Princess Alice Hospice

Care Before and After Death Policy (C15)

Policy Summary
A key goal of palliative care is the achievement of the best quality of life for patients and their families which includes end of life care and support in bereavement.

Document Detail	
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Author	In-Patient Unit Manager
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Relevant external law, regulation, standards	Mental Capacity Act (2005)

Change History		
Date	Change details, since approval	Approved by

1. Scope

1.1 This Policy applies to all employees and appropriate volunteers who care for patients before and after death.

1.2 The policy covers the period leading up to death and the time immediately after and all the issues which need to be dealt with surrounding the death of a patient at the Princess Alice Hospice (the Hospice).

1.3 We will conform with all requirements covering the care of patients before and after death, including those with external partners.

2. Rationale

2.1 A key goal of palliative care is the achievement of the best quality of life for patients and their families which includes end of life care and support in bereavement.

2.2 For the relatives and friends the nature of a loved one's death may have long term implications on their bereavement and future mental health.

3. Principles

3.1 The impact on our diverse population and our employees and volunteers has been considered and reviewed according to the principles laid down in the Policy on Policies.

3.2 Palliative care regards dying as a normal process. The quality of dying for patients includes being free of symptoms and remaining in control over as many aspects of their life as possible.

3.3 At all times patients and their families will be treated with dignity and respect.

4. Duties

See Appendices 1 - 10 for detailed procedures.

4.1 Nurse in Charge of the Team

4.1.1 Ensures that every patient who is felt to have entered the last 48 hours has an End of Life Care plan completed (Appendix 1) and an updated entry to this effect on Crosscare.

4.1.2 Ensures information (Bereavement Pack 1 and/or 2) is given to patients and relatives in an appropriate manner and at the appropriate time and entered on Crosscare under care record.

4.1.3 Ensures all care for patients comfort is maximised.

4.1.4 Informs the doctor in a timely manner when a patient dies, depending on whether the death is expected or unexpected.

4.1.5 Ensures care and dignity is afforded to the patient after death as in life.

4.1.6 Ensures relevant documentation is completed for verification of death.

4.1.7 Ensures all patient belongings are carefully sorted, soiled belongings sent to the laundry and returned, and all packed neatly and listed in the property book ready to return to the patient representative/family member.

4.1.8 Makes an appointment for the patient's representative to collect the medical certificate and property as soon as practically possible taking into account weekends and bank holidays and the time that the medical team may require to complete the certificate.

4.2 **Medical employees**

4.2.1 A doctor who has previously seen the patient must complete the medical cause of death certificate and cremation form, if required, within 24 hours of occurrence or as soon as possible after a weekend or a bank holiday.

4.2.2 If a patient has an Intra Cardiac Device (ICD) and the shock mode of the ICD has not been deactivated before the patient's death, the cardiac physiologist must be contacted to deactivate it before the device can be removed prior to cremation.

4.2.3 Discussion as required with the family any reasons why referral to the coroner or possibility of a post-mortem may be required.

4.3 **The multidisciplinary team**

4.3.1 Assists the patient to prepare for their death, taking into account the individual needs of each patient.

4.3.2 Recognises and facilitates advance care planning taking into account the circumstances of each patient.

4.3.3 Provides holistic support to families before death and into the bereavement period.

4.4 **IPU Clinical Administrator**

4.4.1 Ensures all documentation eg medical certificate of cause of death and cremation papers are completed in a timely way.

4.4.2 Liaises with funeral directors to organise collection of the body.

5. Policy

5.1 We strive to ensure that relevant employees, volunteers, patients and their families are adequately prepared and supported for a patient's impending death.

5.2 We strive to ensure that a dignified and appropriate environment is maintained for the patient who is dying and for their families after death.

6. Monitoring and assurance of this Policy

Audit Components	Audit Measure	Responsibility of:
a) All clinical employees and appropriate volunteers are aware of and adhere to policy	Survey compliance with the policy	IPU Manager
b) Information on patient's personal representative and instructions for contact is available	Patient's record	IPU Manager
c) The Testamentary capacity form is used when PAH is required/requested to	Patient assessed by Consultant and recorded in patient's notes	Medical Consultant

assess the patient's testamentary capacity		
d) Only registered nurses can verify death	Patient's record	Registered nurse/IPU Manager
e) The named nurse ensures handover of death certificate and property in a sensitive manner	Patient's record Carer Audit	Named nurse/IPU Manager

7. Definition of Terms Used

Policy: is a written commitment stating our aims and acceptable practice.

Procedure: is a step by step account of how to implement a particular policy or part of a policy.

Guidelines: are practical instructions and should usually be followed.

Working Groups: comprise interested and appointed employees who draft and review specific policies and procedures.

Verification: establish truth or correctness of by examination.

Certification: document formally attesting fact.

8. Supporting documents

8.1 The policy standards will be met through working procedures, protocols, guidance, standards.

8.2 The supporting documents will not form part of the policy but are listed below with links to their *dovenet* location and identification of the owner, author and approving authority.

8.3 List of supporting policies

Document	Owner	Author	*dovenet* location	Approving authority
Patient's Property Policy (C4)	Director of Patient Care & Strategic Development	IPU Manager		

Affix PAH patient label here

Princess Alice Hospice

Appendix 1

PERSONALISED END OF LIFE CARE PLANNING

Five Priorities for the Care of Dying People

1. The possibility that a person may die within the next few days or hours has been recognised and is being communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly being reviewed and decisions revised accordingly. ☐

This patient has been identified as actively dying:

Date: …….. Time: ……

Signature: ……. (Nurse) Signature: …….. (Doctor)
(End of life care planning should not be delayed in order to obtain a signature from a doctor if there is not one immediately available. Evidence of agreement amongst the MPT that the patient is actively dying case should available – i.e. Crosscare records)

[Tick as and when you judge that these have been taken on as priorities within the person's care]

2. Sensitive communication is taking place between employees, volunteers and the dying person, and those identified as important to them. ☐

3. The dying person and those identified as important to them, are being involved in decisions about treatment and care to the extent that the dying person wants. ☐

4. The needs of families and others identified as important to the dying person are actively being explored, respected and met as far as possible. ☐

5. An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is being agreed, coordinated and delivered with compassion. ☐

Care Planning to include:

Please check that the following information has been documented on Crosscare:

Has the *Coping with Dying* leaflet been given to the relative or carer? Yes ☐ No ☐

If no, reason why?

……

Is there up-to-date contact information for the relative or carer? (Include information on a 1st and 2nd contact name, their relationship to the patient and whether they wish to be called at any time or during restricted hours ie not at night)		Yes ☐	
Has there been an expressed wish for tissue donation?		Yes ☐	No ☐
If yes has the Transplant Coordinator been contacted to ascertain eligibility? Telephone 0800 432 0559 (24 hrs)	N/A ☐	Yes ☐	No ☐

If 'yes', put an alert on Crosscare

Have the patient's cultural norms, values and belief systems been identified?	Yes ☐	No ☐
Has the support of the chaplaincy team been offered to the patient and their family?	Yes ☐	No ☐
Have any specific needs been identified following patient's death?	Yes ☐	No ☐
Has a decision been made about the patient's resuscitation status?	Yes ☐	
If the patient has an Implantable Cardioverter Defibrillator (ICD) has it been deactivated? N/A ☐	Yes ☐	No ☐
Has the GP been informed that the patient is imminently dying?	Yes ☐	No ☐

Appendix 2

PROCEDURE UPON DEATH

1. The nurse in charge of the team must inform the IPU doctor who has been treating the patient when a patient dies. The nurse in charge of the IPU and the IPU clinical administration team must also be informed. In the event of expected death occurring at night the doctor may be informed the following morning and a nurse who has been trained to do so (see 3 below) may verify the death.

2. Where there is an unexplained unexpected death, the Consultant on call must be contacted immediately to explore the circumstances of death and to notify the coroner. Where there is a death and the patient was admitted less than 24hrs, had a surgical procedure in last 30 days (e.g. ascitic drain insertion) and/or is subject to a Deprivation of Liberty Safeguard application; then the coroner must always be notified. Where a death is not expected, but there are no unexplained circumstances, the doctor in charge of the patient will be informed the next working day.

3. Verification of death is undertaken by a doctor or a registered nurse. The registered nurse should have attended the verification of death training, completed the competency document and be confident that the circumstances of the death mean that it may be verified by a nurse (patients subject to a deprivation of liberty authorisation are not excluded from nurse verification as long as they do not also fall into any other excluded groups). The Procedure for Verification of Death form should be completed (see Appendix 4) and placed on the front of the notes.

4. The nurse/doctor who verified the death ascertains whether the person had a known or suspected legally reportable infection.

5. We recognise the importance of accommodating special, cultural, religious and/or individual requests of patients and families. Employees should aim to assess as much information about what the patient and family expect or wish after death; assumptions should be avoided. It is, however, not possible to allow burning candles in patient's bedrooms.

6. If the family were present at the time of death then a nurse from the team should, if possible, sensitively ask whether the patient is for burial or cremation. If the family were not present they must be informed of the death by a professional with appropriate communication skills as soon as possible and offered support and, if possible, asked for their wishes regarding burial or cremation.

7. If the patient has expressed a wish to be a tissue or body donor telephone the Transplant Co-ordinator or London Anatomy Office as soon as possible. If an individual's wishes regarding tissue donation were not formally recorded before death, but an employee feels he/she might have wished to be a donor, the opinion of a nominated representative can be sought. If the representative feels the patient would have liked to have been considered for tissue donation inform the representative of the procedure as outlined in Appendix 1. Whole body donation can only be agreed by individuals themselves and not by anybody else on their behalf after death.

8. Straighten the body as soon after the death as is possible and appropriate. Place the arms at their side and leave one pillow in place. Facilitate family/friends who would like to spend time with their relative after death. Agree that the family communicate when they are ready for the employee to commence last offices. For last offices and after death procedure please see Appendix 5 and 6.

10. The family must be given a time to return to the IPU to collect the paperwork and property, usually the following day If they were present at the time of death then this is to be recorded on a returning relatives' card and bereavement pack 2 is to be given. If they were not present then they must be phoned and given the time of the appointment. It is preferable that the family are not asked to return to the IPU on the day of death even if the death has occurred early in the morning.

11. The family support form must be completed including a brief history of the circumstances of the death (see Appendix 3) and placed on the front of the notes.

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Appendix 3

Family Support Form

☐ **ROUTINE** …standard follow-up: letter at 1 month; telephone call by bereavement volunteer at 3 months; invite to relatives' evening at 5 months

☐ **SOCIAL WORK** …if there are financial, legal or housing issues, form to be copied to welfare/benefits

☐ **URGENT** …most people do not require urgent follow-up (less than 3 months) unless there is a specific, defined risk, eg recent bereavements, history of traumatic bereavement, previous suicide attempt etc

Patient	**Patient representative**	Signature of person completing this section
Affix patient label here Age……..… Date of referral to PAH ……..…….. Date of admission to PAH ……..……..	Surname ……..…….. Forename …….. Address ……..….... ……..…… ……..…… Post Code …….. Tel No ……..…….. Relationship to patient …….….....	*Name* *Sign* *Role* *Date*

DATE OF DEATH……..

Place of death: PAH ☐ Hospital ☐ Care home ☐ Home ☐ Other ☐

Name
Sign
Role
Date

FAMILY TREE	*Name* *Sign* *Role* *Date*

Other people who may be most affected by the death:

Name	Address	Tel no	Age	Relationship	*Name* *Sign* *Role* *Date*
1.					
2.					
3.					
4.					

PTO

BRIEF HISTORY INCLUDING CIRCUMSTANCES OF DEATH eg Long illness? Was it a difficult death? Was it expected? Who was present? etc What is the bereaved person(s)/family's current view of their need for support?	Signature of person completing this section *Name* *Sign* *Role* *Date*
BEREAVEMENT RISKS – please describe particular circumstances and concerns below eg previous/multiple losses; marital and/or family discord; isolated from social support networks; young children/teenagers in the home; financial issues; possible alcohol/drug abuse; relevant history of/current mental illness; unresolved legal/housing issues.	*Name* *Sign* *Role* *Date*
RETURNING RELATIVES MEETING/POST-DEATH TELEPHONE CALL Please comment on the returning relatives' appointment/telephone call...	*Name* *Sign* *Role* *Date*
ADDITIONAL COMMENTS eg by relevant multi-disciplinary team members	*Name* *Sign* *Role* *Date*
PLEASE ENSURE ALL DETAILS ARE COMPLETED IF FOLLOW-UP IS REQUIRED *Thank you.*	

Affix PAH patient label here

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Appendix 4

PROCEDURE FOR VERIFICATION OF DEATH

Observe the physiological signs of death and please document record of clinical examination below:

1. **EYES** **Check pupil reactions to light** :

   Pupils are fixed and non-reactive to light Yes ☐ No ☐

2. **PULSE** **Check for *either* carotid pulse *or* heart sounds**:

   Absence of carotid pulse for at least one minute Yes ☐ No ☐

   Absence of heart sounds for at least one minute Yes ☐ No ☐

3. **BREATHING** **Check for *either* breath sounds, listening with stethoscope *or* chest movements by placing hand on chest**:

   Absence of breathing sounds for at least one minute Yes ☐ No ☐

   Absence of chest movements for at least one minute Yes ☐ No ☐

   To verify death ensure you have completed the above checks before signing below documenting time and date of death

Burial ☐ **Cremation** ☐ **PHCT / GP informed of death** ☐

Other appropriate services informed: **District Nurse** ☐ **CNS** ☐

Community Matron ☐ **Hospital Palliative Care Team** ☐ **Others** ☐

Date of death:……. Time of death: ……..

Persons present:

Family: ……..

Staff: ……

None: ……

Who verified death: …… Patient was in room no: ……..…....

Who was contacted:...……

Contd overleaf…

Contd….

Nurses who cared for patient: ……

Doctors who cared for patient: ……..

When are relatives returning: ……..

Signature of Nurse undertaking verification ….……....

Date …….. **Time** ……

Medical certificate of cause of death signed by: ……..…….

I a Disease or condition directly leading to death: ……

I b Other disease or condition, if any, leading to Ia: ……

I c Other disease or condition, if any leading to Ib: ……..

II Other significant conditions CONTRIBUTING to DEATH but not related to the disease or condition causing it:

……..…

……

Has the patient been discussed with Coroner's Office? Yes ☐ No ☐

Has the patient been referred to the Coroner? Yes ☐ No ☐

Signature of Doctor ……....

Date …….. **Time** ……

.

Name …… Hospice no ……..…..

Appendix 5

PROCEDURE OF CARE OF THE DECEASED PATIENT

1. Position the deceased patient on their back and straighten their limbs (if possible) with their arms lying by their sides. One pillow should be left under their head for support and to help the mouth stay closed.

2. Close the eyes by applying light pressure for 30 seconds. If corneal donation is to take place, close the eyes with gauze (moistened with normal saline) to prevent them drying out.

3. Clean the mouth to remove debris and secretions. Clean and replace dentures as soon as possible after death. If they cannot be replaced send them with the body in a clearly identified receptacle.

4. 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. If the family/carers request it earlier then sensitively discuss the consequences and clearly document this. Be aware that some faith groups prohibit shaving.

5. Support the jaw if necessary by placing a rolled up towel underneath (remove it before the family/carers view the person).

6. Remove syringe pumps and patches. Disposal of any controlled drug in the syringe pump should be carried out as per the Controlled Drugs Destruction Procedure (Medicines Management Policy).

7. Spigot urinary catheters. Renew / cover exuding wounds and secure with occlusive tape. Replace stoma bags with a clean bag. Remove intravenous lines, secure central / epidural lines with tape. Depending on reason for NG tubes consider removing or aspirate and leave in place. Cover tracheostomy and PEG / RIG tubes with occlusive dressing.

8. Give the patient a full bed bath, affording him/her the same degree of care and dignity as afforded in life and dress in a dignified manner. Apply a pad and pants.

9. All patients must be placed in a body bag which will be left open. An infection control/ death notification sheet must be completed and inserted in to the clear wallet on the bag (appendix 9). An ID wrist band must include the full name, date of birth and hospice number.

10. After consultation with the family remove jewellery (apart from the wedding ring) unless specifically requested to do otherwise. Secure any rings left on with minimal tape. Follow patient property policy for the documentation and storage of valuables.

11. The doctor who has previously seen the patient must complete the medical cause of death certificate within 24 hours of occurrence. At weekends and bank holidays the certificate may be signed the following working day, unless there is an urgent indication

for earlier certification.

12. Nursing employees must transfer the body on to a mortuary pallet using the Air Pod. Nursing employees must not move bodies off the mortuary pallet unnecessarily or assist in unnecessary body transfer activities.

13. Record patient's name, date of birth, religion, any jewellery left on patient and any artefacts / other items left with the patient in the mortuary book. Include the names of the two nurses who carried out the care after death. Put patients name on the mortuary door.

14. If the patient is to be cremated, the IPU doctor will normally also complete the cremation form and request a second doctor who has not been directly involved with the patient's care to examine the body, interview relevant employees members and complete parts four and five of the cremation form.

15. If the patient had a pacemaker explicit arrangements should be made with the funeral director. Reference should be made to the Infection Control/Death Notification sheet.

16. If for any reason a post-mortem examination is desirable but not legally required by the coroner, the procedure must be discussed by the doctor with the family. The pathologist who is to undertake the post mortem should be asked to fax his/her consent form which will then be discussed with the relatives.

17. The funeral director chosen by the family will be contacted to make arrangements to collect the deceased. The deceased person must be checked prior to being taken away by the funeral director and any last minute hygiene needs dealt with.

Appendix 6

PROCEDURE FOR CARE OF THE DECEASED'S FAMILY

1. If the relatives are not present they must be contacted as soon after the death as appropriate and the news must be broken in a sensitive manner.

2. During the day the Hospice receptionist should be informed that the patient has died and that the family will be returning.

3. Relatives present at time of death or on later arrival must be offered sensitive support and the opportunity to ask questions and discuss issues such as type of body disposal (burial or cremation) and tissue donation.

4. Allow the family to sit with their relative immediately after death for as long as is reasonably required.

4. Some family members/carers may wish to assist with the personal care in acknowledgement of individual wishes, religious or cultural requirements. Prepare them for changes to the body after death and infection control issues.

5. The nurse in charge of the team must make an appointment for the patient's representative/legal executor to collect the medical certificate of cause of death and any remaining property the following day. If they were present at the time of death the appointment date and time must be written on a returning relative's appointment card. The family should be given a bereavement pack. If they were not present they must be given the appointment time over the phone. It is preferable that relatives are not given an appointment to return to the IPU on the same day as the death.

6. Where the death is being referred to the coroner the family must still be given an appointment to return to the IPU. Although they will be unable to collect the medical certificate of cause of death they will be able to collect the property and be informed about the bereavement service.

7. Ideally a nurse who has met the family should see the relatives when they return. It may be appropriate to ask a member of the social work team/chaplain/doctor to also be present.

8. At the meeting the patient's representative will receive the property and valuables according to the Patient's Property policy.

9. The Department of Social Services document "What to do when someone dies" must be given to the representative.

10. The medical certificate of cause of death is handed to the representative and the correct spelling of the patient's name is checked. The procedure for registering the death is explained.

11. The role of the bereavement team and future telephone and written contacts is explained including information on support groups and bereavement evenings. The family are to be given the opportunity to talk and ask questions.

12. If the family wish to view the body when they return to the IPU then this must be facilitated by transferring the body to the viewing room and by ensuring that the body looks as presentable as possible. A nurse will accompany the family in to the viewing room and either

stay in the room or outside nearby. Nursing employees are discouraged from doing unnecessary mortuary transfers. The family will normally be dissuaded from future viewings but informed that this will be possible at the funeral directors.

13. Ask the family to complete and sign the Permission to Remove Form (Appendix 11). Pass this information on to the IPU clinical administrator.

14. Complete the family support form at the returning relatives meeting (Appendix 3) giving as much information as possible. The recommendation for urgent referrals should be highlighted and presented at MDT. This form then goes to the Clinical Admin Team for forwarding to the hospice at home team.

Appendix 7

TRANSFER OF THE DECEASED PERSON OUT OF THE HOSPICE

1. Routine transfer

1.1 The funeral director will usually undertake transfer of the deceased, although case law has determined that the deceased's executor (generally a family member) may also do this (see 3).

1.2 The undertakers will arrive at the IPU, present a form of identification and documentation that states the name of the deceased whom they have been instructed to collect to the IPU clinical administrator. (Mon – Sun 0800-16.00hrs). At all other times the nurse in charge will be informed. During the above times the IPU clinical administrator will accompany the undertakers to the mortuary. At other times the nurse in charge will delegate a nurse to do so.

1.3 If the deceased is for cremation the funeral director will be given the cremation papers.

1.4 The person seeing the deceased out of the mortuary signs and dates the list of deceased patients which is kept on the IPU clinical administrators' desk.

1.5 The vehicle access doors are opened to allow the undertakers to enter and closed again whilst the deceased is transferred to the vehicle.

1.6 The undertakers will transfer the body from the mortuary on to their trolley. The IPU clinical administrator must not assist with mortuary transfers. Nursing employees may only assist by following the correct manual handling procedures.

1.7 The undertaker will have a body ID pack containing the name and date of birth of the deceased. The details from the pack are checked against the name band on the deceased and the white form which is inserted in to the body bag. If the details are correct the funeral director will attach another name band to the body.

1.8 Any jewellery on the body will be recorded in the undertakers pack and checked with the person seeing the body out of the mortuary. Any artefacts/possessions will likewise be recorded.

1.9 The undertakers must sign the mortuary book.

1.10 The garage doors must be locked once the undertakers have left.

2. Procedure for the transfer of the deceased to a funeral director when the mortuary is full. Weekends and bank holidays

2.1 When the mortuary is full, it may be necessary to move the deceased from the mortuary if there are further impending deaths.

2.2 The Hospice has an agreement with both Lodge Brothers and FW Paines undertakers to collect and store the deceased even if the family do not wish to use them as their chosen funeral directors.

2.3 Phone the next of kin of the deceased and diplomatically explain that as the Hospice has only limited facilities, it is unfortunately necessary to move the patient to an undertaker. If they already know which undertaker they wish to use then facilitate the transfer to that of their choice. If they have not chosen an undertaker they should be given the name and contact details of the undertaker the patient is being moved to. The next of kin must be reassured that they will not be charged and they may still use their chosen undertaker at a later date. This must all be communicated in a sensitive manner.

2.4 Only the minimum number of deceased should be transferred. If relevant, this can only be facilitated if the Medical Certificate (Cremation 4) has been completed. If the paperwork has not been completed check if the doctor on-call has seen the patient and can complete the necessary forms. If not and there is a Hospice consultant on call then phone them. If neither of the above has seen the patient then the deceased may have to be moved without the completion of the medical certificate. To complete the paperwork a doctor will go to the undertakers once the holiday period is over.

2.5 On no account should the deceased be returned to the Hospice to facilitate certification.

2.6 Document the names of the deceased who have been moved in the IPU clinical administrators' diary. Enter the name of the deceased, the name of the undertaker and whether the Medical Certificate has been collected on the form kept on the IPU clinical administrator's desk.

3. Collecting of body for personally arranged funeral

3.1 A copy of the book "New Natural Death Handbook", Weinrich, S & Speyer, J 4th edition Rider 2003 is in the library, shelved at R WIE, with detailed guidance on personally arranged and "green" funerals.

3.2 The Natural Death Centre is a charitable project launched in Britain in 1991 to assist patients and carers to arrange inexpensive, "do it yourself" and green funerals. Their telephone number is 0871 2882098. Further information can be obtained from: www.naturaldeath.org.uk

3.3 Where relatives have indicated that they wish to organise their own funeral the nurse in charge should receive a copy of confirmation of this from the relevant cemetery, crematorium or other place of burial, before releasing the body.

3.4 The nurse in charge should also establish that the mode of transport is suitable and there is a minimum of four people able to carry the body from the mortuary trolley to the chosen vehicle parked (transit van or large estate car) in the mortuary garage.

3.5 If a family member collects the deceased then Hospice employees must not be involved with the transfer to vehicles. The person seeing the deceased out of the mortuary must see the ID of a family member. The family member must sign the mortuary book.

Appendix 8

Princess Alice Hospice

TESTAMENTARY CAPACITY FORM

Patient's full name: ……

I certify that:

The above named patient, who I last examined on the ……. day of …….. 20...., in my opinion has the testamentary capacity to execute a testamentary disposition.

In reaching this conclusion, I have regard to the Patient's ability to understand, retain and express his/her decision in relation to the following matters:

1. The nature of the testamentary disposition and its effect in legal terms.
2. The extent of property to be disposed of.
3. The claims of those to benefit or be excluded from his/her testamentary disposition.

Signed: ……

Print name: ……

Designation: ……

Appendix 9

PRINCESS ALICE HOSPICE
INFECTION CONTROL/DEATH NOTIFICATION SHEET

Name of Deceased	
Date of Birth/Religion	
Date and time of death	

Pacemaker in situ Yes ☐ No ☐

This person presents a potential source of infection from (please tick as appropriate)

Intestinal Infection	
Clostridium difficile	
Salmonella	
Norovirus	
Dysentery	
Blood Borne Virus	
Hepatitis B	
Hepatitis C	
HIV	
Neurological Infection	
Transmissable spongiform encephalopathy (CJD)	
Meningococcal meningitis	
Respiratory/airborne infection	
Tuberculosis	
Bacterial Infection	
Methicillin resistant staphylococcus aureus	
Other (Please specify)	

Appendix 10

PRINCESS ALICE HOSPICE
GUIDELINES ON WILLS

1. If a patient wishes to make a will, he/she should be advised to use a solicitor and ideally his/her own solicitor should be contacted. A list of local solicitors is available on the IPU if needed.

2. If at all possible Hospice employees and volunteers should not be involved in this process.

3. In exceptional circumstances, a solicitor may ask for additional confirmation of a patient's testamentary capacity. In this situation, the patient's testamentary capacity should be assessed by the most well-placed employee, most probably a Medical Consultant. (Appendix 8)

4. In very exceptional circumstances, if an imminently dying patient wishes to make a will and there is insufficient time for a solicitor to be present, a Medical Consultant could assess and document the patient's testamentary capacity.

5. In exceptional circumstances, if there is nobody from outside the organisation to witness a signature, an uninvolved non-clinical employee could do so if he/she is willing.

6. A lawyer should normally be present to assess testamentary capacity and to support the witnessing of the signature.

Appendix 11

Permission to Release

In respect of ……

Date of birth ……..

Crosscare number .....……

Of: Princess Alice Hospice, West End Lane, Esher, KT10 8NA.

I ……,

being the patient representative for the person named above, have instructed / will be instructing:

Funeral director's name: …….....

Branch: …….....

Branch Telephone number ……...

I authorise this company to take _____ into their care.

Signed: …….. Date …….....

Nursing staff name: …….

Nursing staff signature: …….....

Clinical/Clinical Admin/Ward/Private/Ward Admin/Clinical Admin Forms/Permission to Release.docx