



NI
Bereavement
Network

Care of the Deceased Adult in Care Homes and Those Important to Them

A Guideline for Care Home Staff in Northern
Ireland

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1. Introduction

'Last offices' is the term traditionally used to describe the final acts of care for a deceased resident's body. The term 'personal care after death' is now more commonly used to describe care of the deceased resident's body and the wider responsibilities that nurses and care home staff have at the time of and immediately after death (The Royal Marsden NHS Foundation Trust, 2020).

Whilst nursing and care home staff roles have evolved in recent years, care of the deceased resident's body continues to afford nurses and care home staff the opportunity to demonstrate respect and sensitivity, including due regard for any required cultural, religious and spiritual considerations. Nurses and care home staff are in a unique position to liaise with colleagues in other professions and services to coordinate health and safety, legal and administrative requirements resulting from the death.

Providing information and support to bereaved carers and family is also an essential element of care after death. The requirement for clear, sensitive and compassionate communication when providing support and information to bereaved relatives is a fundamental element of person-centred care after death.

The Northern Ireland Bereavement Network and Trust Bereavement Coordinators (TBCs) support regional implementation of the Health and Social Care (HSC) Services, Strategy for Bereavement Care (Department of Health, Social Services and Public Safety, 2009). The strategy outlines six standards for care that guide the quality of service and support provided by HSC staff before, at the time of and after death (see Appendix 1). These can be used in the care home sector as a guide to best practice.

This guideline provides relevant information in relation to care after death, including reporting the death to medical colleagues and being aware of the legal and professional responsibilities of doctors. These responsibilities include verification, certification and establishing whether Coroner's requirements will affect how staff care for the deceased resident as per Department of Health (DoH) guidelines for matters relating to the coroner (Department of Health, 2018).

<https://www.health-ni.gov.uk/publications/guidelines-matters-relating-coroner>

Originally published in 2017 for HSC staff, this regional guidance aimed to provide nursing and care staff with a holistic perspective on all processes associated with care after death. It is considered important to review and update this guideline to include care homes and to ensure the continued provision of safe, effective and sensitive care for deceased residents and those important to them.

Throughout this document, the term "family" is used to describe family in the widest sense to incorporate all those who are important to deceased residents.

2. Review of the guideline

Trust Bereavement Coordinators reviewed the Care after Death for Adults in the acute sector in 2024, and a consultation process invited responses from nurses, other health care professionals, the Northern Ireland Bereavement Network, external stakeholders and patient and public involvement within Northern Ireland. The guidelines for care after death for adults in care homes were adapted from these guidelines, in 2025 with further consultation from the independent sector providers and PHA (Public Health Agency).

3. Who will find this guideline useful?

The guideline has been written for nurses and care home staff who have the responsibility for the care of deceased residents within a care home setting. It will also be informative within other health care settings and for healthcare professionals and external stakeholders who provide care at the time of and following the death of a resident.

The principles contained within this guidance can be utilised to inform and develop local guidance for care homes.

It complements the information and related theory in the Royal Marsden Manual of Clinical Nursing Procedures (The Royal Marsden NHS Foundation Trust, 10th Ed. 2020) promoted as the gold standard in evidence-based care.

4. Aim of the guideline

The guideline aims to:

- Promote safe, sensitive and high-quality care of the deceased resident at the time of and after death, taking into consideration the known wishes of the deceased resident and their family.
- Ensure the deceased resident is treated with dignity and respect, and that cultural, religious and spiritual needs are met.
- Promote effective partnership working by outlining the roles and responsibilities of relevant staff who are involved in caring for deceased residents and their relatives.
- Promote effective communication to assist families with the practical issues that arise because of the death e.g. registration of death or a death that is referred to the coroner.
- Inform the development of relevant policies, procedures and protocols to guide the practice of staff in care homes.
- Provide a resource that will be useful for pre- and post-registration training and education to contribute to the professional development of nurses and care home staff in the care of the deceased resident and their family.

5. Principles for care of the deceased resident and their family

- 5.1. Death may be expected, sudden, peaceful or traumatic. The nature of the death and the context in which it has occurred, may determine the type of immediate or further support and information required by those who are bereaved. This is described in the [Adult Bereavement Care Pyramid - Irish Hospice Foundation](#). In the circumstances where a resident with no known next of kin is approaching end of life, the named nurse/social worker/care manager/ GP should be informed immediately so that information gathering can take place and the necessary arrangements made.
- 5.2. Regardless of the nature and circumstances of the death, the overarching principles contained within this guideline should be applied.
- 5.3. The following principles should inform practice when death occurs:
- The resident's GP or Out of Hours GP should be contacted to verify the death and, where possible, arrange for the death certificate to be issued.
 - Acknowledging grief and recognising the impact of loss, providing compassionate emotional and practical support tailored to each individual's circumstances.
 - Consideration for the religious, spiritual and cultural wishes of the deceased resident and their family.
 - Ensure that legal obligations are met in relation to sudden and unexpected death. Please refer to section 8 for further information.
 - Preparation of the deceased resident's body and the immediate environment.
 - Provision of a dignified space for the family to be together in the time immediately after the death of a resident.
 - Coordination of the transfer of the deceased resident to the funeral director's premises or the mortuary, in cases referred to the coroner.
 - Facilitation of family participation in the care after death process, if this is requested. For example, washing and dressing the resident in accordance with safe moving and handling guidance and Infection Prevention and Control policy.
 - Give contact details to the family in the event that they may have questions or queries after leaving the care home.
 - Protection of the privacy and dignity of the deceased resident and their family.
 - Protection of the health and safety of those coming into contact with the deceased resident. See [NI Infection Control Manual](#) and/or the care home's local infection prevention and control policy.
 - Preparation of the environment to provide a quiet and respectful space when a resident has died or is likely to die. The Irish Hospice Foundation developed a symbol of a purple spiral [End-of-life Care Resources - Irish Hospice Foundation](#) and this or a similar previously agreed symbol, chosen by the care home, could be displayed in the immediate area to inform others that end of life care is being provided or that a death has occurred. The chosen symbol should also be included in the Resident's Guide so that other residents and their families are familiar with it and understand its meaning.
 - Return possessions of the deceased resident to the legal next of kin in a respectful manner and record this in the resident's record.
 - Provision of verbal and written information on Coroners post-mortem examination if relevant. See for further information see DOH where copies of information for families on post-mortem can be found [Coroners postmortem examination | Department of Health](#)

6. Before death - steps to creating a supportive experience for the resident and their family

- 6.1. Where death is anticipated and predicted, it is important that an agreement is reached between residents and their families, medical, nursing and care staff about clinical decisions and a plan of care is developed that is appropriate to meet the needs and known preferences of the dying residents.

In keeping with the principles of Advance Care Planning (ACP), there should be clear and unambiguous communication to ensure there is an understanding that death is imminent (Department of Health, 2022). This allows timely and appropriate preparation to meet the wishes of the dying resident and their family. If appropriate, make contact with those who can provide spiritual support to the resident as they approach end of life.

Decisions documented in the resident's care plan may include:

- The resident's preferences around their treatment and care.
- Resuscitation status (Resuscitation Council UK, 2016).
- Management of implanted cardiac devices. If the resident has an implantable cardiac defibrillator, this should be deactivated before the resident dies. Pacemakers or other type of implants, may need to be removed before cremation. (See care home policy for deactivation and cremation advice).
- Preferences for place of death, whenever possible.
- Any religious, spiritual, cultural or practical wishes. This is particularly important if immediate release for burial or cremation is a faith requirement. Advice on the requirements of a range of faiths and cultures around death is available on the Bereaved NI website: [Faith, Spiritual, Cultural - Bereaved NI](#)
- Spiritual support, for both the dying resident and those that are important to them, can be provided by their own faith representative. This should be offered in a timely manner and revisited regularly to allow for meaningful interaction with the resident and their family.
- Contact information for those that the dying resident would like to have with them at the time of death is discussed, recorded and should be readily accessible by all appropriate staff. It is advisable that more than one contact telephone number is recorded in case relatives cannot be reached.
- Every effort should be made to accommodate the preferences of the dying resident.
- Where there is no nominated next of kin, record the name and contact number of the resident's key worker and nominated solicitor or nominated funeral director, if available.
- Any wishes regarding whole body donation for medical research, can only be arranged prior to death by the resident.

- 6.2. The environment in which a dying resident and their family are cared for can have an impact on their experience both at the time, as well as, later in the grieving process. Where possible, a dying resident should be cared for in a single room where the family can spend time with their loved one before, at the time of and after the death. This may not always be available. Nurses and care home staff should be aware of the potential impact of this situation on other residents and visiting relatives in the care home. Measures should be taken to ensure the privacy and dignity of everyone involved. Where possible, a quiet and confidential space should be arranged to facilitate family discussions. Refreshments should also be made available, for family members, as required.

In the circumstances where families are unable to visit, the option of virtual visiting should be offered to the resident/family, where appropriate.

In cases of sudden death, many of the principles previously outlined remain applicable. However, nursing and care home staff should be particularly mindful of the potential impact of trauma on those affected. Individuals may respond in a variety of ways during such highly stressful and overwhelming circumstances. It is essential to recognise their immediate need for compassionate support and care following a sudden and unexpected loss.

7. At the time of death - steps to creating a supportive experience for the family

- 7.1.** The resident's family should be told of the death in a clear, supportive and compassionate manner. The compassionate use of communication strategies for breaking bad news may help reduce the risk of causing further or unintentional distress (National Council for Hospice and Specialist Palliative Care Services, 2003).
- 7.2.** Spiritual care is an important aspect of holistic support for many individuals and should be addressed at appropriate stages throughout the resident's journey. Faith-based support services should be contacted to provide support to residents, their families, and staff upon request.
- 7.3.** If the family's first language is not English, the timely services of an interpreter should ensure that they receive the information they need to make sense of what has happened, especially if the death was not expected. They should be supported with the appropriate translated written bereavement literature, where available.
- 7.4.** If the family is not present at the time of death, they should be contacted and hear the news in a sensitive and compassionate manner. In those instances where staff are unsuccessful in contacting the family, the police service can be of assistance in locating them and breaking significant news. When relatives arrive at the care home, staff should meet them and accompany them to the deceased resident and provide the necessary support and compassionate care.
- 7.5.** Anticipate and answer any questions the family may have in relation to their loved one's care, before, at the time of and after death.
- 7.6.** The family will require a sensitive verbal explanation from nursing and care staff of what will happen next, which will be dependent on the circumstances of death. This includes:
 - when formal verification of life extinct has taken place
 - completion and explanation of the Medical Certificate of Cause of Death
 - reporting the death to the Coroner's Service, if appropriate
 - transfer to funeral director or mortuary, if applicable, for Coroner's cases
- 7.7.** The HSC bereavement booklet *When Someone Dies Information, Guidance and Support for family and friends*, is available on the [Bereaved NI](#) website and provides practical and emotional information for people who are bereaved. (This booklet is available in the top ten languages spoken in Northern Ireland).

- 7.8.** Personal care of the deceased resident and attention to the surrounding environment is an important aspect of care prior to a family spending time with their loved one. Families who have requested the opportunity to participate in personal care after death should be facilitated to do so where possible, following safe moving and handling, and local infection prevention and control policies.

Following traumatic death, the family should be prepared for the physical changes that may have occurred because of trauma and death.

- 7.9** If the resident is receiving medication via a syringe pump at time of death and the death was expected; in a nursing care home, the registered nurse should stop the pump and complete a monitoring check, detailing the syringe pump being stopped in the care records. The syringe pump must be left in-situ with the resident until the verification of death has been completed.

In a residential care home setting the management of the syringe pump remains the responsibility of the community nursing service. The residential care home and community nursing service should agree on a plan of care for discontinuation of the pump out of hours. The professional completing the Medical Certificate of Cause of Death must confirm whether a referral to the coroner is required or not. If the coroner is involved, they will direct if the pump needs to be left in-situ. This verification is often carried out by medical staff; in some settings a registered nurse with the relevant training and experience will be the professional verifying death.

If no referral is being made to the coroner, in a nursing care home a registered nurse should clamp any drains and remove subcutaneous lines still in-situ. Remove any connected infusion lines and infusions. If intravenous cannulas remain in-situ insert bungs to prevent leakage. In a residential care home setting this remains the responsibility of the community nursing service.

When the death is being referred to the coroner to investigate the cause of death, but where there are no suspicious circumstances, then leave IV cannulas and lines in situ and catheters should be spigotted. Infusions and medicines being administered prior to death via pumps can be taken down and disposed of, according to local policy and following discussion with appropriate medical practitioner, and any actions must be recorded in the resident's records. The contents of catheter bags can be discarded according to local policy. Personal care can then be given as for deaths without coroner involvement. Liaise with the resident's GP to confirm that any implantable cardioverter-defibrillator (ICD) has been deactivated, if this was not completed prior to the resident's death. [CIEDs Deactivation.pdf](#)

When the death is being referred to the coroner and the circumstances surrounding the death give rise to suspicion, there should be minimal contact with the body. Leave all drains, tubes, intravenous (IV) cannulas and lines in situ and IV infusions clamped but intact (this includes syringes with controlled drugs from syringe pumps). Leave any urinary catheter in situ with the bag and contents. Do not wash the body or begin mouth care in case this destroys evidence. Continue using universal infection control measures to protect people and the scene from contamination. Medical staff can provide guidance on this at the time of death. As above, liaise with GP ensure any implantable cardioverter defibrillator has been deactivated.

- 7.10** The physical care after death begins once verification of life extinct has been completed and documented. The deceased resident's body can then be prepared for transfer to the funeral director. Families should be offered the opportunity to spend some time with their

loved one following death, should they wish.

- 7.11. Further resources to support bereaved people are available on the [Bereaved NI](#) website.
- 7.12. Some families may request a memento, such as a lock of hair from the deceased resident. These wishes should be accommodated where possible.

8. After death - governance and legal Issues

In Northern Ireland, holding a 'wake', where family and friends come together to view and pay respect to the deceased resident and support the bereaved family and relatives in their own home or funeral home, is a common occurrence. The expectation that a funeral can be arranged within three to four days of death has a deep religious, cultural and social significance. While every effort is made by all services with a responsibility after death to facilitate this practice as far as is possible, certain legal and practical processes must be completed after death prior to a funeral and burial/ cremation taking place, which may impact upon the timing of the funeral.

Nursing and care home staff caring for deceased residents and their families should be familiar with such statutory and legal requirements for burial and cremation. Knowledge of the roles and responsibilities of other relevant healthcare professionals and agencies is essential as they too may inform the actions care home staff are required to undertake or coordinate at the time of death.

This section outlines the processes of which nurses and care home staff need to be aware.

8.1. Verification of Life Extinct (VOLE)

All deaths need to be formally confirmed or verified. A medical practitioner or a health care professional, trained in the verification of life extinct, is required to attend and formally verify that death has occurred. This must be completed prior to the resident being transferred from their place of death (Department of Health, 2019).

It is best practice that verification takes place as soon as possible, especially when family is present, or when death occurs close to midnight: the recorded time and date of verification informs the time and date of death that will be entered on the Medical Certificate of Cause of Death.

Care homes should have an appropriate policy and procedure in place for verification of life extinct.

For further information please see: [Registered Nurse Verification of Expected Adult Death guidance \(RNVoED\) | Hospice UK](#)

8.2. Completion of the Medical Certificate of Cause of Death (MCCD)

Registered Medical Practitioners have a legal duty to provide a Medical Certificate of Cause of Death if, to the best of their knowledge, that resident died of natural causes, for which they had treated that resident in the last 28 days as stipulated in Guidance surrounding Death | Department of Health.

The GP completes a Clinical Communication Gateway eReferral (**CCG**) under Regional Services Death Notification. This produces a death certificate template that the GP

completes. This is then printed and signed, then emailed to the General Register Office (GRO), in line with their practice's policies and procedures.

The GRO email the Medical Certificate of Cause of Death to the local council registry office, who contact the family/representative to arrange collection of the Death Certificate. It is good practice that the information on the Medical Certificate of Cause of Death is explained to the family by the treating medical practitioner.

The Medical Certificate of Cause of Death should be processed as soon as possible, so burial or cremation arrangements are not unduly delayed. If this timeframe is not met the reasons for this should be explained sensitively to the family. Cultural or religious practices requiring completion on the same day should be accommodated if possible.

8.2. The Death Certificate

Families should be informed that they will be contacted by the local Registrar who will arrange for the Death Certificate to be posted out or collected. See [Practical Steps To Take When Someone Dies - Bereaved NI](#) for further information.

The Death Certificate is the permanent legal record of the death. It provides the family with an explanation of how their relative died and allows them to settle the affairs of the deceased.

It also contributes to statistical information on causes of death used for monitoring the health of the population as evidenced by the [Home | Northern Ireland Statistics and Research Agency](#)

Once the death is registered, the family can then make funeral arrangements.

8.4. Cremation

Nurses and care home staff have a role in establishing if cremation is being considered. The funeral director nominated by the family will make the necessary arrangements for completion of cremation documentation and will liaise with medical staff.

Bereaved relatives may ask nursing or care home staff about the process for arranging cremation and they should be reassured that their nominated funeral director will assist them with arrangements. Universal forms must be used for all requests for cremation at both Cremation Authorities and are available to be downloaded at the relevant Council websites at: [Crematorium - Antrim & Newtownabbey Borough Council](#) or [Cremations | City of Belfast crematorium](#)

8.5. When is a Death Reported to the Coroner?

All care home staff should be aware of the reasons why a death should be reported to the coroner and have a responsibility to inform the GP of all relevant information.

8.6. Duty to give information to Coroner

There is a legal requirement under Section 7 of the Coroners Act (Northern Ireland) 1959 for every medical practitioner, registrar of deaths or funeral undertaker and every occupier of a house or mobile dwelling and every resident in charge of any institution or premises in which a deceased resident was residing to report a death to a coroner if it resulted, directly or indirectly,

from any cause other than natural illness or disease for which the deceased had been seen and treated within 28 days of death.

A death is reported to a coroner by a medical practitioner in the following situations:

- A doctor did not treat the resident during their last illness
- A doctor did not see or treat them in the 28 days before they died
- The cause of death was sudden, violent or unnatural such as an accident, or suicide
- The cause of death was murder
- The cause of death was an industrial disease of the lungs such as asbestosis, or
- The death occurred in other circumstances that may require investigation

Doctors should also consider the Extra-Statutory List of Diagnoses [Guidelines for Matters Relating to the Coroner | Department of Health](#) that are referable to the Coroner. If in doubt, seek advice from the Coroner's Office.

This advice applies equally to care homes. In every case the resident's next of kin (and key worker if one is appointed) should be informed as soon as possible. The Regulation and Quality Improvement Authority (RQIA) must also be informed of all expected deaths and those unexpected deaths arising from adverse incidents in the home or deaths occurring within the home in which a coroner has directed a post mortem e.g. industrial or occupational diseases such as asbestosis.

Decisions concerning referral to the Coroner are based on the DoH Guidance Surrounding Death, available at: [Guidelines for Matters Relating to the Coroner | Department of Health](#)

8.7 What happens after a death is reported to the Coroner?

Following the report of a death, the coroner in NI will direct one of three courses:

- Advise doctor to complete Medical Certificate of Cause of Death
- Allow death to be processed under Pro Forma system
- Direct a post-mortem examination

If the coroner directs to use the Pro Forma system, they will ask the doctor to complete a special Pro Forma form (or accompanying letter) that briefly sets out the background and circumstances to the death.

The coroner then directs if they agree with the proforma outlining the cause of death. The coroner must complete the actual Medical Certificate of Cause of Death as GPs do not use the Northern Ireland Electronic Care Record System (NIECR or Encompass).

In order to establish the cause of death the coroner may direct that a post-mortem examination take place.

At this particularly distressing time, bereaved families should be given information and support to help them understand the coroner's process and what will happen next. In particular, families must be informed that they will need to formally identify the body of their loved one, in the presence of the Police Service of Northern Ireland (PSNI). Advice on the Coroner's processes and frequently asked questions is available at [Coroners Service for Northern Ireland | Department of Justice](#).

Police officers, acting as coroner's agents, will speak with relatives to gather information

about the deceased resident's last minutes/hours of life and give details about where and when a post-mortem examination, if directed, will take place.

Regardless of the coroner's decision to proceed with a post-mortem examination, any contact with the coroner's Office should be shared with the family. Families should be encouraged to employ the services of a Funeral Director, even when the coroner is involved to enable them to plan future arrangements.

Nursing and care home staff can assist medical colleagues in providing support and information to the family in these situations. They also need to be made aware that, as part of the coroner's process, they may be required to provide information on the circumstances of death. It is best practice that all care homes have their own policy and guidance for assisting the coroner's investigations that staff must be familiar with and adhere to. Formal statements or medical records are usually requested through the care home's senior management who will follow agreed protocols and assist staff to provide information to the coroner's Service.

8.8 Implications for practical care of the deceased resident when the coroner directs a post-mortem examination

A key consideration for nurses and care home staff when the coroner directs a forensic post-mortem examination is the restrictions that will apply to the practical care of the deceased resident. If a forensic post-mortem examination is ordered, it is essential that the deceased resident is seen by the pathologist exactly as the deceased was at the time of death. Please refer to local policy/guidance.

Where the Coroner directs a post-mortem examination, liaise with GP for confirmation of the coroner's directions and adhere to the instructions below in relation to caring for the deceased resident:

- Do not wash the deceased resident. Fluids or discharge should be managed by using absorbent dressings or pads.
- Leave all intravenous and subcutaneous cannulas and lines in situ and infusions clamped but intact. In a residential care home setting this remains the responsibility of the community nursing service. Please refer to Section 7.9.
- Sensitively inform the family of the reasons why devices are left in situ and that after examination they will be removed.
- Families should be advised to liaise with the GP and contact their local funeral director to make suitable arrangements for collection of the deceased resident, following the post-mortem examination.
- Where there is a registered nurse, they can stop the infusion, complete a monitoring check and record the details in the resident's care records. Please refer to Section 7.9. The syringe pump must be left in situ and only when instructed by the doctor who has had the discussion with the coroner can the syringe pump be removed and medication discarded.
- Leave endotracheal (ET) tubes in situ. Please refer to Section 7.9.
- Leave catheter/drains in situ with the bag and contents.
- Continue using standard Infection Prevention and Control measures to protect people and the scene from contamination.
- All care home staff need to cooperate with the PSNI and GP to preserve evidence in suspicious circumstances. Arrangements will be made by the coroner to ensure that the deceased resident is transferred from their place of death to the forensic mortuary at the Royal Victoria Hospital.

9. Care after death

The body of the deceased resident needs to be cared for with dignity and respect, and it is helpful if the surrounding environment conveys this. Evidence suggests that the entire holistic end of life care and the environment may have a substantial effect on relatives and also a profound impact on the grieving process.

- 9.1. The personal care of the deceased resident's body is the responsibility of two people. The care home staff are responsible for correctly identifying the deceased resident as part of practical care and communicating accurately with the funeral director in line with local policy and protocols. If a coroner is involved, please refer to Section 8.6
- 9.2. Resident's care after death should be carried out within **four hours** of the resident dying, to preserve their appearance, condition and dignity. This is because rigor mortis can occur relatively soon after death and the time period are shortened in warmer environments. Tasks such as laying the deceased resident flat with a single pillow supporting their head, need to be completed as soon as possible within this time. If the family are not present at the time of death and they request to view the deceased resident, arrangements should be made for this to take place in an appropriate setting, if available. Families wishing to spend time with the deceased resident should be accompanied and supported by an appropriate member of staff.
- 9.3. Standard Infection Prevention and Control precautions should be followed during the care of all deceased residents. Any additional infection control precautions in place before the resident died should continue after death, during the resident's care of the deceased resident's and the funeral director should be made aware of these precautions. See below links for precautions relevant to infection, including advice on when a body bag may be required or where viewing the deceased resident is affected. For further information see: [Transmission Based Precautions – NI Infection Control Manual](#)
- 9.4. To encourage a quiet and respectful environment when a resident has died or is likely to die, a previously agreed symbol (e.g. Purple Spiral) should be displayed in the immediate area of the care home.
- 9.5. The family should be facilitated to spend time with their loved one in the period immediately after death if they wish. Regardless of the circumstances surrounding the death, families' wishes to view the deceased resident should be facilitated where possible. Families should be gently prepared by staff for what they may see when viewing their loved one, with reassurance and sensitive guidance throughout.
- 9.6. The resident's property should be returned to the legal next of kin with consideration for the feelings of those receiving it and in line with local policy. If the deceased resident has any soiled or cut clothes, this should be discussed sensitively with the family. They should be given the option to have these returned or disposed of by staff. They may wish to be involved in gathering and packing their loved one's personal property and should be given the opportunity to do so.
- 9.7. In circumstances where the deceased residents have **no** next of kin, care home staff need to alert the key worker, care manager, GP and funeral director of this.

- 9.8.** Nurses and care home staff should take time to explain to the family what will happen next and subsequently provide them with suitable written/electronic bereavement support information to supplement the conversation. This information should be given to the family after the death of the resident has occurred, with an opportunity for the family to ask further questions. Additional specific bereavement resources are available on the website.
- 9.9.** When family members are ready to leave their loved one, it is good practice for a member of staff to accompany them as they leave and offer a final word of condolence, providing an opportunity to answer any questions they may have.
- 9.10.** Staff health and wellbeing is important, and bereavement support/resources should be available to staff in all organisations. These can be accessed on the [Bereaved NI](#) website.

10. Transfer of the deceased resident from the place of death

- 10.1.** After death, the deceased resident will be taken from the care home, to a funeral home while burial and cremation arrangements are made. The privacy and dignity of the deceased resident on transfer from the place of death is paramount. Note if a Coroner is involved, please refer to Section 8.6.
- Each service involved is responsible for ensuring that transfer procedures for the deceased resident demonstrate respect for the values of resident's dignity, for example the way in which the deceased resident is covered and how they are moved from their place of death to their destination.
- 10.2.** If the family request to see their loved one in the funeral home, nursing and care home staff should advise them to contact the funeral directors directly to arrange this.
- 10.3.** Funeral Directors should be informed about any deceased resident who presents a serious infection hazard. Nursing and care home staff can seek advice from their local Trust Infection Prevention and Control Team, if required. Please refer to Section 9.3.
- 10.4.** There needs to be clear communication to funeral directors regarding valuables being transferred with the deceased resident, the presence of implanted device, body composition e.g. residents who are bariatric or have contractures and any other relevant information.
- 10.5.** Follow standard Infection Prevention and Control precautions during transfer, please refer to Section 9.3 [Transmission Based Precautions – NI Infection Control Manual](#).
- 10.6.** Where a family member wishes to accompany their relative on their transfer, consideration should be given to this request and discussed with the funeral director.

11. Recording the care provided after death

- 11.1.** It is important that all aspects of care carried out after death are recorded in the resident's care records. This should include the date, time and who was present at time of death and confirmation that the deceased resident's General Practitioner (GP) has been informed.
- 11.2** Staff should ensure the key worker is informed of the death and a notification sent to RQIA as well as the relevant internal departments of the care home.
- 11.3.** Any risks or problems that may have arisen and the steps taken to address them should be documented in the resident's care notes. An example checklist for use following the death of a resident has been included in this guidance. Please refer to Appendix 3. This can be adapted by individual care homes to document the actions taken by nursing and care staff following the death of a resident.
- 11.4.** Document that bereavement information has been shared with the family.

12. Education, training and support for staff providing care after death

- 12.1.** Education and training on all aspects of care after death should be included in relevant pre-registration curricula for nursing. Ongoing education should be provided to contribute to the professional development of nurses and care home staff.
- 12.2.** The practical aspects of care after death including communication and documentation should be included in the home's induction and training programmes.
- 12.3.** The opportunity for reflection and support should be available for staff after a death and the senior staff within the home, e.g. home manager, deputy home manager or clinical lead should facilitate this. In some circumstances, referral to support services may be helpful such as: Occupational Health, or any other employee wellbeing initiatives, where available.
- 12.4.** All incidents or concerns related to care after death should be reported to RQIA and via organisational arrangements for incident reporting with outcomes and learning points or actions shared with the staff involved.
- 12.5.** All comments or compliments received from families, relating to care before, at the time of and after death, should be shared with relevant staff to demonstrate the impact their care had on the family. If helpful, families can be directed to speak with the home manager or senior member of staff.

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This guidance references the HSC Services Strategy for Bereavement Care (2009) Standards, (Appendix 1) which could be adopted for use by care homes if they wish.

Appendix1

HSC Services Strategy for Bereavement Care (2009) Standards

Standard 1: Raising Awareness

Health and Social Care staff will be suitably trained to have an awareness and understanding of death, dying and bereavement. Staff should also acknowledge the fact that grief is a normal process following loss and that needs vary according to an individual's background, community, beliefs, and abilities.

Standard 2: Promoting Safe and Effective Care

Health and Social Care staff who have contact with people who are dying and/or those affected by bereavement will deliver high quality, safe, sensitive and effective care before, at the time of and after death according to individuals' backgrounds, communities, beliefs and abilities.

Standard 3: Communication Information and Resources

People who are dying and those who are affected by bereavement will have access to up to date, timely, accurate and consistent information in a format and language which will be helpful to their particular circumstances and consistent with their needs, abilities and preferences. Staff will remember that the availability of written or other information does not negate their personal support role.

Standard 4: Creating a Supportive Experience

Those who are dying and their families will be afforded time, privacy, dignity and respect and wherever possible, given the opportunity to die in their preferred environment with access to practical, emotional and spiritual support based on their individual needs and preferences.

Standard 5: Knowledge and Skills

Health and Social Care organisation recognize the value of a skilled workforce by ensuring that those coming into contact with, or caring for people who are dying and those affected by bereavement are competent to deliver care through continuing professional development; and by having systems in place to support them.

Standard 6: Working Together

Good communication and coordination will take place within and between individuals, organisation and sectors, to ensure that resources are targeted efficiently and effectively and that there is integration of care to meet the needs of people who are dying and their families, friends and carers.

Appendix 2

Legislation and standards for care homes

The Health and Residential Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003

Available at: <https://www.legislation.gov.uk/nisi/2003/431/data.pdf>

The Nursing Homes Regulations (Northern Ireland) 2005

Available at: <https://www.legislation.gov.uk/nisr/2005/160/contents/made>

The Residential Care Homes Regulations (Northern Ireland) 2005

Available at: <https://www.legislation.gov.uk/nisr/2005/161/contents/made>

Care Standards for Nursing Homes – December 2022 | Regulation and Quality Improvement Authority

Available at: https://www.rqia.org.uk/wpfd_file/care-standards-for-nursing-homes-december-2022/

Residential Care Homes Minimum Standards – December 2022 | Regulation and Quality Improvement Authority

Available at: https://www.rqia.org.uk/wpfd_file/residential-care-homes-minimum-standards-december-2022

Appendix 3

Checklist Following the Death of a Resident

Name of Resident: Room No:

Date of Birth:

Verification of life extinct <i>Please tick box</i>	YES	NO	N/A
Has Verification of Life Extinct been carried out?			
Date and time of verification of death recorded in the resident's care record?			
GP informed of the death of the resident by nurse/care home staff?			
If no, delegated to: Name.....			
Designation Date			
Care of the Family of the Deceased Resident's <i>Family refers to all those important to the patient</i>	YES	NO	N/A
Family informed of the death?			
Family facilitated to spend time with the resident?			
End of life Care Symbol displayed in the immediate area?			
Resident or family's spiritual advisor contacted, if requested?			
Religious/cultural requirements for care of the deceased resident discussed and documented?			
Does the family want cremation? If yes, please inform the doctor			
Verbal and written bereavement information, including link for the Bereaved NI website, provided to family?			
If Medical Certificate of Cause of Death (MCCD) not completed, was the family informed?			
Resident's belongings returned to legal next of kin?			
Procedures after death	YES	NO	N/A
Have Funeral Directors been contacted to collect the deceased resident?			
Has the death been reported to the Coroner?			
MCCD completed and emailed to the General Register Office (GRO) by the GP?			
If deceased resident does not have a next of kin - Key Worker / Care Manager/ Nominated Solicitor informed?			
Notification of death sent to RQIA?			
Care after Death procedure carried out by: Name: (print)..... Designation: Name: (print)..... Designation:			

Staff member completing the checklist:

Print Name: Designation:

Signature: Date:

Appendix 4A

NI Bereavement Network - Guideline Review Working Group

Name	Designation
Dr Patricia Donnelly	Chair Northern Ireland Bereavement Network Department Of Health
Michael Deery	Policy Lead Department of Health
Laura Creaney	Trust Bereavement Coordinator Southern Health and Social Care Trust
Donna-Louise Laird	Trust Bereavement Coordinator South Eastern Health and Social Care Trust
Leona Laverty	Trust Bereavement Coordinator Northern Health and Social Care Trust
Carole McKeeman	Trust Bereavement Coordinator Western Health and Social Care Trust
Tracey Ashfield	Trust Bereavement Coordinator Belfast Health and Social Care Trust
Diane Walker	Palliative Care in Partnership Macmillan Programme Manager

Appendix 4B

Working subgroup for Care of the Deceased Adult in Care Homes and Those Important to Them. A Guideline for Care Home Staff in Nursing Practice Northern Ireland

Name	Designation
Jo Browne	Director of Care Services Optimum Care Group
Sharon Smyth	Safeguarding & Quality Improvement Director Hutchinson Care Homes
Tracey Ashfield	Trust Bereavement Coordinator Belfast Health and Social Care Trust
Donna Louise Laird	Trust Bereavement Coordinator South Eastern Health and Social Care Trust

Appendix 5

Glossary of Terms

ACP	Advanced Care Plan
CARE STAFF	Includes healthcare assistants (social care practitioners) and all other staff who provide care to the resident
CIED	Cardiac Implantable Electronic Devices
CNO	Chief Nursing Officer
DOH	Department of Health
DHSSPS	Department of Health, Social Services and Public Safety
ET	Endotracheal
FAMILY	Includes all those important to the resident, including friends, loved ones and all significant others
GP	General Practitioner
GRO	General Register Office
ICD	Implantable Cardioverter-Defibrillator
IPC	Infection Prevention and Control
MCCD	Medical Certificate of Cause of Death
NHS	National Health Service
NIBN	Northern Ireland Bereavement Network
NIECR	Northern Ireland Electronic Care Record
NISRA	Northern Ireland Statistics and Research Agency
NMC	Nursing and Midwifery Council
PME	Post-Mortem Examination
PSNI	Police Service of Northern Ireland
RQIA	Regulation and Quality Improvement Authority
TBC	Trust Bereavement Coordinator
VOLE	Verification of Life Extinct