives will advise staff if the patient wears a one or two piece sacred undergarment. If this is the case, relatives will dress the patient in these items.

Muslim

Where possible, the patient's bed should be turned so that their body (head first) is facing Mecca. If the patient's bed cannot be moved, then the patient can be turned on to their right side so that the deceased's face is facing towards Mecca. Many Muslims object to the body being touched by someone of a different faith or opposite sex. If no family members are present, wear gloves and close the patient's eyes, support the jaw and straighten the body. The head should be turned to the right shoulder and the body covered with a plain white sheet. The body should not be washed nor the nails cut. The patient's body is normally either taken home or taken to a mosque as soon as possible to be washed by another Muslim of the same sex. Burial takes place preferably within 24 hours of death. Cremation is forbidden. Post-mortems are permitted only if required by law. Organ donation is not always encouraged although in the UK, a Fatwa (religious verdict) was given by the UK Muslim Law Council which now encourages Muslims to donate organs.

Rastafarian

Customary final care is appropriate, although the patient's family may wish to be present during the preparation of the body to say prayers. Permission for organ donation is unlikely and post-mortems will be refused unless absolutely necessary.

Sikhism

Family members (especially the eldest son) and friends will be present if they are able. Usually the family takes responsibility for final care, but nursing staff may be asked to close the patient's eyes, support the jaw, straighten the body and wrap it in a plain white sheet.

Do not remove the '5 Ks', which are personal objects sacred to the Sikhs:

- **Kesh**: do not cut hair or beard or remove turban.
- **Kanga**: do not remove the semi-circular comb, which fixes the uncut hair.

- **Kara**: do not remove bracelet worn on the wrist.
- **Kaccha**: do not remove the special shorts worn as underwear.
- **Kirpan**: do not remove the sword: usually a miniature sword is worn.

The family will wash and dress the deceased person's body. Post-mortems are only permitted if required by law. Sikhs are always cremated. Organ donation is permitted but some Sikhs refuse this as they do not wish the body to be mutilated.

Zoroastrian

Customary final care is often acceptable to Zoroastrian patients. The family may wish to be present during, or participate in, the preparation of the body. Orthodox Parsees require a priest to be present, if possible.

After washing, the body is dressed in the Sadra (white cotton or muslin shirt symbolizing purity) and Kusti (girdle woven of 72 strands of lambs' wool symbolizing the 72 chapters of the Yasna (Liturgy)). Relatives may cover the patient's head with a white cap or scarf. It is important that the funeral takes place as soon as possible after death. Burial and cremation are acceptable. Post-mortems are forbidden unless required by law. Organ donation is forbidden by religious law.

10.4 Appendix D: Mortuary Identification Form

County Durham and Darlington NHS
NHS Foundation Trust

A. For use by Ward Staff / Funeral Service

Ward / Funeral Service……

Name

Address

ADDRESSOGRAPH

DoB

Unit No.

NHS Number. / /

Valuables / Jewellery

Clothing / Shroud / Nightwear

If none, state none

Date & time of death..... Id bracelets in situ: yes / no PC number yes / no

Body bag used: yes / no Reason: Leakage / infection State infection…….....……

Hazardous Implantable device in situ: yes / no Type: Pacemaker /ICD/Loop Recorder/Other……...…

Medical Device in situ: yes / no Catheter/Cannula/Butterfly/Other……..……

State site of device……..……...

……

Current Radioactive Treatment: yes / no / NK

Dentures in situ yes / no / NA

Care after death performed by 1)……. 2)……

Staff member completing form (Print name)……...…… Designation……....

Signed……..……..…Date & time…….....…….……..

B. For use by Portering Services

Transferred to Mortuary. Date & time:……..……..…

Porter No 1: Print name……..……..…… Signed ……..……

Porter No 2: Print name ...……...… Signed ……..……

All sections of this form must be completed in full

Mortuary Patient Information

Name……..… Date of Birth……...……

Presentation of patient on arrival in mortuary / Remedial action taken: e.g. pad/pants changed OR packing needed

……..……

……

Height……x…… ……cm Weight……kg

C. For use by Mortuary Staff

Identity checked: yes / no Valuables checked: yes / not applicable

Name…… Date & time……..…..……...……

D. Information for Funeral Directors - Pacemakers

- The patient does **not** have a pacemaker.
- The patient does have a pacemaker and this does not require removal. (Burial).
- The patient does have a pacemaker and this will be removed by the funeral service.
- The patient had a pacemaker but it was removed at post mortem.
- The patient has an ICD, and this has been deactivated to make it safe for your removal.
- The patient had a pacemaker, and it was removed by mortuary staff on gaining consent.

E. For use of the Funeral Director's Representative

3 types of identity checked: yes / no Valuables checked: yes / no / not applicable

I confirm that I am acting on behalf of the patient's representative, and have the authorisation to remove the deceased into our care, and I am aware of the pacemaker status.

Name of firm……...…….

Name of representative - Print and sign……..

Mortuary countersignature……..…...… Date & time……...…….

Acceptable presentation of patient: yes / no If No state reason why…….……..

……

Disposal: Cremation Burial Part A GP HMC Inquest no PM Other……..

All sections of this form MUST be completed in full.

10.5 Appendix E: CQC Statutory notification about the death of a person APPENDIX E etained or liable to be detained under the Mental Health Act 1983

Death of a person detained or liable to be detained under the Mental Health Act 1983
RESTRICTED information

Death Notification reference:

Statutory notification about the death of a person detained or liable to be detained under the Mental Health Act 1983

Care Quality Commission (Registration) Regulations 2009 Regulation 17

Guidance on the completion of this form
From 1 April 2010, NHS service providers will be required to make notifications about the death of a patient who is detained or liable to be detained as a condition of registration under the Health and Social Care Act 2008. For independent service providers, such notifications are requirement of registration from 1 October 2010. However, prior to that date, CQC will continue to require such notifications under general powers provided to it under the Mental Health Act 1983, Section 120.

You must provide information in the mandatory sections (marked*). Please also provide all other requested information. **Forms must be submitted as soon as possible after the incident.**

Type all entries where possible and enter dates in the format dd/mm/yyyy

To be forwarded to the Commission by fax or secure email within three working days of the death. This form can be emailed **VIA NHS.NET ONLY** by arrangement with the Mental Health Operations Team by calling number below. Any failure to ensure that its transmission meets current standards for secure delivery of confidential patient identifiable material will be the responsibility of the sender. It is the responsibility of the detaining/responsible authority to ensure this form is completed and sent.

Tel: 0115 873 6250 Fax: 0148 477 2179

A. Detaining or responsible authority *		
Name/Address of Trust	Name/Address of Purchaser	
Name/Address of Hospital	Ward	Approved Clinician

B. Details of deceased *	
Name	
Date of Birth	Date of Admission
Section	Date of Section
Ethnicity	Gender
C. Circumstances of death	
Date & Time of Death (If known)	Place of death
Time & place patient last seen alive by staff	How death occurred (if known)
Level of observation at time (please specify)	Certified Cause of Death if known
Has Coroner been informed	If so, name and contact telephone number
Have police been informed	If so, name and contact telephone number
D. Other information	
Psychiatric Diagnosis	
All medication at time of death (drug by name & dosage)	
Regular	PRN
Was the patient consenting?	
Was a statutory form certifying treatment in place at the time of death? If so, please describe which form? If not, please confirm the circumstances? (e.g. Within the 3 month/1 month (CTO) period)	
Was ECT given in previous 14 days?	
Please give details of any of the following for the 7 days preceding the death	
Was the patient in Seclusion/Time Out?	

Any incident of Control or Restraint?		
Any incidents of physical self-harm?		
Any record of untoward incidents?		
Was the patient on Section 17 leave at the time of the death?	Was the patient AWOL at the time of the death?	Did the patient die on a medical ward? If so please give details
Any other relevant information		
Contact Details (Please provide the name and professional status of the person who can be contacted about the content of this form if required):		
Contact Telephone Number:		Date:

10.6 Appendix F: Equality Impact Assessment

Equality Analysis / Impact Assessment

EAIA Assessment Form **v3/2013**

Division/Department:	Nursing & Transformation
Title of policy, procedure, decision, project, function or service:	Care after Death Policy
Lead person responsible:	Joanne Todd
People involved with completing this:	Head of Unscheduled Care Chaplain Lead for Cellular Science – Pathology Mortuary Technicians Matrons -

Type of policy, procedure, decision, project, function or service:

Existing	☐
New/proposed	✓
Changed	☐

Date Completed:	4th August 2014

Step 1 – Scoping your analysis

What is the aim of your policy, procedure, project, decision, function or service and how does it relate to equality?

The policy describes the standard of care and service that the deceased and their next-of-kin can expect, from before death to when the deceased is released from County Durham & Darlington NHS Foundation Trust (the Trust), facilitating the Trust's compliance with legislative requirements.

This policy aims to ensure that the deceased patient is cared for with:

- Compassion
- Confidentiality
- Privacy
- Respect

Who is the policy, procedure, project, decision, function or service going to benefit and how?

Clinical staff will benefit as the policy will provide a framework to ensure Care after Death is delivered consistently across the whole organisation.

The policy will also ensure that next of kin/family members are treated with dignity and respect on the loss of a loved one

The policy will outline how differing religions require different approaches after death and therefore will benefit all patients irrespective of religious beliefs

What barriers are there to achieving these outcomes?

Lack of knowledge amongst staff about what different religions expect care after death to be

How will you put your policy, procedure, project, decision, function or service into practice?

Policy will be available on Trust intranet.

Policy will be highlighted in Trust Bulletin

Does this policy link, align or conflict with any other policy, procedure, project, decision, function or service?

1. Chaplaincy Policy (POL/CHAPS/0004) 2. The Verification of Death by a Registered Health Professional (POL/NQ/47) 3. National End of Life Care Programme & Royal College of Nursing (2012) Guidance for staff responsible for care after death 4. Department of Health (2006) Care and Respect in Death: Good Practice Guidance for NHS Mortuary Staff. HMSO

Step 2 – Collecting your information

What existing information / data do you have?

National End of Life Care Programme & Royal College of Nursing (2012) Guidance for staff responsible for care after death Department of Health (2006) Care and Respect in Death: Good Practice Guidance for NHS Mortuary Staff. HMSO

Who have you consulted with?

Associate Directors of Nursing Head of Unscheduled Care Mortuary Technicians Cellular Pathology Manager

What are the gaps and how do you plan to collect what is missing?

None

Step 3 – What is the impact?

Using the information from Step 2 explain if there is an impact or potential for impact on staff or people in the community with characteristics protected under the Equality Act 2010?

Ethnicity or Race

Positive impact for patients from a diverse range of religious backgrounds

Sex/Gender

None

Age

None

Disability

None

Religion or Belief

Positive impact for patients from a diverse range of religious backgrounds as guidance is given on how to treat the patient after death

Sexual Orientation

None

Marriage and Civil Partnership (applies to workforce issues only)

None

Pregnancy and Maternity

None

Gender Reassignment

None

Other socially excluded groups or communities e.g. rural community, socially excluded, carers, areas of deprivation, low literacy skills etc.

None

Step 4 – What are the differences?

Are any groups affected in a different way to others as a result of the policy, procedure, project, decision, function or service?

No

Does your policy, procedure, project, decision, function or service discriminate against anyone with characteristics protected under the Equality Act 2010?

Yes ☐ **No** ✓

If yes, explain the justification for this. If it cannot be justified, how are you going to change it to remove or mitigate the affect?

Step 5 – Make a decision based on steps 2 - 4

If you are in a position to introduce the policy, procedure, project, decision, function or service? Clearly show how this has been decided.

Policy will be ratified at Quality and Healthcare Governance Committee

If you are in a position to introduce the policy, procedure, project, decision, function or service, but still have information to collect, changes to make or actions to complete to ensure all people affected have been covered please list:

How are you going to monitor this policy, procedure, project or service, how often and who will be responsible?

See page 15 Monitoring Compliance

Step 6 – Completion and central collation

Once completed this Equality Analysis form must be forwarded to Jillian Wilkins, Equality and Diversity Lead. jillian.wilkins@cddft.nhs.uk and must be attached to any documentation to which it relates.