Health and Social Care in Northern Ireland

Department of Health, Social Services and Public Safety

Northern Ireland Audit: Dying, Death and Bereavement

Policies, procedures and practices in hospital and hospice settings

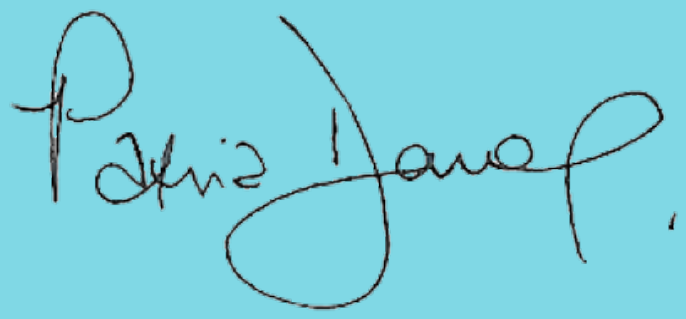
2009

Foreword

Funded by the Regional Multi-professional Audit Group this important audit was the first piece of work undertaken by the Northern Ireland Health and Social Care Bereavement Network. Its findings form the basis of the Bereavement Strategy for Health and Social Care Services in Northern Ireland which is launched in 2009.

The findings have identified the excellent work in hospitals and hospices across Northern Ireland in supporting patients, relatives and staff at the time of and following bereavement. The audit also identified the significant pressures experienced by the services and the need for ongoing training and support.

Thanks must be given to the Area Bereavement Coordinators for their central role in the audit and in the development of the Bereavement Strategy. The audit would not have been achievable without the active cooperation and enthusiasm of the NI Hospices and HPSS Trusts, in particular the clinical and management staff to whom special thanks is given.



Dr Patricia Donnelly
NI Health & Social Care Bereavement Network

Contents Page

Executive Summary

The Department of Health, Social Services and Public Safety (DHSSPS), in response to the Northern Ireland Human Organs Inquiry 2002, established the Northern Ireland Bereavement Network and appointed five Area Bereavement Coordinators (ABCs) to coordinate and develop bereavement care standards and training across the province.

Approximately 14,000 to 15,000 people die each year in Northern Ireland, over half of them in hospitals. In 2006-07, an audit was undertaken of 35 HPSS hospitals and all 5 hospices in Northern Ireland. The aims of the audit were to map current services across the province and identify the profile of need for care of the dying and bereaved, to inform the development of the strategy for bereavement care for Northern Ireland.

The audit was undertaken by the Bereavement Coordinator in each Health and Social Services Board area on behalf of the Bereavement Network for Northern Ireland. The Bereavement Coordinators posts were funded by the DHSSPS, following recommendations 9, 10 and 12 of the Human Organ Inquiry 2002.

It is recognised that care of dying patients and support of bereaved relatives requires a multi-disciplinary approach therefore this audit was divided into eight strands:

1. Demographics – information on the profile of deaths across Northern Ireland.

2. Organisational – information on services provided in HPSS and hospice including governance arrangements underpinning services.

3. Ward visits – information from a sample of wards in different specialities, in respect of policies, procedures and practices.

4. Mortuary services within HPSS – information on facilities and practices.

5. Chaplaincy service in HPSS and hospices – information on services provided and how patients' spiritual needs are met.

6. Palliative care services – information on the make-up of teams and services provided.

7. Porters and funeral directors services – information on the transfer and release of deceased patients.

8. Individual staff questionnaires – information on knowledge, skills and experience of caring for dying patients and their families.

The audit identified areas of good practice, as well as pressures faced by staff in the acute hospital setting and the need for appropriate staff training and support systems.

The main findings of the audit, together with the outcomes of a number of workshops, have informed the development of the Northern Ireland HSC Strategy for Bereavement Care, to be published in 2009.

1. Introduction

1.1. Background and purpose of the audit

The Northern Ireland Human Organs Inquiry 2002 made specific recommendations 9, 10 and 12 in respect of bereavement care in public health services. In consequence the Northern Ireland Bereavement Network was established by the Department of Health Social Services and Public Safety (DHSSPS) as a partnership across Health & Social Care Trusts. Five Area Bereavement Coordinators (ABCs) were appointed to deliver the work of the Network, to coordinate and develop bereavement care standards and training within the health and social care sector across the province and to work in partnership with the non-statutory, voluntary and community sector

The Northern Ireland Audit on Dying, Death and Bereavement was commissioned by the DHSSPS and funded through the Regional Multi-professional Audit Group (RMAG). It is planned as a two stage audit with the second stage in years 2009/10 focusing on community services and user experience. The first stage undertaken in 2006/07, reported here, maps current services across the province and identifies the profile of need for the care of the dying and bereavement care in the HPSS and hospice service.

The audit assessed policies, procedures and practices in relation to death and bereavement care within hospitals and hospices across Northern Ireland. It was informed by national and regional standards alongside current legislation, core strategies, guidelines and literature, including the following:

- Births and Deaths Registration (Northern Ireland) Order (1976)
- Coroners Act (Northern Ireland) 1959 (Section 7)
- Human Tissue Act 2004
- DH (2003), NHS Chaplaincy: Meeting the Religious and Spiritual Needs of Patients and Staff
- DH (2005), When a Patient Dies: Advice on Developing Bereavement Services in the NHS
- DH (2006), Care and Respect in Death: Good Practice Guidance for NHS Mortuary Staff
- DHSSPS (2000), Partnerships in Caring: Standards for Service. A Review of Palliative Care
- DHSSPS (2003), Breaking Bad News: Regional Guidelines, Developed from Partnerships in Caring (2000)
- DHSSPS (2005), A Code of Good Practice on Post Mortem Examinations: A Careplan for Women who Experience a Miscarriage, Stillbirth or Neonatal Death
- DHSSPS (2005), Post Mortem Examinations - A Code of Good Practice: Rights of Patients and Relatives: Responsibilities of Professionals
- DHSSPS (2006), The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS

- DHSSPSNI, PSNI, Court Service NI and HSENI (2006), Memorandum of Understanding: Investigating Patient or Client Safety Incidents (Unexpected Death or Serious Untoward Harm)
- Equality Commission NI and DHSSPS (2003), Racial Equality in Health and Social Care - Good Practice Guide
- Human Tissue Authority (2006), Codes of Practice
- National Institute for Health and Clinical Excellence (2004), Improving Supportive and Palliative Care for Adults with Cancer
- NHS Executive (2000), Resuscitation Policy
- NHS Estates (2005), A Place to Die with Dignity: Creating a Supportive Environment

The main findings of the audit, together with the outcomes of a number of workshops, whose participants were drawn from across the statutory, voluntary, private and community sectors which included individuals from a diverse range of faiths and interests, have already informed the Northern Ireland Health and Social Care Services Strategy for Bereavement Care.

1.2 Scope of the audit

The most recent year for which official figures were available prior to the audit being carried out was January-December 2005. During this year 14,224 deaths were registered in Northern Ireland; of these (Figure 1) 57% were reported to have occurred in 'hospitals', a further 16% in 'nursing homes and other hospitals, including psychiatric hospitals', and the remaining 27% in 'all other places, for example private residences or public buildings' (Eighty-fourth Annual Report of the Registrar General 2005).

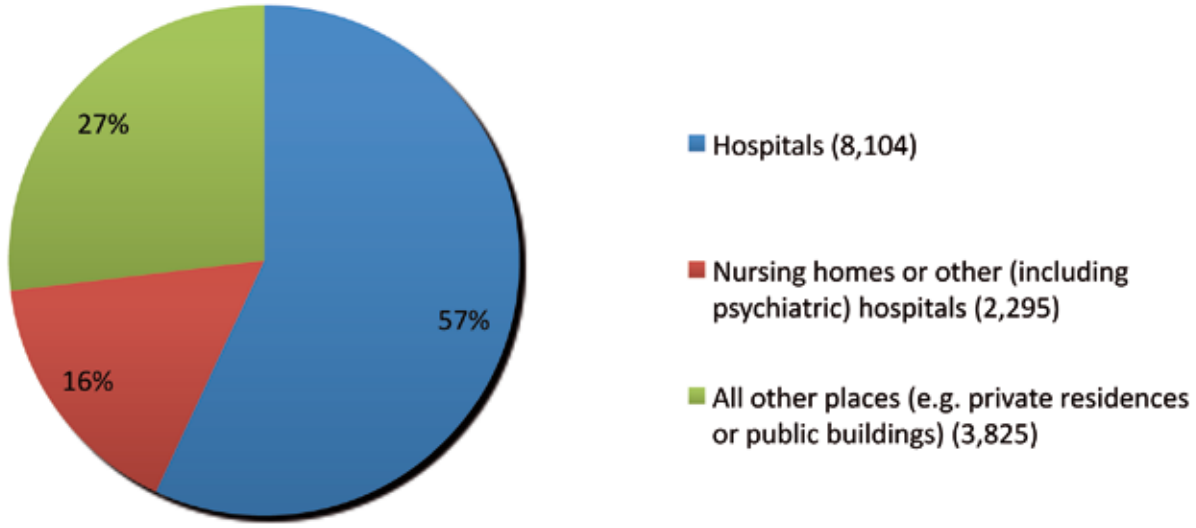


Figure 1: Number and location of deaths registered in Northern Ireland in 2005 (Registrar General statistics)

Given that the majority of deaths in Northern Ireland occur within the hospital sector, it was the care and practices in relation to end of life and bereavement care across the province's hospitals (as well as in all five of its hospices, given the central purpose of hospices in the care of terminally ill patients) that formed the focus of the current audit.

The population of Northern Ireland is estimated at just over 1.75 million. Table 1 shows the population distribution across the five current Health & Social Care Trusts; and the eighteen legacy HSS Trusts which were operational at the time of the audit. It is recognised that the Belfast Trust provides a number of specialist regional services to the wider population.

HSC Trust	HSS Legacy Trusts	Population
Belfast HSC Trust	Belfast City Hospital Trust, Greenpark Trust, Royal Group of Hospitals and Dental Hospital Trust, Mater Hospital Trust, South and East Belfast Trust, North and West Belfast Trust.	340,000
Northern HSC Trust	United Hospitals Trust, Causeway Trust, Homefirst Community Trust.	450,000
South Eastern HSC Trust	Ulster Community and Hospitals Trust, Down Lisburn Trust.	335,000
Southern HSC Trust	Craigavon Area Hospital Group Trust, Craigavon and Banbridge Community Trust, Newry and Mourne Trust, Armagh and Dungannon Trust.	343,000
Western HSC Trust	Altnagelvin Hospital Trust, Sperrin Lakeland Trust, Foyle Trust.	295,000

Table 1: Population and organisation of local HSC trusts

For ease of reference the remainder of this document will collate information and refer only to the new HSC Trust configurations.

The audit targeted every hospice as well as all the main acute and local hospitals and a significant proportion of minor and more specialist hospitals (specifically, in the areas of eldercare, mental health and learning disability) across Northern Ireland. The sample consisted of 35 hospitals (including an inpatient mental health unit) listed in Table 2 by HSC Trusts, and the 5 hospices listed by geographical location.

HSC Trust	Hospitals	Hospices
Belfast HSC Trust	Belfast City Hospital, Royal Victoria Hospital, Royal Jubilee Maternity Service, Royal Belfast Hospital for Sick Children, Mater Hospital, Musgrave Park Hospital, Forster Green Hospital, Muckamore Abbey Hospital, Knockbracken Healthcare Park.	Northern Ireland Hospice Care
Northern HSC Trust	Antrim Area Hospital, Mid-Ulster Hospital, Whiteabbey Hospital, Causeway Hospital, Moyle Hospital, Braid Valley Hospital, Dalriada Hospital, Robinson Memorial Hospital, Holywell Hospital.	Northern Ireland Children's Hospice
South Eastern HSC Trust	Ulster Hospital, Ards Hospital, Bangor Hospital, Lagan Valley Hospital, Downe Hospital, Downshire Hospital.	Marie Curie Hospice
Southern HSC Trust	Craigavon Area Hospital, South Tyrone Hospital, Daisy Hill Hospital, Lurgan Hospital, Mullinure Hospital, Inpatient Psychiatry Unit, St Luke's Hospital, Longstone Hospital.	Southern Area Hospice Services
Western HSC Trust	Altnagelvin Hospital, Tyrone County Hospital, Erne Hospital.	Foyle Hospice

Table 2: Hospitals (n=35) and hospices (n=5) included in the audit

1.3 Audit methodology

The Chief Executives with responsibility for each of the HSC hospitals and hospices referred to in Table 2 were invited to take part in the audit, and all agreed and signed up to the project. Trust and audit leads were identified to assist the Area Bereavement Coordinators in the collection of information.

The audit comprised eight strands and used a mixed methodology of both quantitative and qualitative data collection.

Demographics

Information on the profile of deaths occurring between 1st April 2005 and 31st March 2006 within each hospital and hospice was collected. This included the number and location of the deaths, the age profile of the deceased, including miscarriages, stillbirths and neonatal deaths, and also 'consented' (i.e. hospital) and 'unconsented' (coroners) post mortem examination activity.

Organisational

The identification and analysis of a number of aspects of service provision and governance arrangements was undertaken, including policies and protocols, which were in place for the care of dying and bereaved people within the various hospitals and hospices audited. Questionnaires were issued to the nominated leads within each hospice or trust.

Ward visits

Data collection proformas from specialties and wards within each hospital were completed by senior nursing staff: Semi-structured interviews were also used with managers of each ward (or their nominees or deputies) on a range of aspects of the care provided to dying and bereaved people.

Mortuary services

As the majority of patients who die in hospital are transferred to a mortuary, information was collected from pathology technicians or those with responsibility for policies, procedures and practices within each of those organisations which identified itself as having an 'operational mortuary' (i.e. one that has the facilities to carry out post mortem examinations and/or has refrigerated body storage). This included information on processes surrounding admission and release of the deceased, access to viewing facilities for bereaved people and the nature of training undertaken by staff.

Chaplaincy services

To assess how the spiritual needs of patients are met, information was collected on the services provided by chaplains, including their referral processes, the availability of literature and the facilities that are available for the use of chaplains. This was obtained either directly through meetings with lead chaplains or from managers with responsibly for chaplaincy services.

Palliative care services

Given their close involvement with dying patients and bereaved relatives, information was obtained directly from team members about the services provided by palliative care teams within acute hospital settings. This included their referral processes, the challenges inherent in providing their services and the training undertaken by members of the team.

Porters and funeral directors

In the majority of hospitals, portering teams are directly responsible for the transfer of deceased patients to mortuaries and some are involved in undertaking mortuary duties directly. A number of hospitals have service level agreements with funeral directors for the transfer and release of deceased patients. Information about the duties undertaken and the challenges in providing these services was obtained from portering managers and, where applicable, the contracted funeral directors.

Individual staff questionnaires

Given the importance of a multidisciplinary team and inter-agency approach to patient care, the final strand of the audit was aimed at a significant cross section of health care employees from a range of professional backgrounds who might be expected to come into contact with dying and bereaved people. In particular, their views were sought on the environments in which bereavement care is provided, the nature of the care itself, and the skills, training and support required and available to staff in relation to end of life care. The Area Bereavement Coordinators distributed over 3,500 questionnaires to wards, departments and key professionals throughout individual Trusts, of which 1,633 were returned for analysis.

The eight strands and the scope of the audit are summarised in Table 3.

Audit Strand	**Sources of Information (with Numbers Included/Returned)**
Demographics	Hospitals (35) and hospices (5)
Organisational	Hospitals (35) and hospices (5)
Ward visits	Wards (140) and hospices (5)
Mortuary services	Staff in operational mortuaries (12)
Chaplaincy services	Chaplaincy teams in hospitals and hospices (33)
Palliative care services	Palliative care teams in acute hospitals (11)
Porters and funeral directors	Portering teams (15) and funeral directors with service level agreements for portering and mortuary duties (5)
Staff questionnaires	Individual staff members (1,633)

Table 3: The strands and scope of the audit

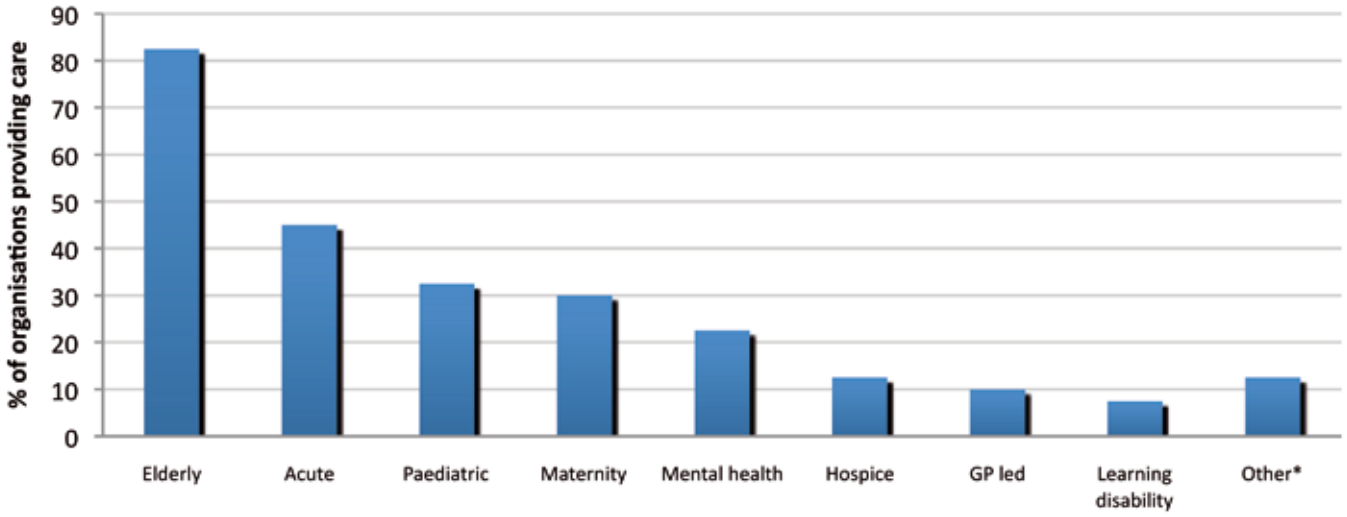
The figures in Table 3, apart from individual staff questionnaires, represent the numbers of organisations (i.e. hospitals and hospices), individual wards (including hospices) and services (mortuary, chaplaincy, palliative care and portering) from whom information was both requested and returned. Although a total of 35 individual hospitals were included in the audit, a single, corporate response was provided in respect of the Ulster, Ards and Bangor Hospitals. Although all organisations had a dedicated chaplaincy service, a number of chaplaincy services operated across more than a single organisation therefore while 27 chaplaincy services participated in the audit they covered 33 individual hospitals and hospices. The figure in the table for the staff questionnaires refers to the number of individual returns that were received.

Information returned was not always complete, particularly the individual staff questionnaires. For that reason, the audit results are presented by percentages as well as number of returns actually received.

2. Overview of HSC Trusts and Services Provided

2.1 Demographics and organisations

The types of inpatient care provided in each of the 35 hospitals and 5 hospices audited are presented in Figure 2. As expected, given the province's increasingly aging population, a large majority of organisations (83%) provided elderly care facilities, with between 20% and 45% providing care in each of the acute, paediatric, maternity and mental health areas and fewer than 15% in any other major specialist area.



* Regional, ambulatory paediatrics (including outpatients), orthopaedic/rheumatology/neurology and elective

Figure 2: Types of care provided by hospitals and hospices in Northern Ireland (n=40)

The data is consistent with that presented in Figure 3, which shows the number of inpatient deaths recorded in each of the main specialist areas within the hospitals and hospices audited throughout the (financial) year 2005-06.

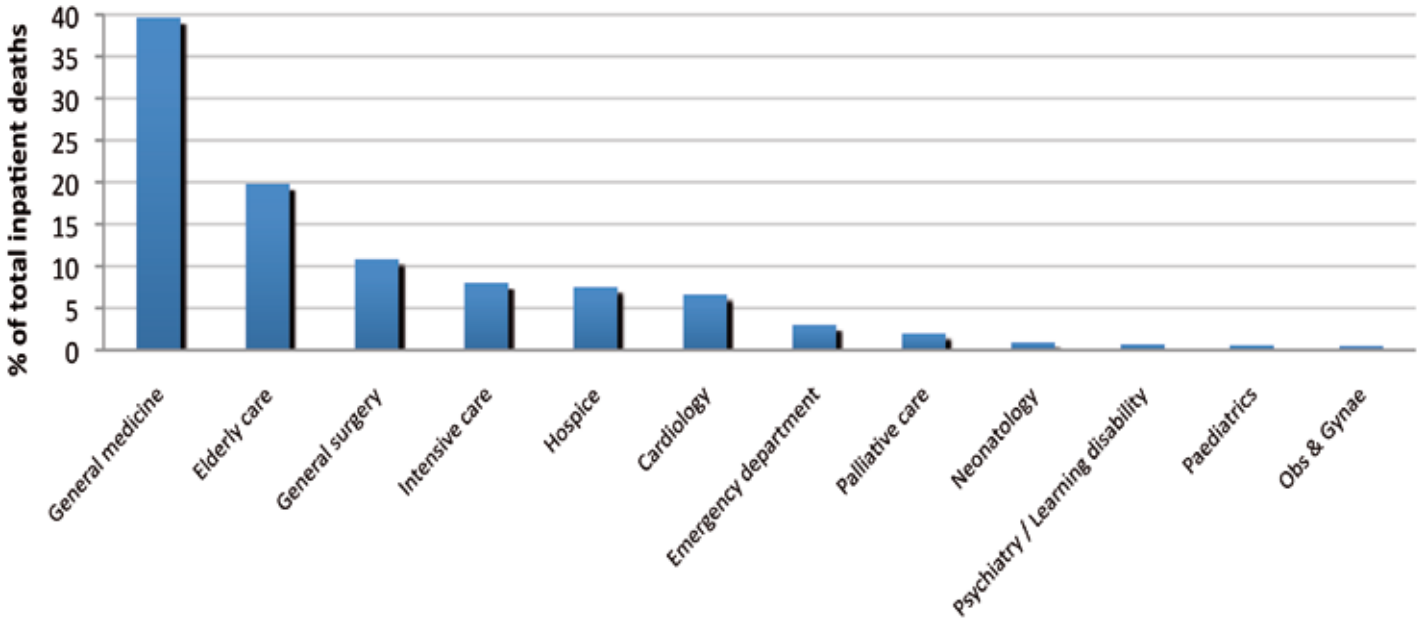


Figure 3: Inpatient deaths by specialist area (1 April 2005 to 31 March 2006)

In 2005/2006 in Northern Ireland there were 7,944 recorded inpatient deaths in total: 7,359 in the 35 HPSS hospitals and 585 in the 5 hospices. General medicine (with almost 40% of all inpatient deaths) recorded the highest percentage, followed by elderly care (with almost 20%). However, there will have been significant overlap between these two areas since a high proportion of deaths in general wards are from the older age group. The next-highest numbers of deaths were general surgery (11%), intensive care units (8%), hospices (7.5%) and cardiology wards (almost 7%). No other speciality accounted for more than 3% of the total recorded inpatient deaths for the year.

Data was collected from every intensive care and neonatal unit, emergency department and hospice across the province, as well as other specialist areas. In all, 25 wards from each of general medicine and elderly care (where the highest numbers of inpatient deaths occur) were visited; together this represents approximately one-third of all visits undertaken.

The number of wards and hospices visited within all of the specialist areas, along with their associated percentages of the overall total of 145, is presented in Table 4. Most organisations have separate wards for obstetrics and gynaecology; however in two of the facilities visited these areas shared a common ward. For the purpose of this audit, the joint wards have been treated separately from the other obstetrics and gynaecology wards.

Area of Speciality	**Number (and % of Overall Total) of Facilities Visited**
General medicine	25 (17%)
Elderly care	25 (17%)
General surgery	16 (11%)
Emergency department	16 (11%)
Intensive care unit	13 (9%)
Cardiology	13 (9%)
Paediatrics	8 (6%)
Obstetrics	8 (6%)
Gynaecology	7 (5%)
Neonatology	7 (5%)
Hospice	5 (3%)
Obstetrics and gynaecology	2 (1%)

Table 4: Number (and percentage of the overall total) of wards and hospices visited within each specialist area

The Miscarriage Association estimates that about a quarter of all pregnancies end in miscarriage. Although not recorded legally as ‘deaths’ if they occur before the age of 24 weeks gestation, miscarriages have a significant impact on the parents concerned, as well as on the care and support they require from staff.

A breakdown of the deaths within the 35 hospitals and 5 hospices, as well as those resulting from miscarriage or stillbirth, are presented in Figure 4. As predicted, the highest number of deaths was in the age group 65 years and over, while miscarriages constituted the second largest group. Whereas the overall number of deaths of children under the age of 18 years is low, it is recognised that the death of a child is especially traumatic for families.

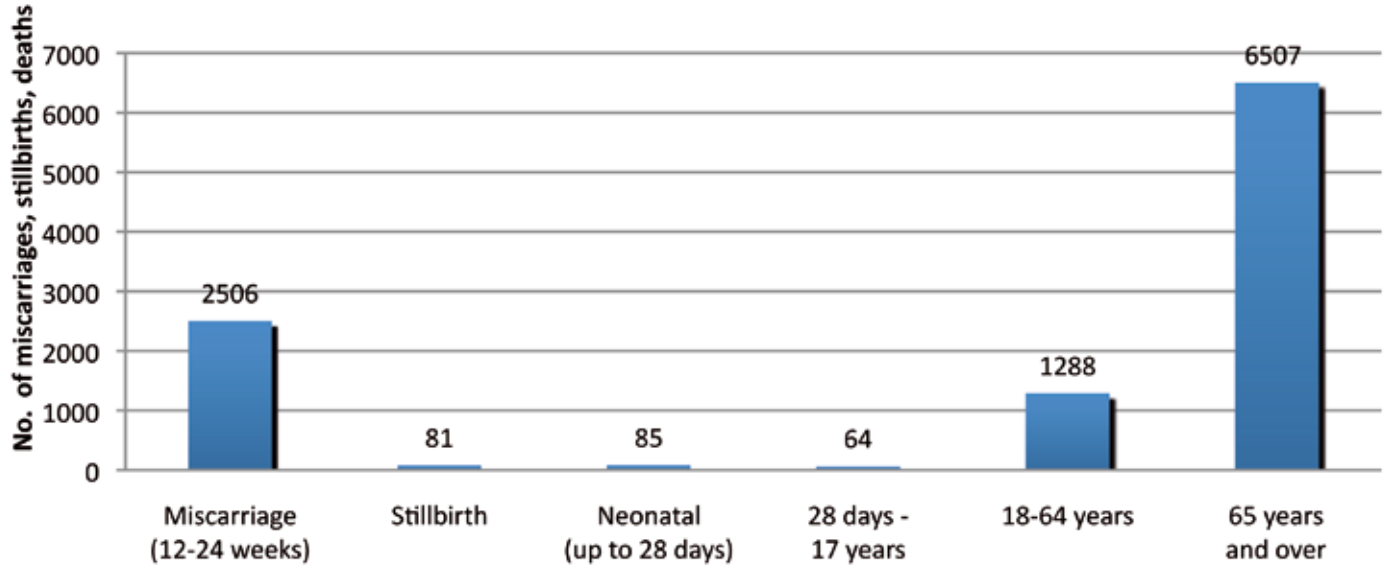


Figure 4: Miscarriages, stillbirths and certified deaths in hospitals (n=35) and hospices (n=5), April 2005 – March 2006

Some hospital deaths, such as those that are unexpected or unexplained, require referral to the coroner and may be subject to a coroners ('unconsented') post mortem examination, while others may involve a hospital ('consented') post mortem examination being carried out.

Public confidence in the post mortem examination process decreased dramatically following the disclosure of the issues that led to the Human Organs Inquiry (2002). The subsequent introduction of new legislation (the Human Tissue Act 2004) has sought to address the shortcomings of earlier practices. The DHSSPS, for example, has introduced new codes of practice, consent forms and information booklets for use by staff and to support families of deceased patients who are undergoing hospital post mortem examinations. These include a careplan for women who experience a miscarriage, stillbirth or neonatal death.

For all of the miscarriages, stillbirths and deaths referenced in Figure 4, data was collected on the relative proportions of hospital (consented) and coroners (unconsented) post mortem examinations carried out within the different age ranges. This information is summarised in Figure 5.

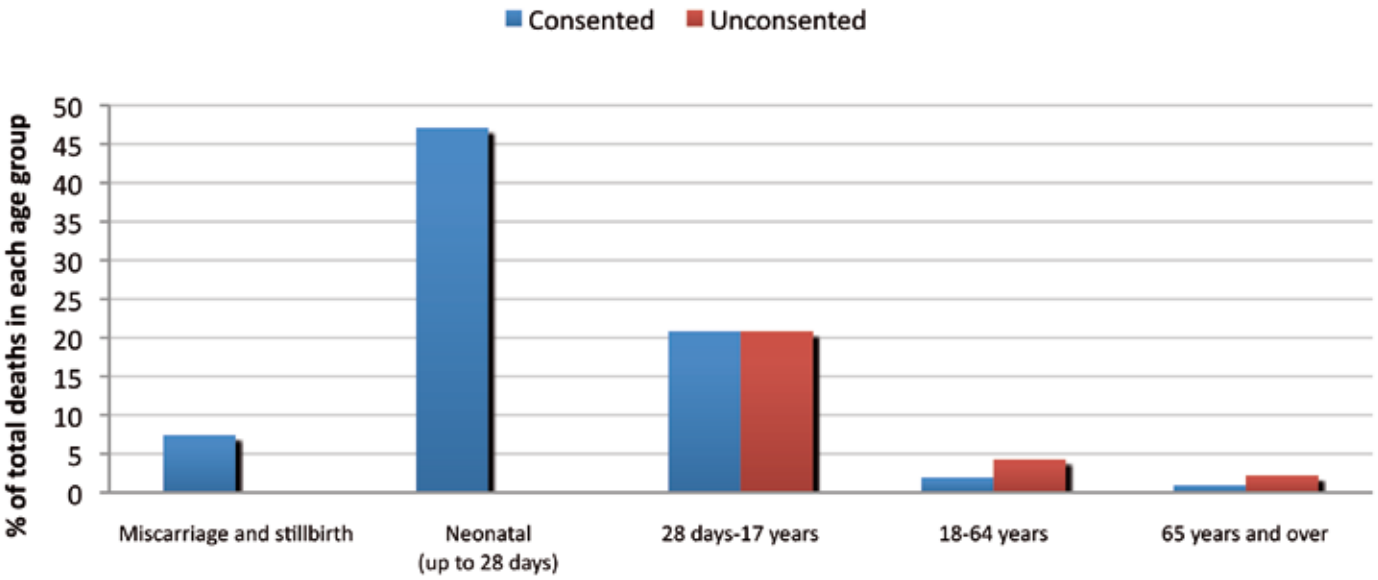


Figure 5: Post mortems completed in respect of miscarriages, stillbirths and deaths in hospitals (n=35), 2005-2006

While the highest percentage of deaths occurred in the over-65 age group, there were relatively few post mortem examinations carried out on this population, as most deaths at that age are expected to be from natural causes or disease processes. The highest number of post mortem examinations was carried out on children under the age of 18 years, with almost half of all children who die in neonatal units undergoing a hospital (consented) post mortem examination.

2.2 Staff groups and services

In addition to the 145 ward visits, over 3500 questionnaires were issued to a variety of healthcare staff groups to collect information on their involvement and experience of caring for dying patients and their families. Of these, 1633 questionnaires were returned. Figure 6 presents a breakdown of the staff groups who responded to the questionnaire, along with the lengths of service of the 94% (1540) who volunteered that information.

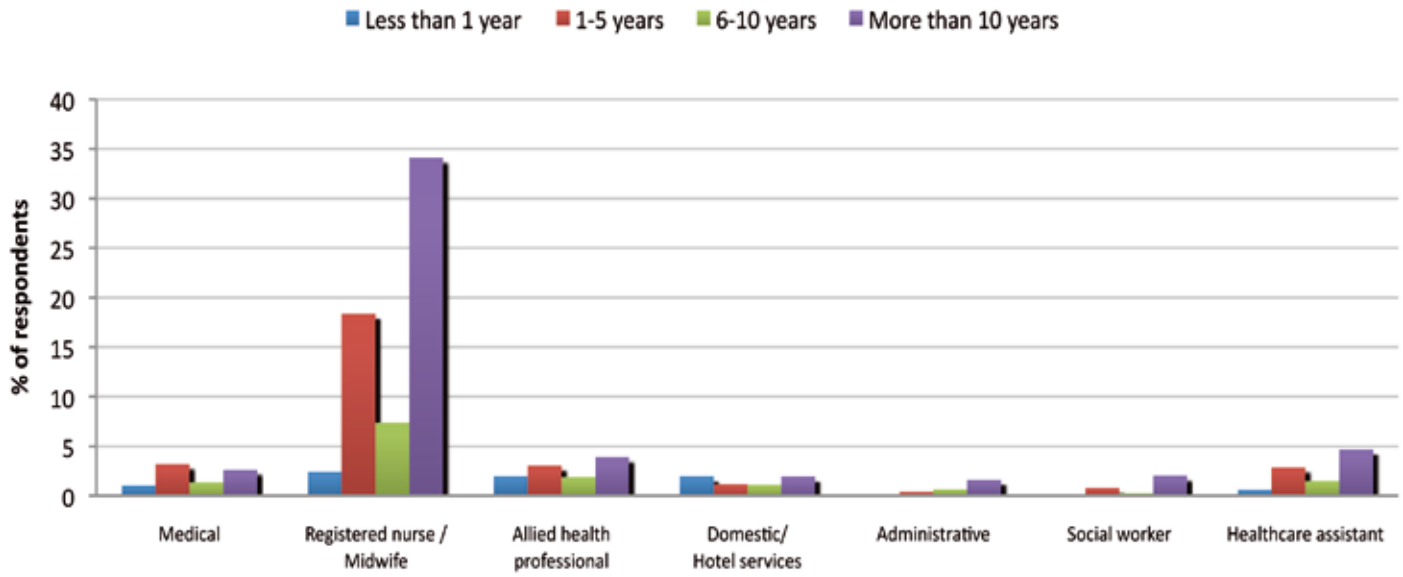


Figure 6: Lengths of service of staff responding to the individual questionnaires (n=1540)

Nurses, by far the largest professional group employed by HSC trusts, provided over 60% of the questionnaires returned. In addition, over half the nurses who responded had been in service for 10 years or over, so they represented a significantly experienced group of staff.

The individual questionnaires asked staff about the frequency of their contact with patients who are dying, their families or with other staff involved with the care of dying patients. As can be seen from Figure 7, around one-third of those staff who responded to the questionnaire often deal with dying patients or others directly affected by their deaths (i.e. at least weekly), with similar numbers having such experiences at least monthly and less than monthly respectively, and only just over 5% having no such contact at all.

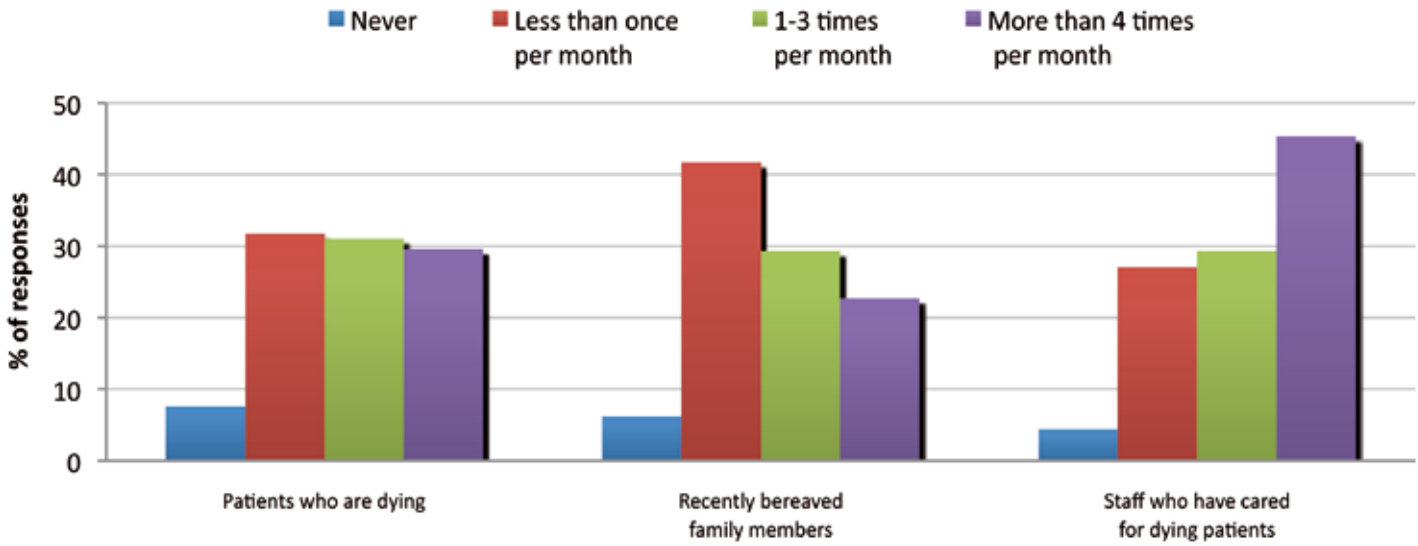


Figure 7: Frequency with which staff deal with issues of death and dying (n=1560)

2.3 Mortuary services

Mortuaries are a vital part of the service the HPSS provides to patients who die in hospital and to bereaved families and friends (Care and Respect in Death, DOH 2005). There are four HSC Trust mortuaries where post mortem examinations are carried out – one in each of four of the five Trusts, with the fifth, the South Eastern Trust, having access to the post mortem facilities of the Belfast Trust.

Figure 8 summarises the different types of mortuary facility available in the hospitals and hospices included in the audit. A total of 18 organisations (45%) had access to a mortuary; 14 (35%) had designated areas where bodies could remain until collected by funeral directors; and in the remaining services (20%) it was practice for funeral directors to collect patients' bodies directly from wards.

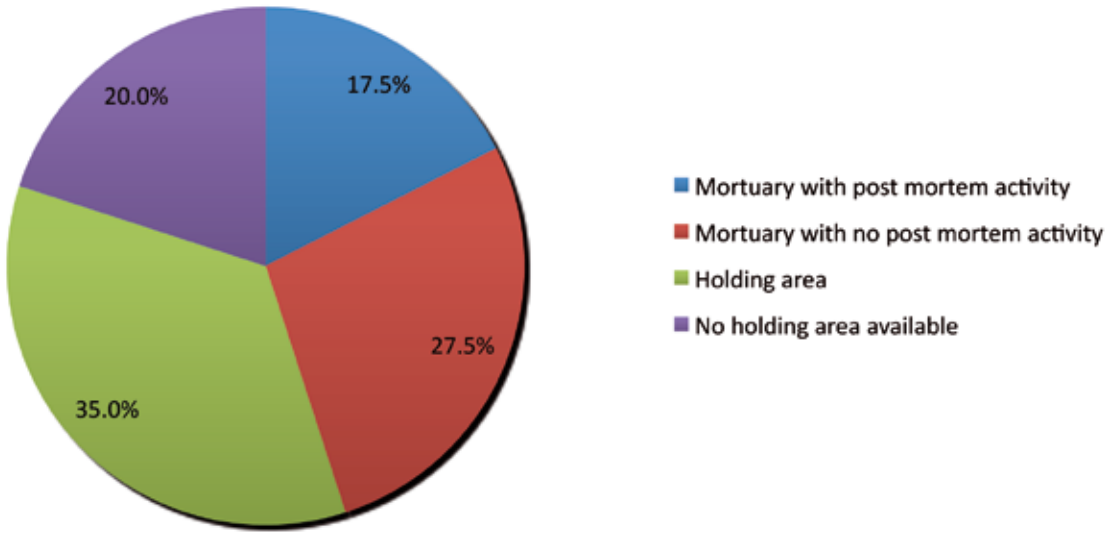


Figure 8: Types of mortuary facilities within the 35 hospitals and 5 hospices

A total of 23 employees were identified as working within the mortuaries. Of these, 15 were qualified pathology technicians, 4 were mortuary attendants, and 2 each were designated porters and laboratory staff. Mortuary staff work a range of full-time, part-time and on-call hours, and some also have duties in other parts of the hospital.

2.4 Palliative care services

The audit identified the profile of specialist palliative care services across the region, with eleven specialist teams within the acute sector across Northern Ireland – three in the Belfast Trust, and two in each of the other four Trusts – based in the Altnagelvin, Antrim, Belfast City, Causeway, Craigavon Area, Lagan Valley, Mater, Daisy Hill, Royal, Erne and Ulster Hospitals respectively. Some of these teams work across both hospital and community sites. Operational policies were in place for 60% of the teams.

Representatives of each palliative care service were asked to identify the different professions in their respective teams. The results are summarised in Figure 9, which shows that whilst all eleven teams comprised specialist nursing staff and 82% had a consultant physician, other disciplines were much less likely to be included.

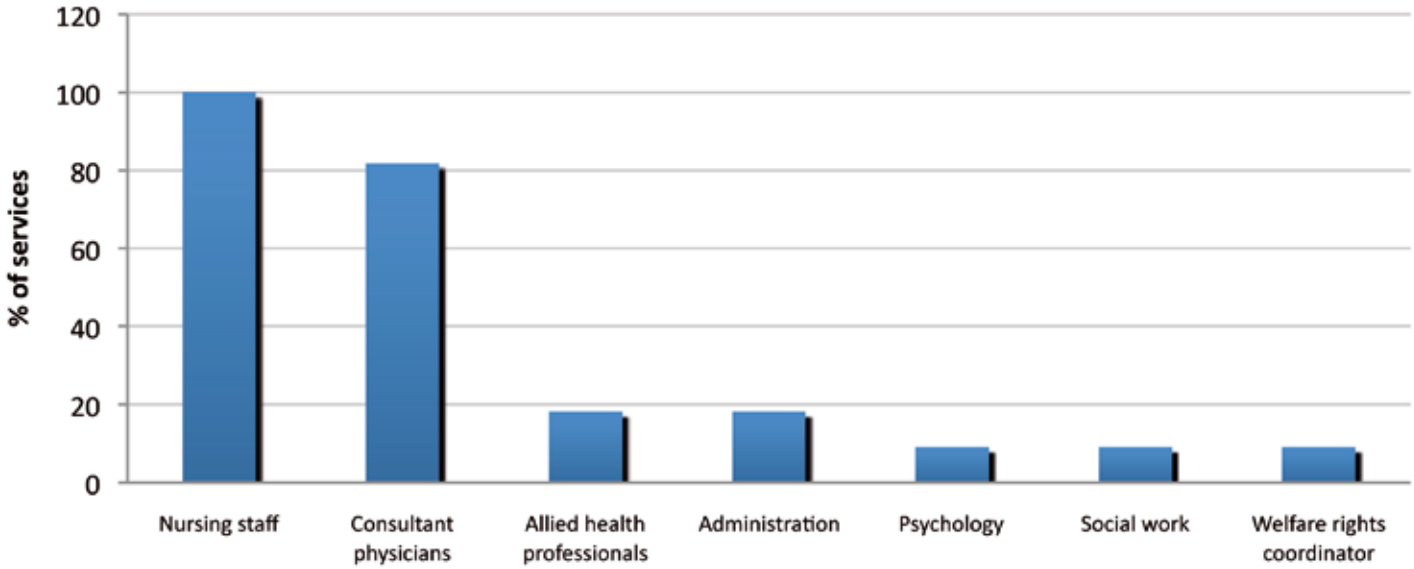


Figure 9: Professional membership of the specialist palliative care teams (n=11)

Recent needs assessments carried out in the palliative care sector have led to the development and inclusion of a limited number of specialist practitioners from disciplines such as speech and language therapy, physiotherapy, occupational therapy, nutrition and dietetics, social work and psychology.

2.5 Chaplaincy services

In recognition of the fact that the quality of services provided to the dying and bereaved can be enhanced through access to different forms of spiritual care (When a Patient Dies, Department of Health 2005), information about chaplaincy services was also collected as part of the audit.

Figure 10 summarises the extent to which the main religious denominations are represented within the 27 chaplaincy teams which, between them, served 33 of the hospitals and hospices included in the audit. Most Trusts employed a chaplain from each of the four main denominations, while it was widely reported that the Methodist chaplain liaises with other appropriate religious/spiritual representatives as required. Within the Northern Ireland Hospice, the spiritual needs of patients are attended to by two generic chaplains. It is also recognised that patients and families often use the services of their home/community church or organisation.

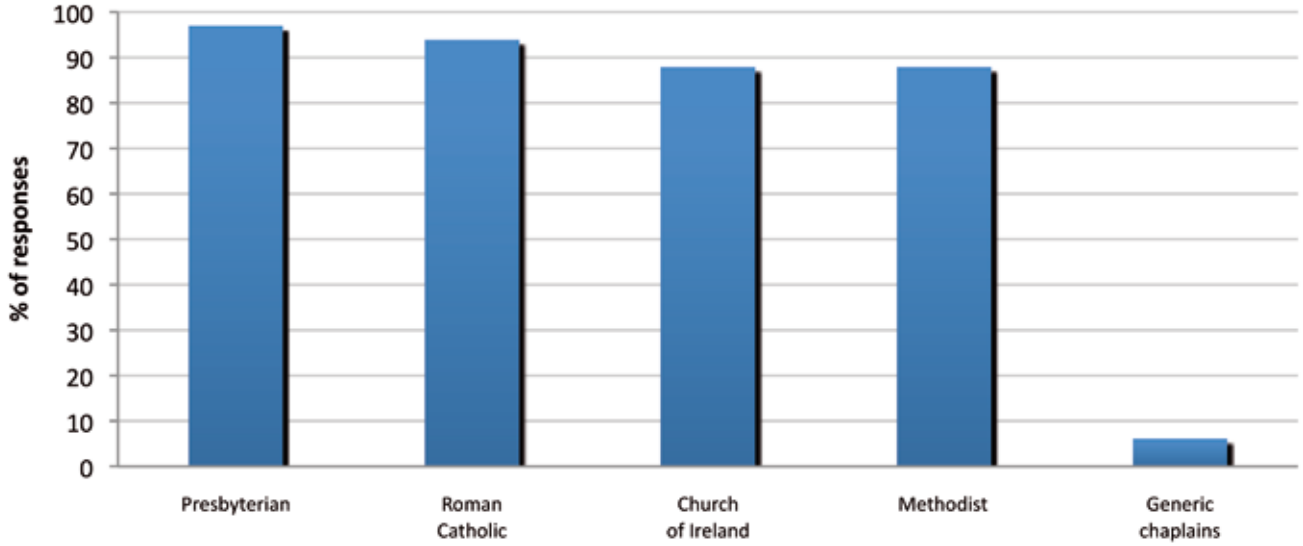


Figure 10: Religious denominations represented within chaplaincy services (n=33 hospitals and hospices)

A policy relating to chaplaincy services was available in approximately 40% of the hospitals and hospices audited. During the ward and hospice visits, the majority of respondents (87%) reported that patients were asked on admission whether they wished their religious affiliation to be documented and if they permitted this information to be provided to the chaplaincy team. In situations where patients initially indicated they did not wish chaplaincy involvement, 78% of respondents advised that this decision would be revisited later, if appropriate, should the patient's condition deteriorate.

As indicated in Figure 11, the chaplains themselves identified a range of facilities and support available to them in the performance of their duties.

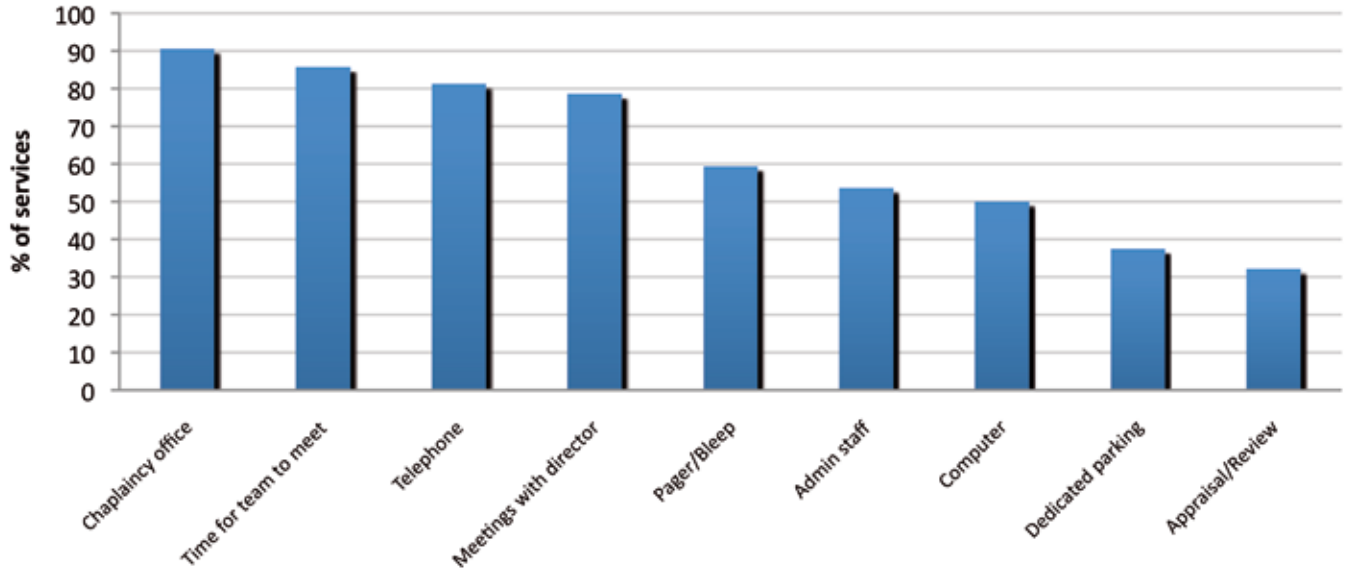


Figure 11: Facilities and support available to chaplaincy services (n=33 hospitals and hospices)

Over three-quarters of the chaplains indicated that they had dedicated offices, telephones and allocated time to meet together and for regular meetings with their respective directors. However, only about one-third had an opportunity for formal appraisal/development review, and just over 50% had access to each of a computer and administrative support.

3. Promoting Safe and Effective Care

All HSC trusts and hospices have a duty to provide safe and effective care by having robust governance arrangements in place that are in compliance with national and regional guidelines and legislation (see section 1.1).

3.1. Policies, guidelines and practices

All 35 hospitals and 5 hospices provided information in respect of their policies, procedures and guidelines associated with end of life and bereavement care. This information was collected from the organisation leads and key individuals within the services audited.

It is acknowledged that the availability of a written policy does not necessarily mean that it has been fully operationalised within a facility, while at the same time many good practices and procedures may take place on a regular basis that are not formalised in a written policy.

Policies and procedures available are presented in Table 5, ranked in order of frequency of availability. Not all organisations provided information in respect of every policy or procedure.

Policy/Procedure Area	Hospitals	Hospices
Accessing translation services	**94%**	**60%**
Do not attempt resuscitation	**94%**	**100%**
Reporting cases to the coroner	**91%**	**100%**
Cultural and religious practices	**88%**	**100%**
Death certification	**82%**	**100%**
Breaking bad news	**77%**	**100%**
Care of the dying pathway	**74%**	**100%**
Care plan for women who experience a miscarriage, stillbirth or neonatal death*	**73%**	**Not applicable**
Post mortem processes	**71%**	**40%**
Cremation	**69%**	**80%**
Memorandum of understanding	**68%**	**100%**
Information for relatives	**62%**	**100%**
Burial by hospital (if no next-of-kin)	**61%**	**60%**
Advance directives	**51%**	**60%**
Identification of the deceased	**49%**	**60%**
Bereavement care	**46%**	**80%**
Chaplaincy/Spiritual care	**46%**	**100%**
Sudden death protocols	**42%**	**20%**

Table 5: Hospitals (n=31-35) and hospices (n=3-5) reporting compliance with bereavement-related policies and procedures
(*Note: applicable to 19 hospitals only)

Hospices had evidence of a higher level of written policies in these areas, as expected in services specialising in end of life care. And while organisations generally had in place policies, procedures and guidelines relating to statutory or legal obligations in end of life and after death care, those that bore no statutory obligation to direct or enhance supportive care tended to be less evident within the hospitals, such as the policy on bereavement and spiritual care.

To promote safe and effective care in both hospitals and hospices, it is clear that further development and standardisation of policies is required, for example hospitals need to develop protocols in relation to sudden death and identification of the deceased.

Policies relating to care after death are commonly referred to as 'last offices'. As can be seen from Figure 12, they include a number of elements of care.

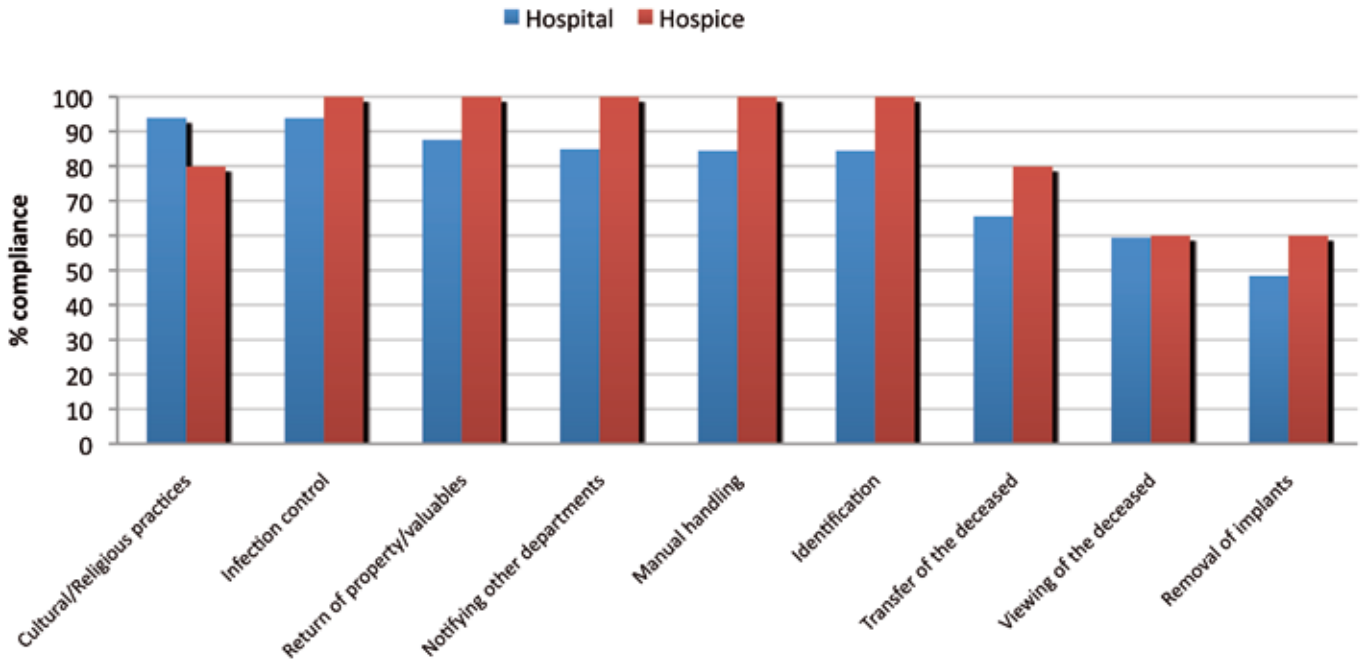


Figure 12: Hospitals (n=35) and hospices (n=5) reporting compliance with policies and procedures relating to "last offices"

As last offices are required for the management of every death and are carried out regularly in hospitals and hospices, it would be reasonable to anticipate 100% compliance in each of these areas. For some, however, most notably the removal of implants and viewing of the deceased, the compliance rate was as low as 60% or less.

Ward managers reported a variety of methods used to inform staff about policies and procedures (Figure 13). Ward induction was the most commonly used (in 95% of the wards and hospices for whom returns were provided), closely followed by team meetings (91%) and training courses (62%). Supervision and the intranet were identified in just under half of all facilities each, although it is likely that the use of these latter methods will increase in the future.

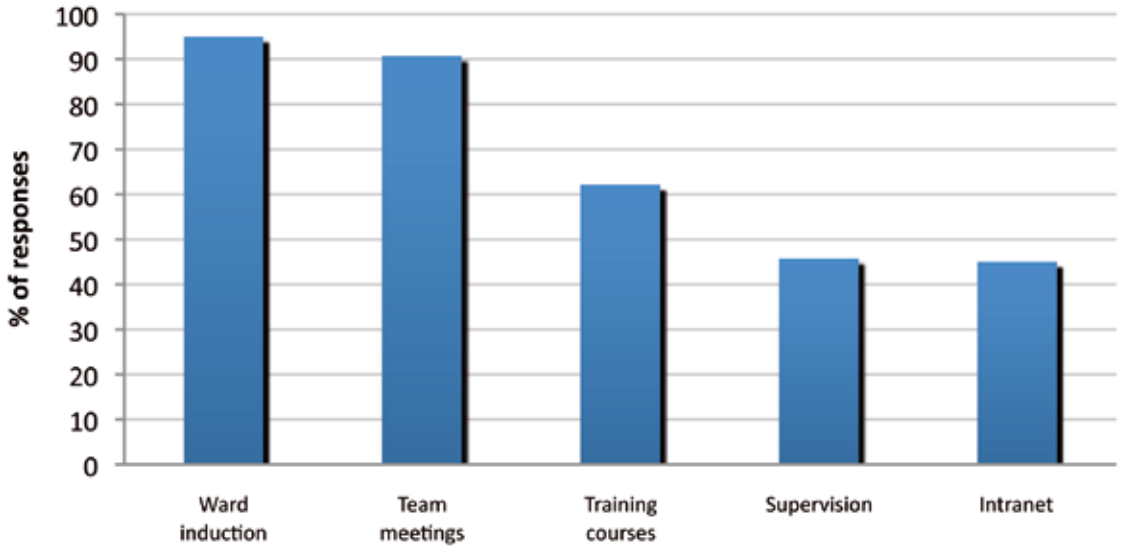


Figure 13: Methods used to inform staff about policies and procedures (n=140 wards and hospices)

During the year for which audit demographic information was available (2005-06), 149 children died before the age of 18 years and 81 babies were stillborn (Figure 4). The death of a baby or child is always a difficult experience for family members as well as for staff, as was made clear by their responses to the audit. Specific policies are necessary to both support staff and to ensure that parents' wishes are carried out in a safe and sensitive manner.

The audit identified 50 wards where parents may be expected to require support before, at the time of and/or after the death of a child. Different Trusts used a variety of checklists and booklets; there were not always written policies in place to support some of the practices that are carried out, such as those concerning information for parents wishing to take their deceased child directly to their home by car.

As the majority of patients who die in hospital are transferred to a mortuary, those individuals with responsibility for mortuaries were asked about the availability of written policies and procedures aimed at supporting their practices. The procedures and guidelines available are summarised in Figure 14, with a variation reported in the policies available in different mortuaries and some practices not always supported by written policies.

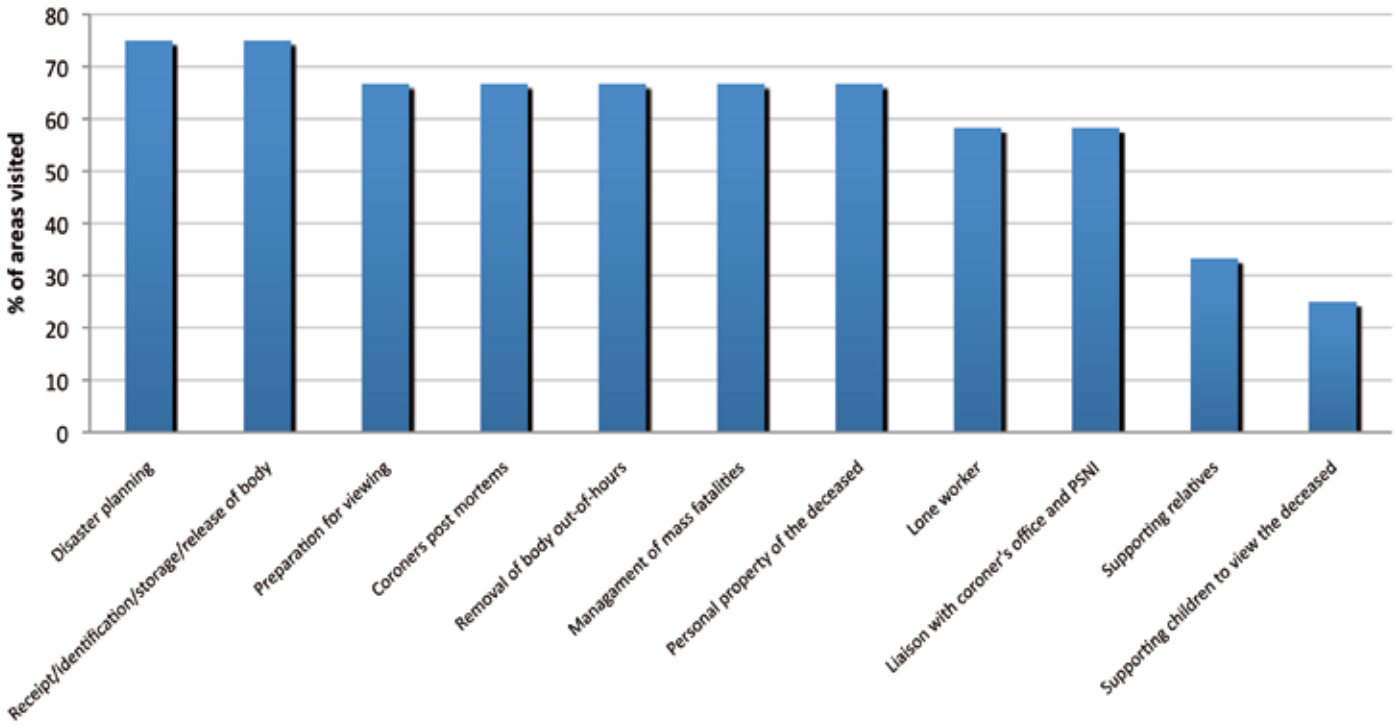


Figure 14: Policies, procedures and guidelines available within mortuaries (n=12)

3.1.1 Bereavement checklists

Some facilities use bereavement checklists to ensure that all necessary actions are taken at the time of a patient's death and that families receive adequate information to assist them. These can be part of an end of life care pathway or a separate checklist which has been developed to address the needs of a specific area.

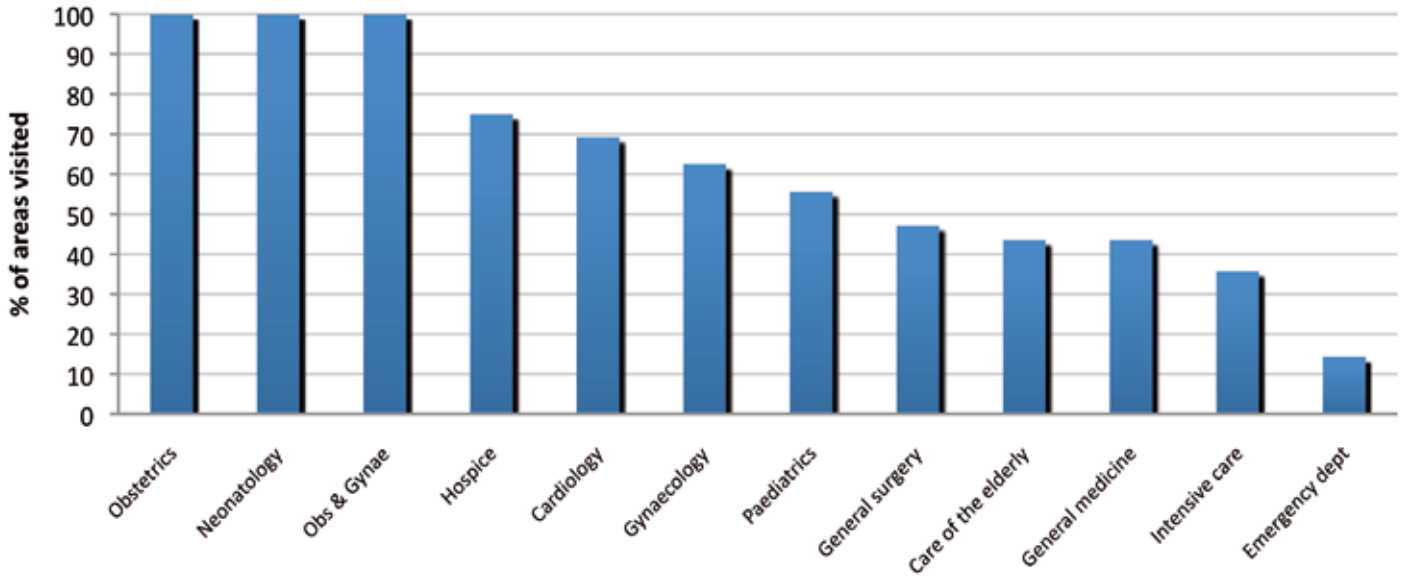


Figure 15: Usage of death and bereavement checklists (n=141)

Figure 15 summarises the availability of checklists across the different specialist areas. It demonstrates a degree of variability across areas, with obstetrics and gynaecology and neonatology units reporting the greatest use of bereavement checklists (100%) and emergency departments – with their high proportion of sudden deaths having fewest (20%).

3.1.2 Identification and labelling

Correct identification and labelling of a deceased patient is vital to avoid the risk of misidentification, which could lead in turn to the wrong body being released.

Ward managers identified the methods used in their respective departments to identify bodies before transfer out of their wards to the mortuary or a funeral director. The results are summarised in Figure 16.

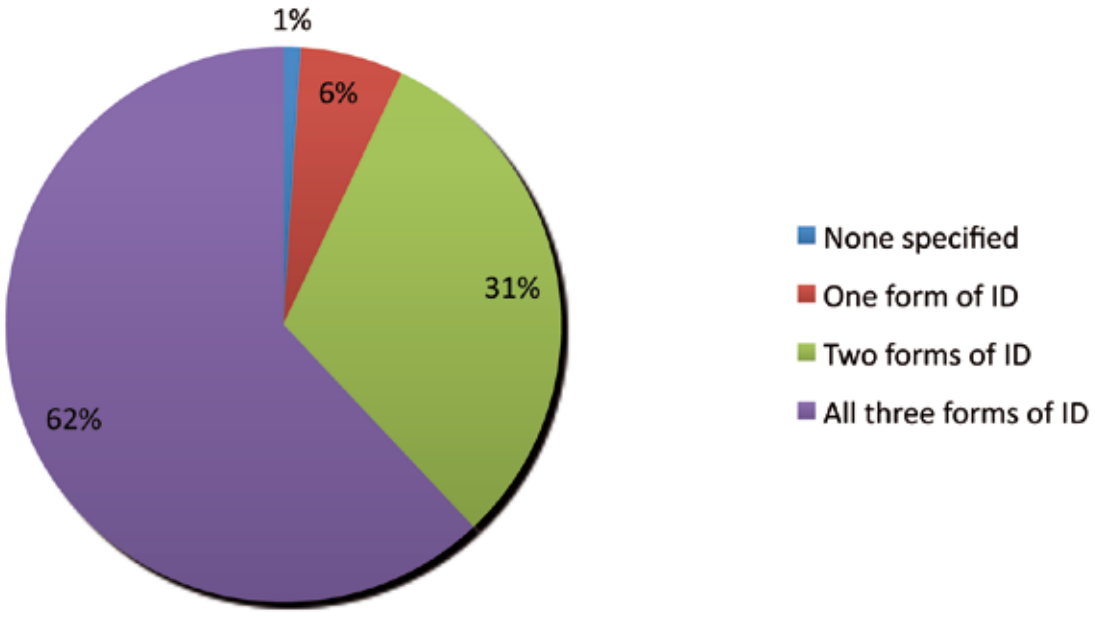


Figure 16: Use of identification accompanying bodies being transferred from wards and hospices (n=142)

Three separate means of identification were listed by the ward managers: patient identification armbands, mortuary forms and patient identification labels. All three were said to be used by 62% of respondents, while 99% reported the use of at least one such form of identification. In the survey of policy and procedures (section 3.1) it is noted that only 46% of hospitals and 60% of hospices had a written policy/procedure for patient identification.

3.1.3 Issue of death certificates

In cases where death is due to natural causes, it is a legal requirement for a Medical Certificate of Cause of Death (MCCD) to be completed by a doctor who has treated the patient within the previous twenty-eight days. There are a number of situations, where, if the cause of death is unknown, unexpected or where there are suspicious circumstances, the doctor has a duty to report the death to the coroner.

In Northern Ireland it is usually the cultural practice for a short interval from death to burial/ cremation and it is good practice for the death certificate to be given to the family as soon as practicable to facilitate this. However, the audit identified that it is issued at the time of death in only 50% of cases. Ward managers specified the reasons for the delay in death certificates being issued, with responses presented in Figure 17.

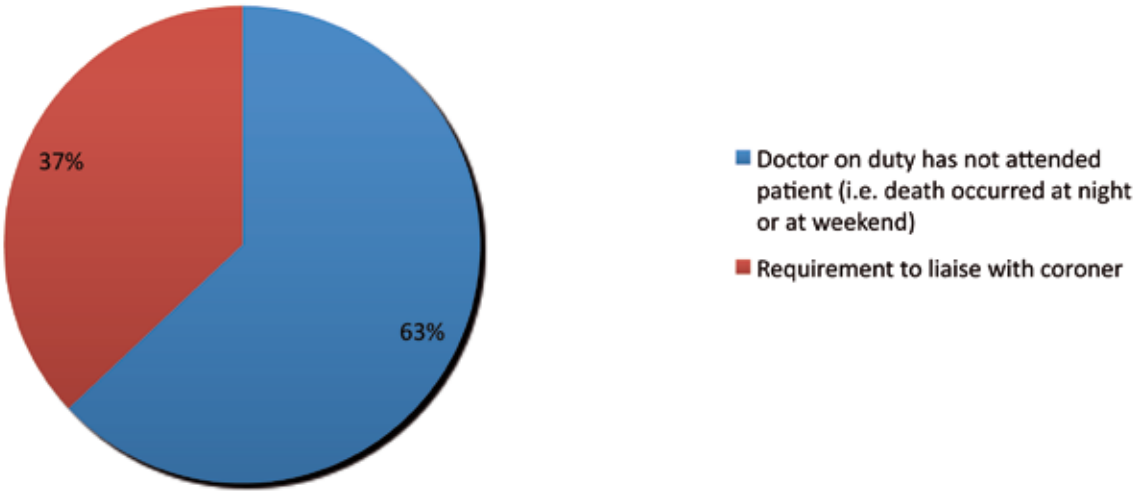


Figure 17: Reasons offered by ward managers (n=95) for a delay in issuing a death certificate

Two reasons were identified for delay: the most common (accounting for 63%) was that changes in junior doctors' working hours mean the duty doctor has not attended the patient personally, and the issue of the certificate has to wait for the return of a doctor who has treated the patient. The second reason (accounting for the 37%) was that the circumstances of the death may require discussion with a consultant and contact with the Coroner for advice as to whether a death certificate can be issued or if further investigation is required.

3.1.4 Transfer of patients

The audit identified three different methods of the transfer of deceased patients from wards:

- Removal by a designated funeral director, under a service level agreement, to a mortuary;
- Removal by portering staff to a mortuary or holding area;
- Removal by a family funeral director to external premises.

Portering managers and funeral directors were asked about the modes of transport used. For children and adults, concealment trolleys were the usual means of transport. For morbidly obese patients (bariatric patients) where the body mass is greater than 40, (National Clinical Excellence definition) transfer generally takes place in the patient's bed. There were a number of different modes of transport available for the transfer of babies, with Moses baskets and small transfer boxes the most frequently used. Fifty per cent of respondents reported that the transfer of babies and children is a particularly difficult duty to perform.

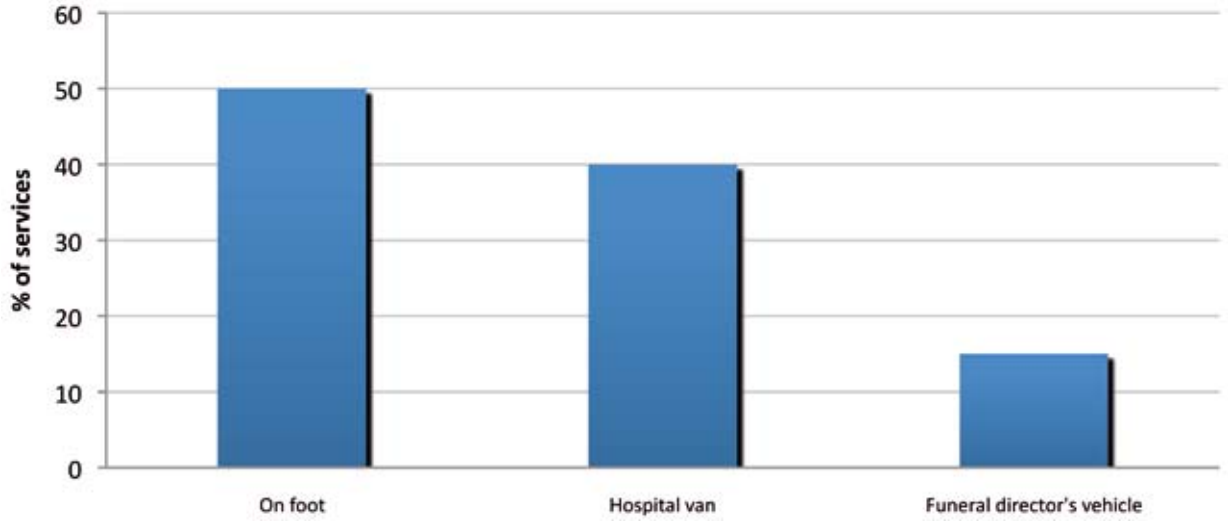


Figure 18: Means of transportation used for the transfer of deceased patients within hospitals, as reported by portering managers and contracted funeral directors (n=20)

Figure 18 outlines the means of transportation used for the transfer of deceased patients within hospital sites. Half of all cases were reported to have been transferred by foot, 40% in a hospital van, and the remaining 15% in a funeral director's vehicle, with bodies at times transferred by a combination of means.

3.1.5. Information and communication

Portering managers and those funeral directors carrying out portering and mortuary duties under service level agreements were asked about the information provided to them at the time of a deceased patient's transfer from a ward. Their responses are summarised in Figure 19, which indicates that information provided by ward staff varied considerably particularly that provided when a request for a body to be removed was being made.

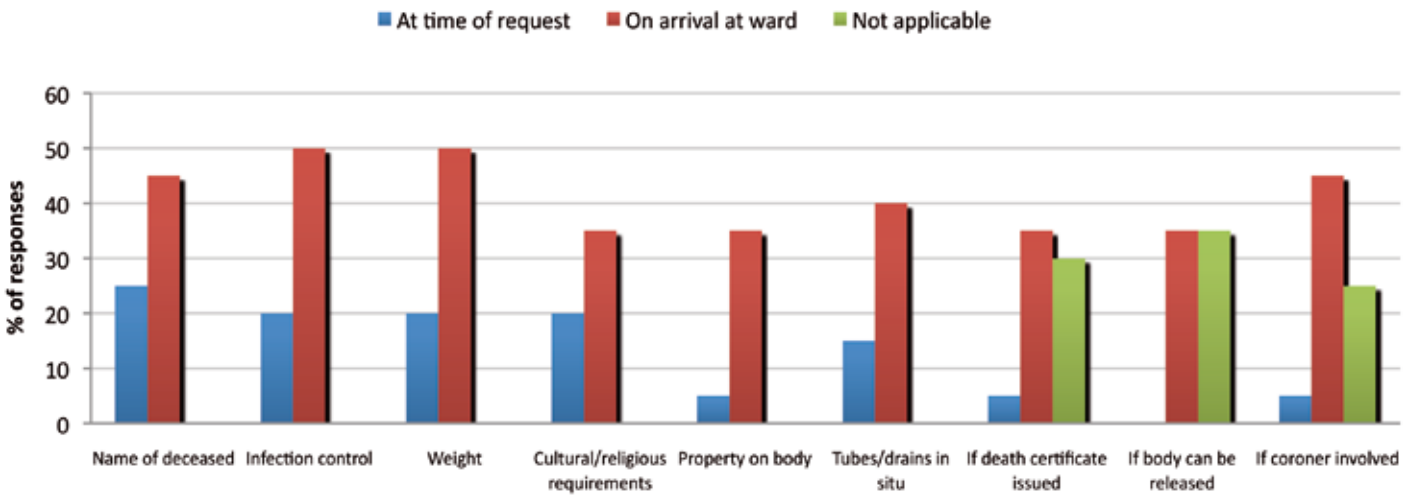


Figure 19: Information provided to porters and contracted funeral directors (n=20) when removing a body from a ward

Some of the porters and funeral directors were given information verbally and others through a mortuary identification form. Given the importance of effective communication on issues such as infection control, identification and release, these figures must be viewed as unexpectedly low.

The information reported as being provided by ward staff to mortuary staff and family funeral directors is presented in Figure 20. As expected, this is more than the information provided to those transferring bodies to the mortuaries (Figure 19). Ward staff appear to provide mortuary staff with a greater amount of information than they do to private funeral directors; although mortuary staff also communicate relevant information to the funeral directors.

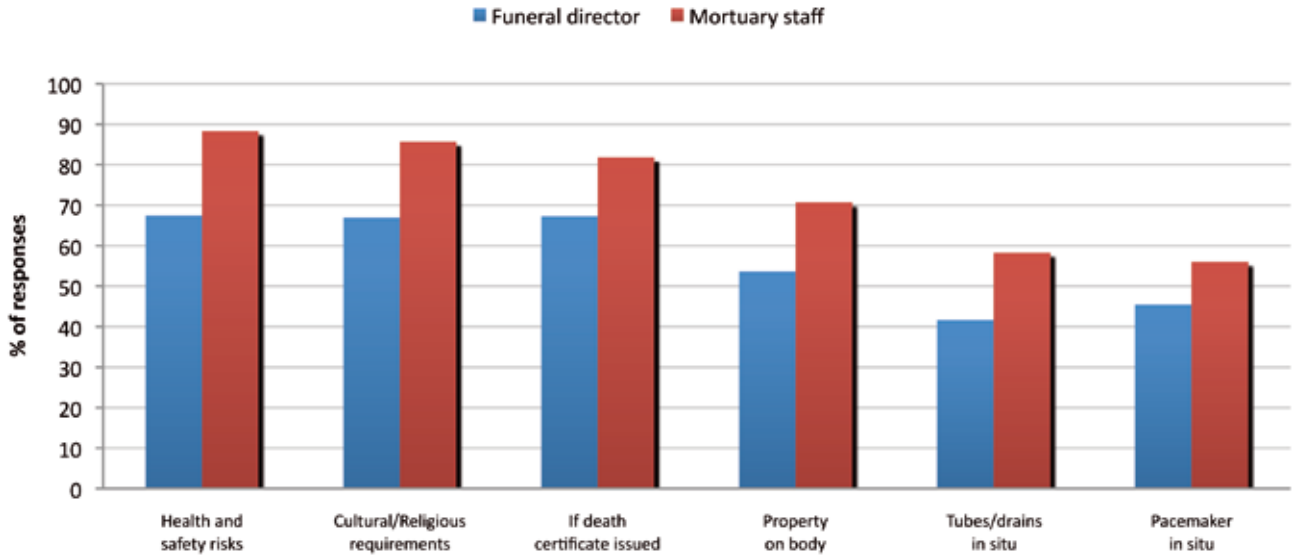


Figure 20: Information reported by ward managers (n=145) as being provided to mortuary staff and family funeral directors

Trusts have their own individual mortuary forms which accompanied 75% of bodies being transferred to mortuaries with mortuary staff reporting a range of information being provided on the forms (Figure 21). The information provided varied according to whether the mortuary had, or did not have, a post mortem facility, although this was not consistent.

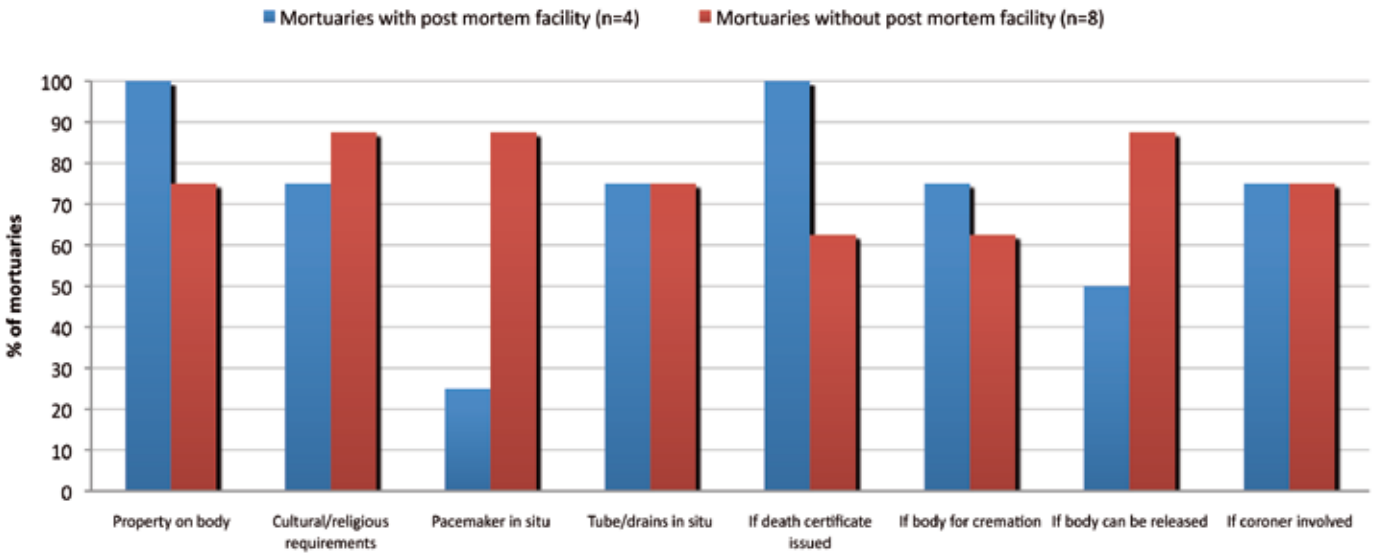


Figure 21: Information provided to mortuary staff (n=12) when receiving a body

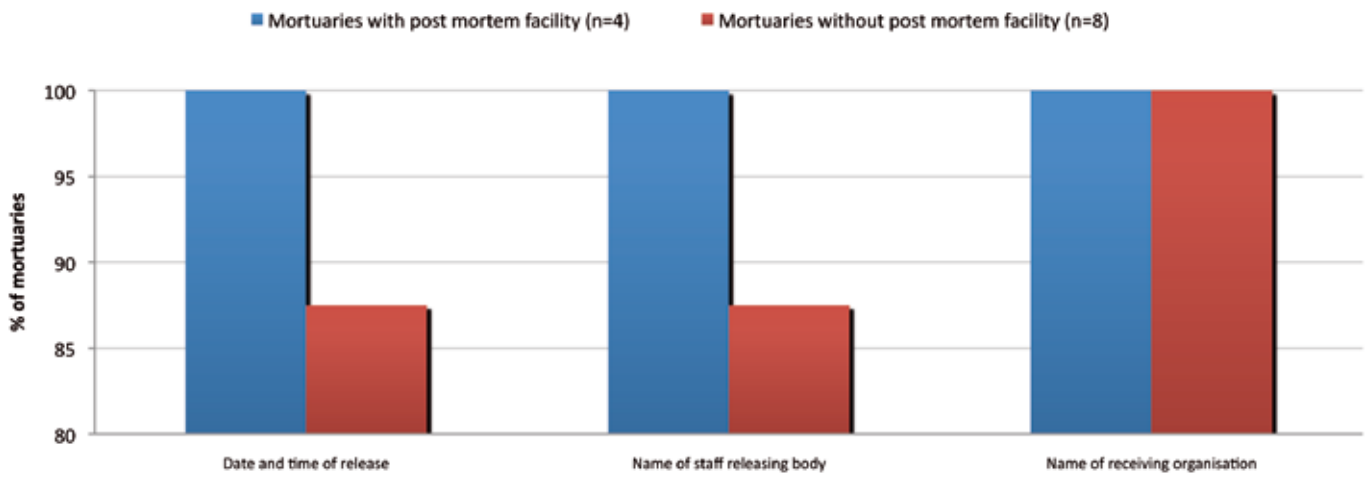


Figure 22: Information recorded in mortuaries when patients' remains are released

Mortuary staff reported the information recorded when a patient's body is released to funeral directors. Figure 22 shows that whereas all mortuaries with a post mortem facility recorded the date and time of release, the name of the staff member releasing the body and the name of the funeral director collecting the body, not all mortuaries without post mortem facilities recorded this information.

3.2. Knowledge and skills

It is essential that those involved in the care of people who are dying and the bereaved are skilled and experienced, so they feel confident about the care and support they give. They should have adequate opportunities to develop their knowledge, understanding, self-awareness and skills (When a Patient Dies, Department of Health 2005).

In both the ward visits and the staff questionnaires, respondents were asked about the availability and uptake of training specific to end of life and bereavement care. Figure 23 sets out the various topics in which staff had received training. It is recognised that while staff may not have had formalised training many have developed knowledge and skills in these subjects through experience and on-the-job training.

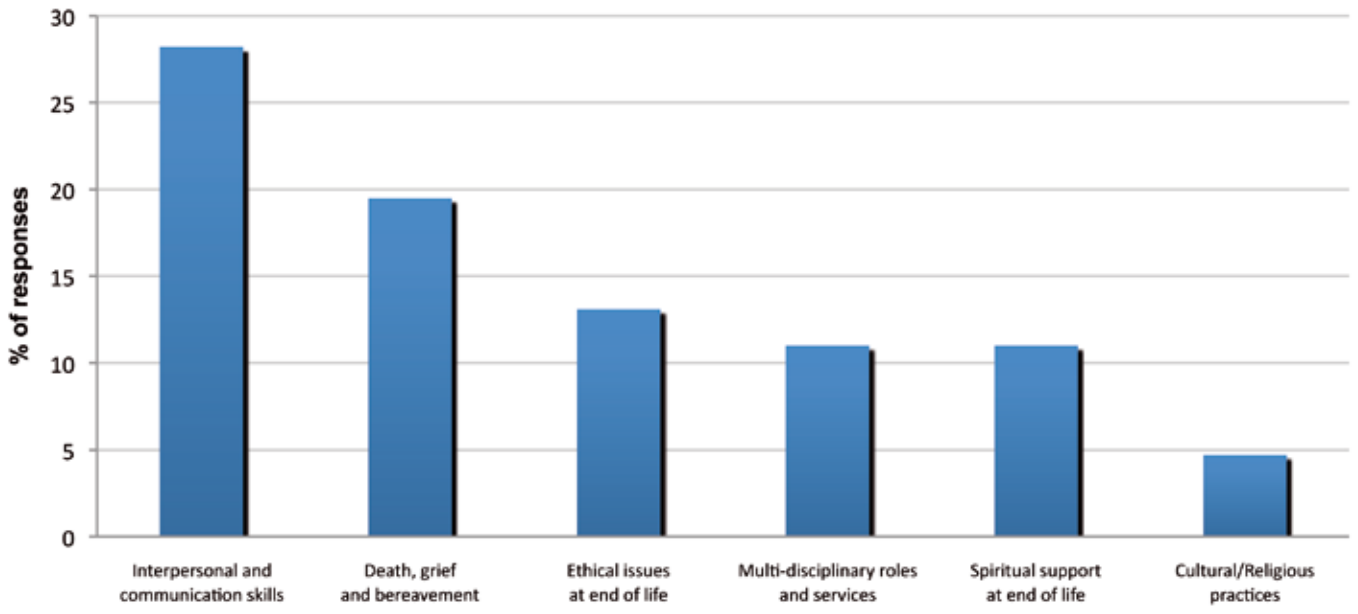


Figure 23: Percentage of staff responding to the questionnaires who had training in care of the dying and their relatives (n=1633)

Staff were asked about their level of confidence in delivering end of life and bereavement care. The results are presented in Figure 24.

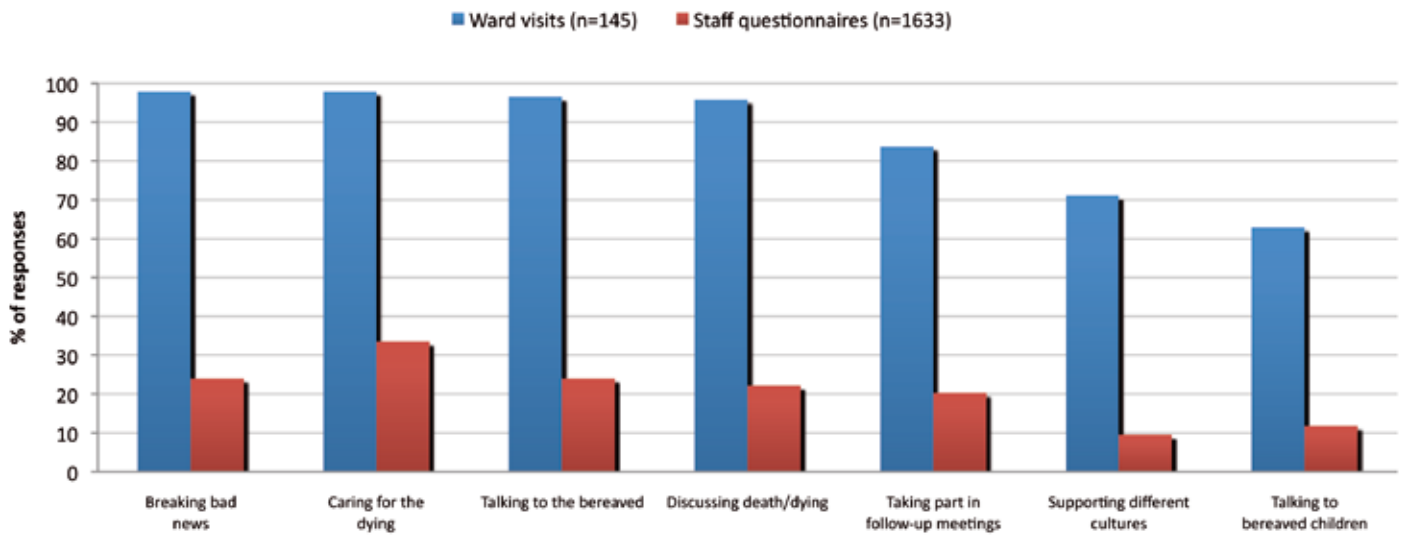


Figure 24: Percentages of staff expressing themselves confident in the delivery of end of life and bereavement care

The ward managers (who provided the information on the ward visits) reported themselves to be significantly more confident in the delivery of all aspects of end of life and bereavement care than did staff who responded by questionnaire, a possible reflection of the high level of experience of the ward managers. Talking to bereaved children and supporting people from different cultures were the most difficult duties for all staff to perform.

Staff were asked about additional training that would be helpful in the performance of their roles. Over 60% of both ward managers and individual staff members indicated they would find a range of training helpful as set out in Figure 25.

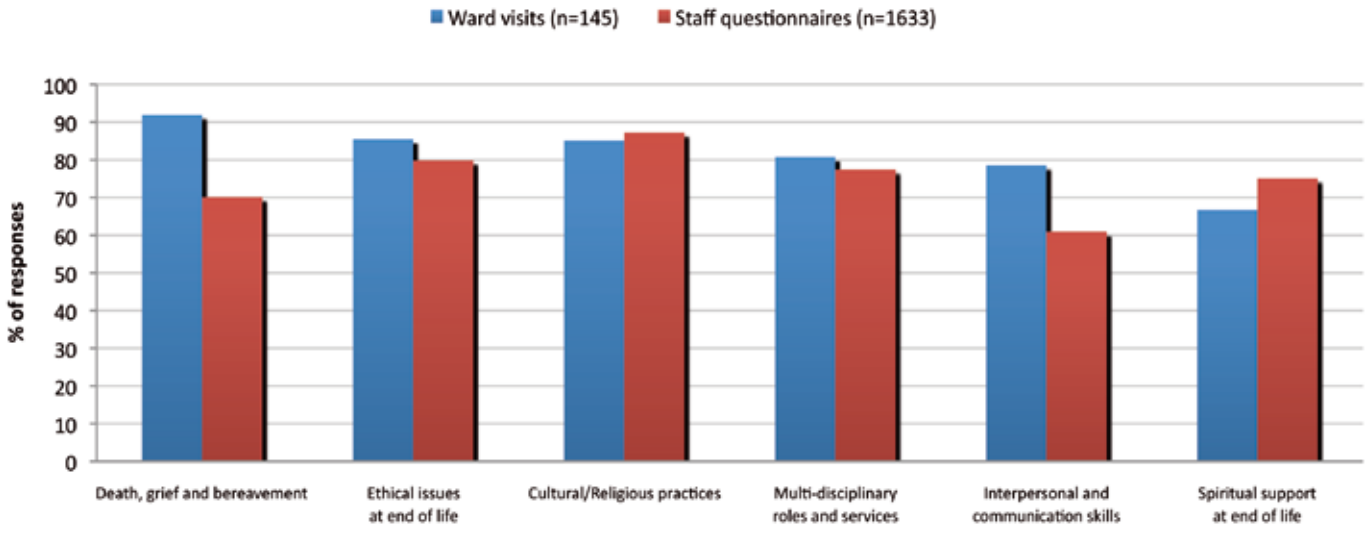


Figure 25: Percentages of staff who would find additional training helpful

Specialist palliative care team members reported on additional training they had received in bereavement care. As Figure 26 indicates, this ranged from postgraduate bereavement and/or local hospital or hospice courses, with over 25% of team members having attended both.

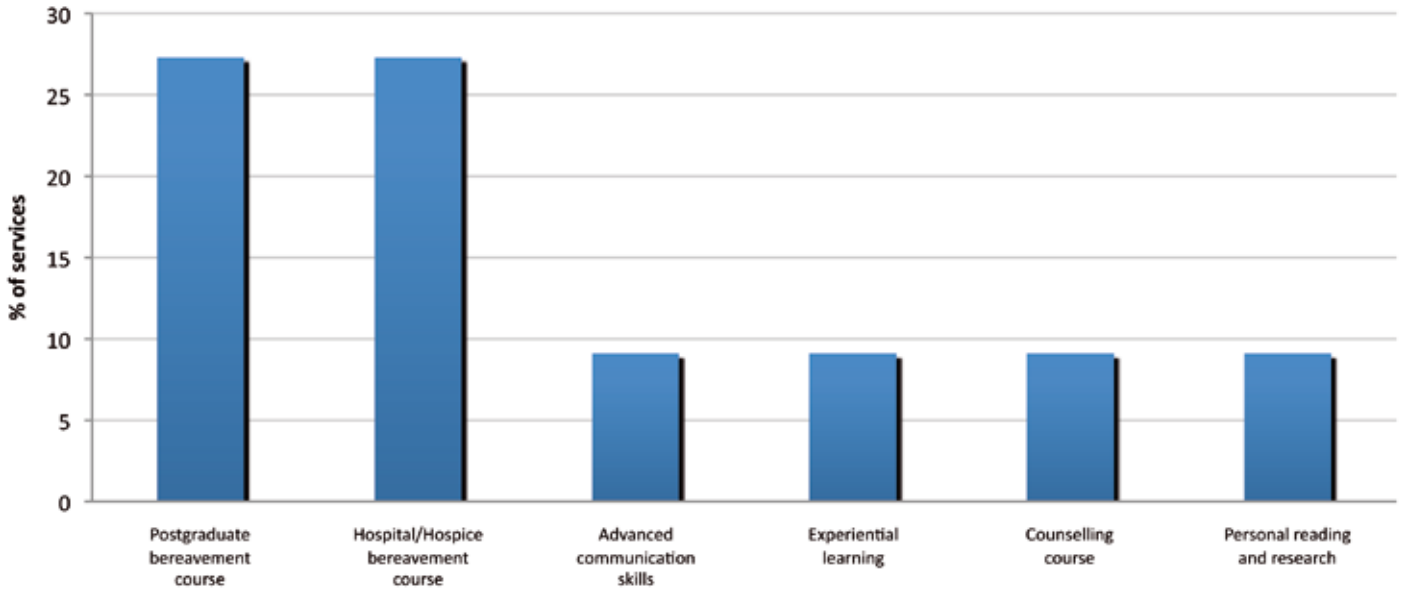


Figure 26: Additional bereavement care training undertaken by specialist palliative care team members (n=11)

Chaplains reported additional training in bereavement care they had undertaken (Figure 27), with local hospital/hospice chaplaincy training undertaken by more than half the chaplains audited.

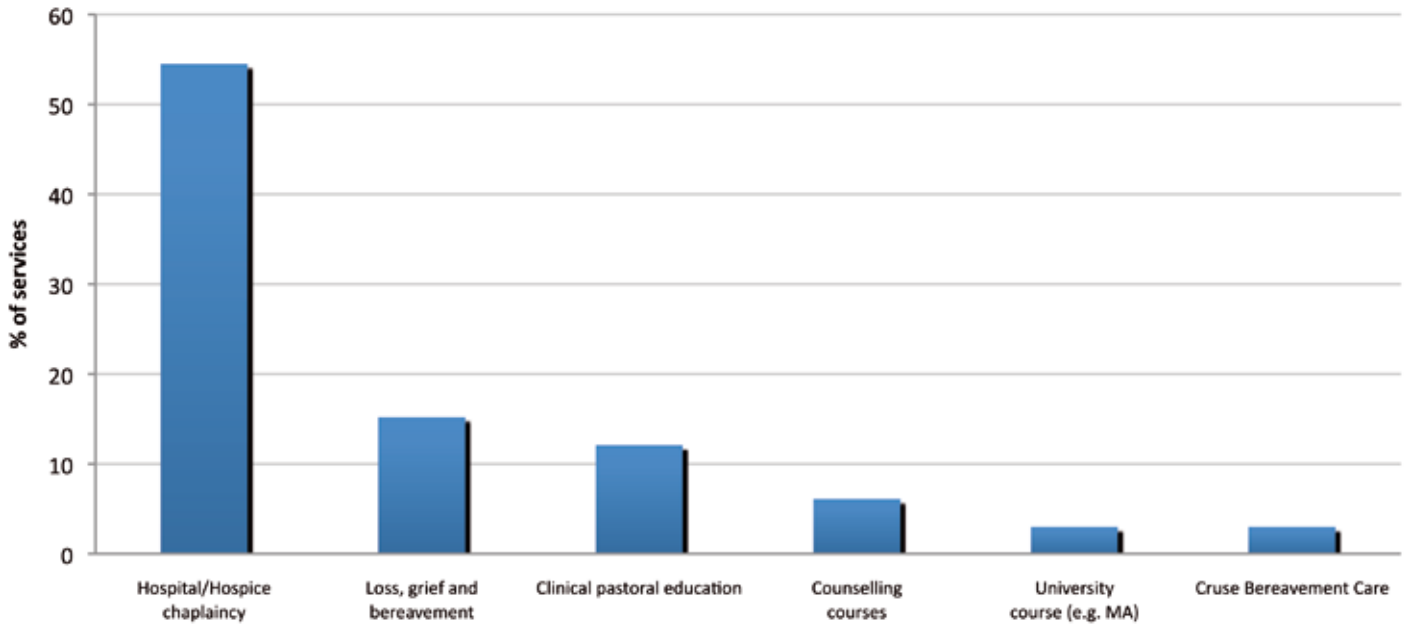


Figure 27: Additional bereavement care training undertaken by chaplains (n=33)

In addition almost one-third of chaplains reported not having received additional end of life or bereavement care training. It is assumed they would have received training in the provision of spiritual care to the sick and dying as part of their initial professional training with such care also forming part of their respective ministries outside the hospital setting.

All funeral directors with service level agreements for portering and mortuary duties reported that they had already received training in all relevant areas. The nature and extent of the training provided to porters in relation to their mortuary duties is summarised in Figure 28.

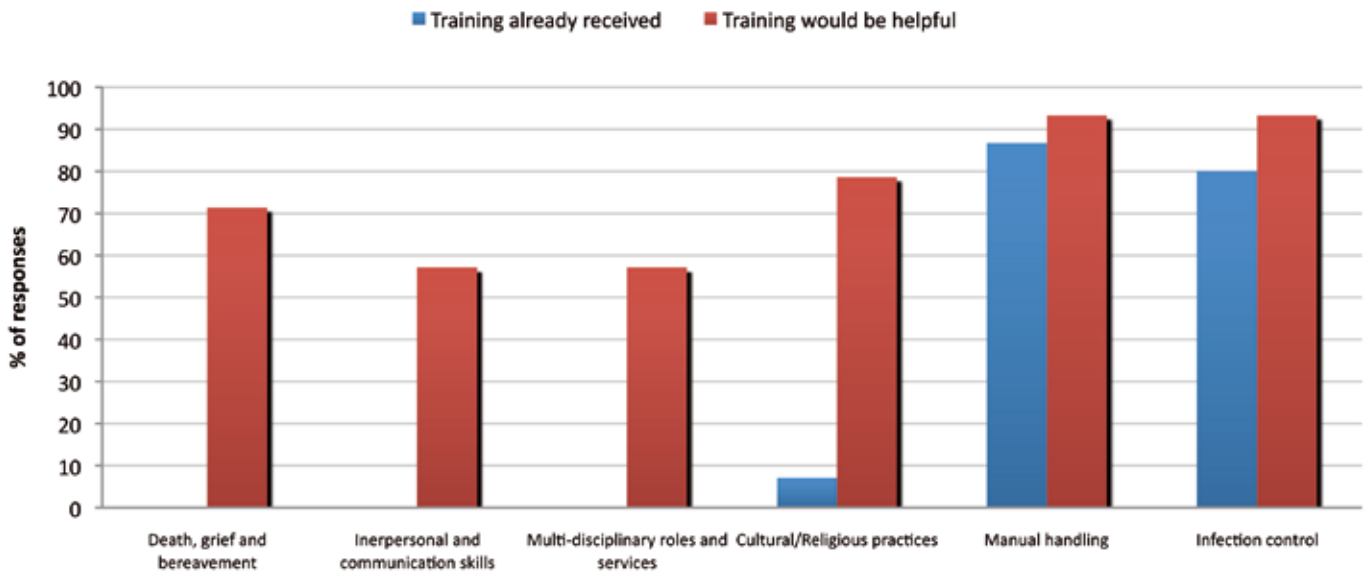


Figure 28: Training courses for portering teams (n=15)

Most of the porters' training to date had been in relation to manual handling and infection control, with at least 80% having received training in each of these areas, with fewer than 10% having received training in multi-cultural and religious practices; this has clear implications for the handling of deceased bodies. Over half of those audited identified that additional training in each of the areas of multi-cultural and religious practices, death, grief and bereavement, interpersonal and communication skills and multi-disciplinary working would be helpful. A number of portering managers also indicated the value of on-the-job training.

Mortuary staff reported on the training they had undertaken specific to their role, summarised in Figure 29.

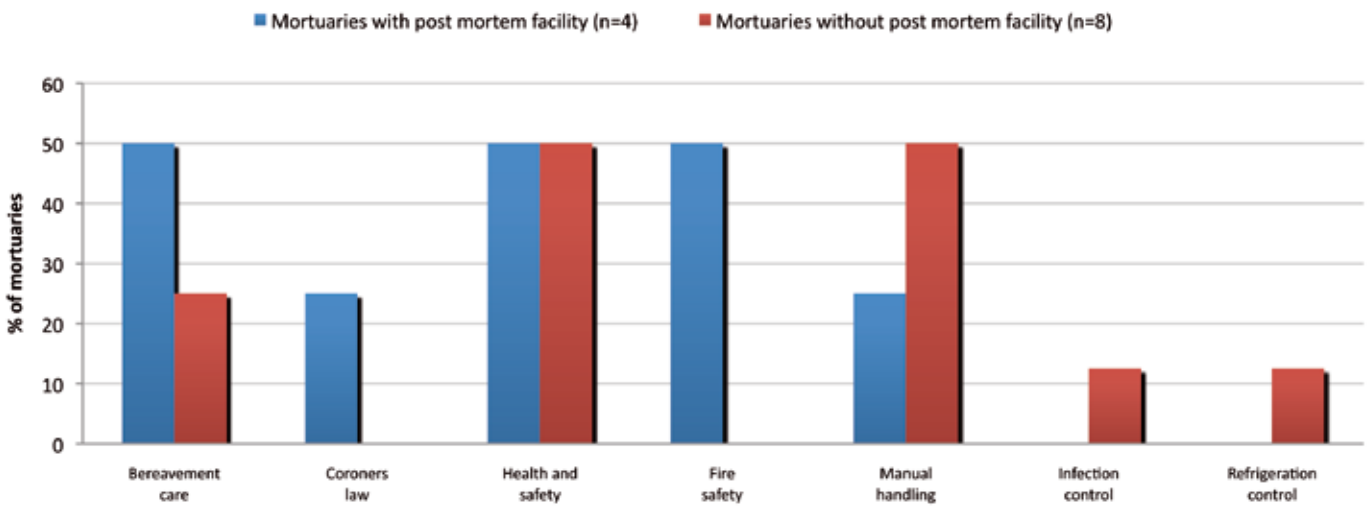


Figure 29: Training courses accessed by mortuary staff

Some areas of additional training (e.g. in respect of bereavement care or health and safety) were identified by staff in all types of mortuaries. Some training such as that in coroners law were highlighted only by staff in mortuaries with post mortem facilities with others, such as in infection control or refrigeration control identified only by staff in mortuaries without post mortem facilities. However, some of this additional training will have been received by some mortuary staff as 15 of the 23 designated mortuary staff were qualified pathology technicians with recognised advanced training.

3.3. Staff support

It is essential that all those who care for and support dying and bereaved people, regardless of their roles, should be provided with support for themselves (When a Patient Dies, Department of Health 2005).

Staff participating in both the ward visits and the individual staff questionnaires were asked about the support systems in place throughout their organisations, with Figure 30 summarising the responses of both groups. The ward managers, reflecting their levels of experience, were more aware of appropriate staff support systems than individual staff members who responded to the questionnaires.

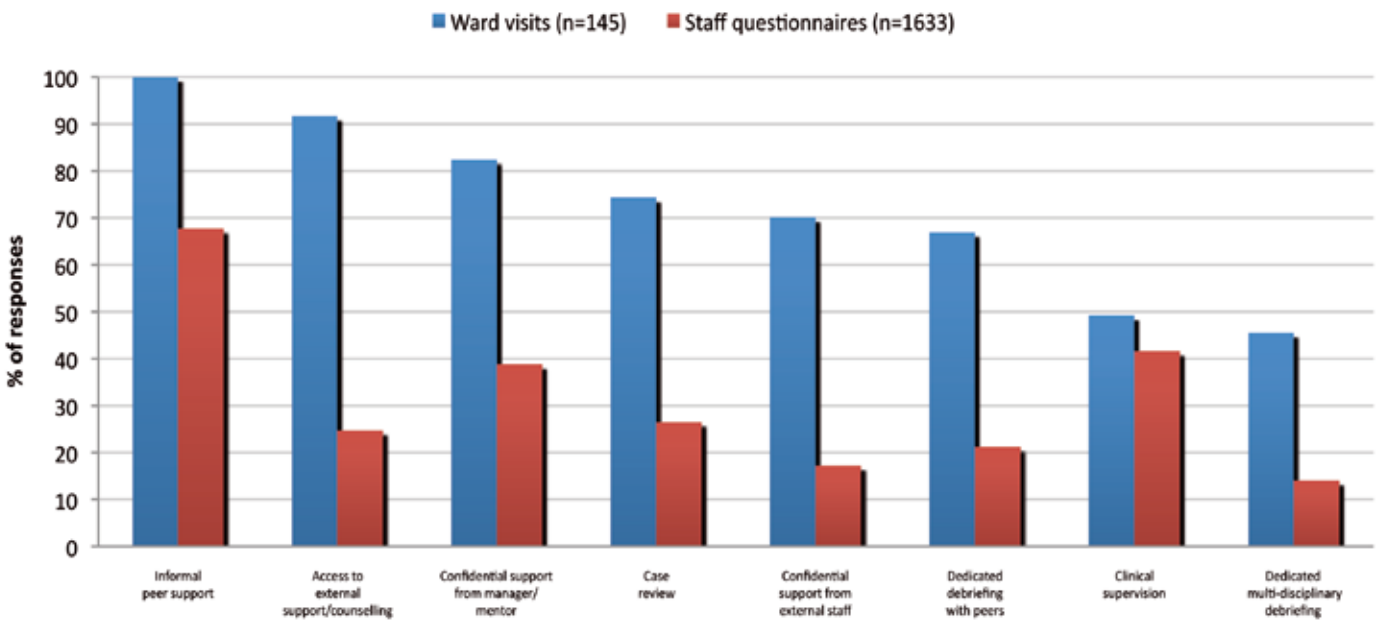


Figure 30: Staff support systems identified as being in place

Figure 31 summarises the responses given by mortuary staff on the availability of staff support systems. All mortuary staff recognised the value of peer support with all also aware on how to access the services of occupational health departments.

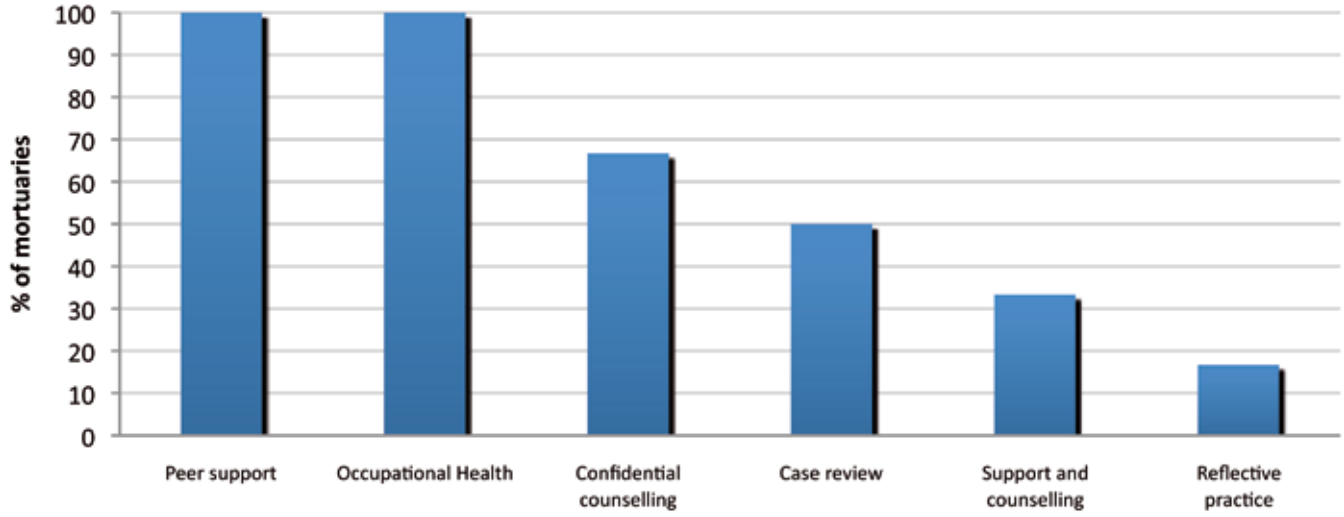


Figure 31: Support systems available to mortuary staff (n=12 services)

The chaplains included in the audit were asked about the services that they provide specifically to members of staff with responses presented in Figure 32.

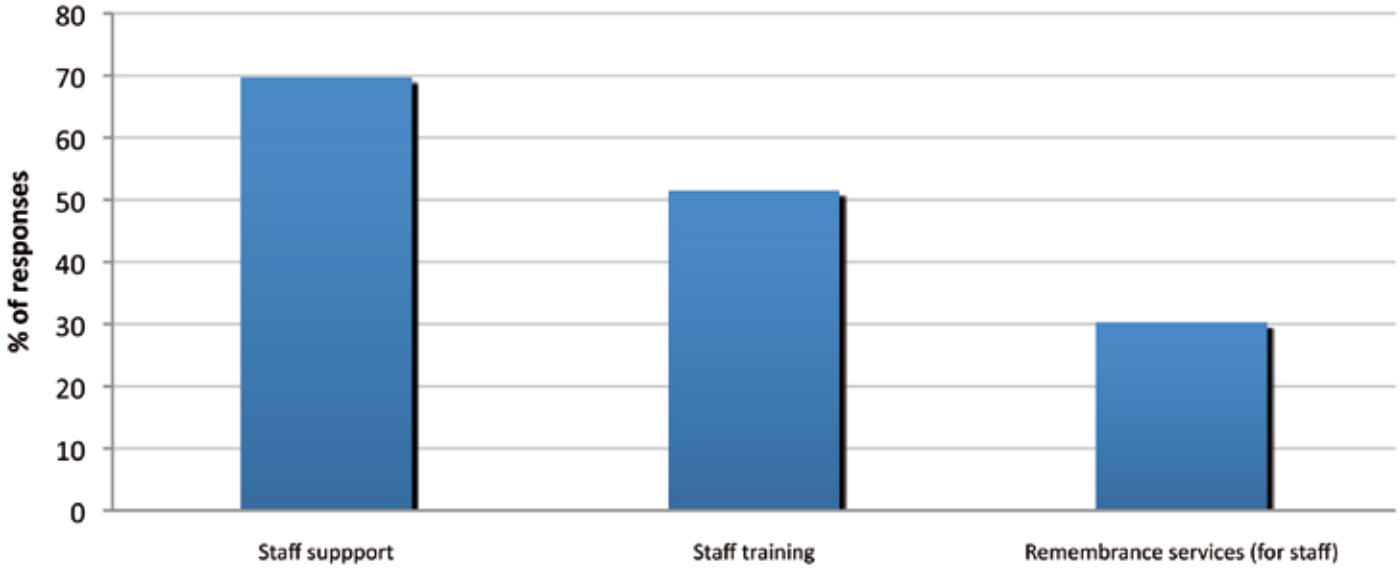


Figure 32: Services provided by chaplains to members of staff (n=33)

This finding suggests that chaplains offer support to staff in three main ways: through direct contact/support, staff training (usually at staff inductions into new posts) and participation in hospital remembrance services. These were reported to be offered by approximately two-thirds, one-half and one-third of chaplains respectively. Staff training was considered by a number of chaplains to be helpful in building good relationships and informing staff of their roles within ward teams.

4. Creating a Supportive Experience

It is recognised that dying people and their families have a right to be treated with dignity and respect and to be cared for in an appropriate environment (section 1.1).

4.1. Environment and facilities

During ward visits, staff were asked to rate the suitability of the environmental aspects of their ward/department for meeting the needs of, and being supportive to, patients who are dying and their families. Their responses are presented in Figure 33.

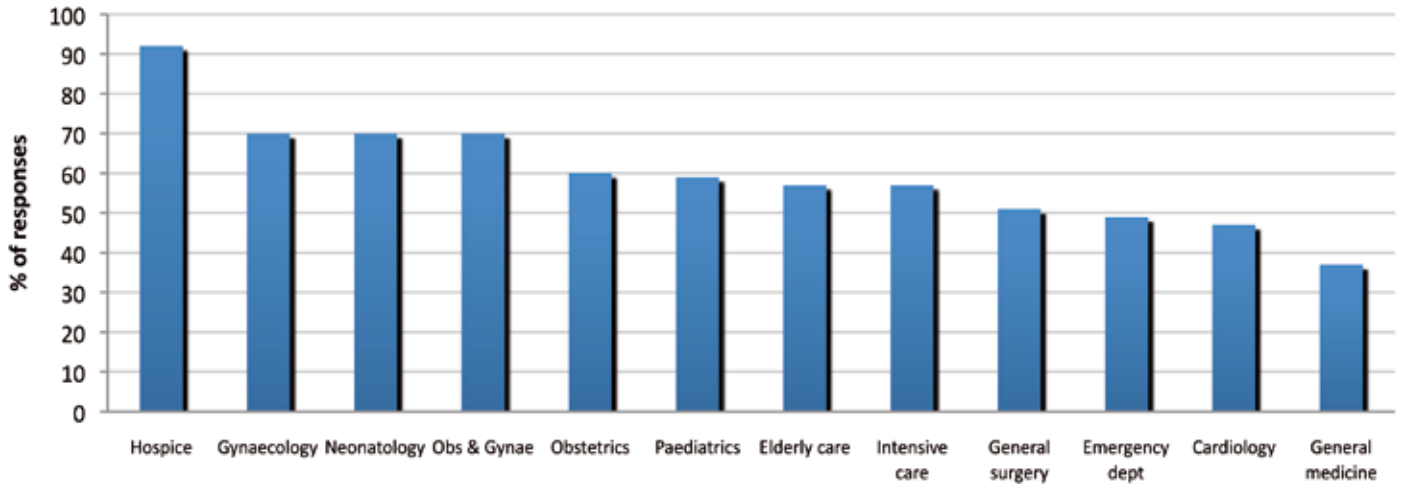


Figure 33: Percentage of wards and hospices rated 'excellent' or 'good' overall by their ward managers (n=145)

As predicted hospices, with their central focus on the care of dying patients, were rated the highest overall in terms of the suitability of their environment for the provision of care to those who are dying and their families. General medical wards, the clinical area identified previously as having the highest death rate (Figure 3), but also amongst the busiest within the hospital sector, were rated the lowest.

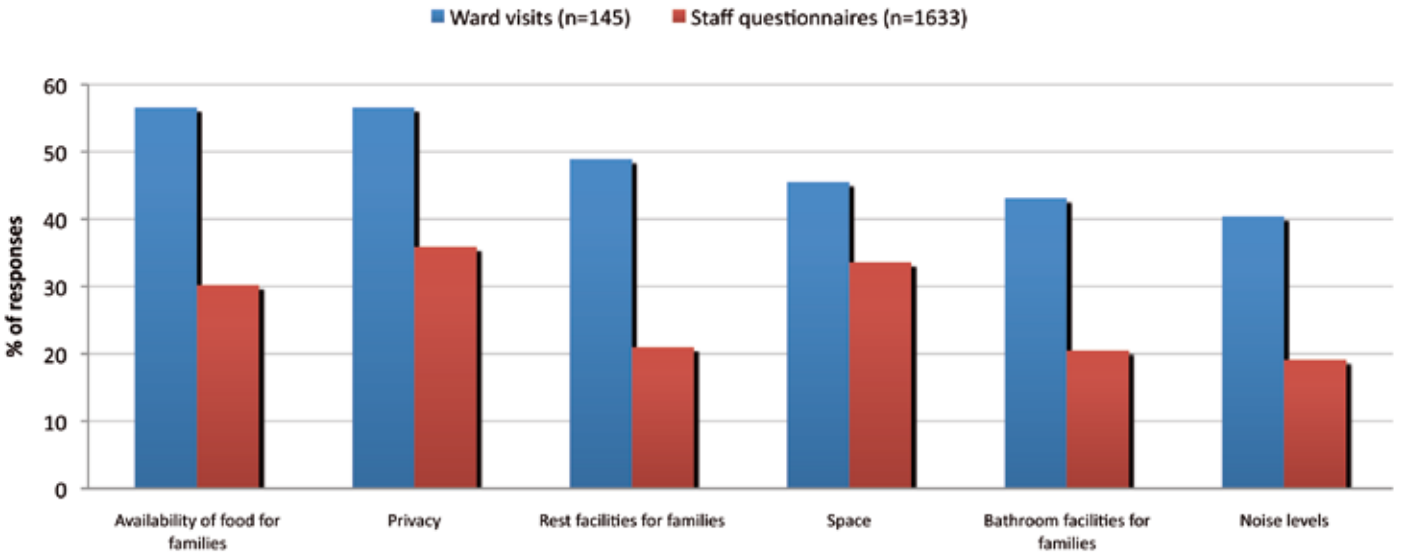


Figure 34: Environmental aspects of wards/facilities rated 'excellent' or 'good' by staff

Staff in ward visits and questionnaires, were also asked to rate specific aspects of the environments. As Figure 34 indicates, the ward managers consistently rated all aspects of

their wards higher than did other members of staff. A significant number of staff in their individual questionnaire responses indicated a level of concern about the limitations of their respective environments for the provision of appropriate end of life care and bereavement support.

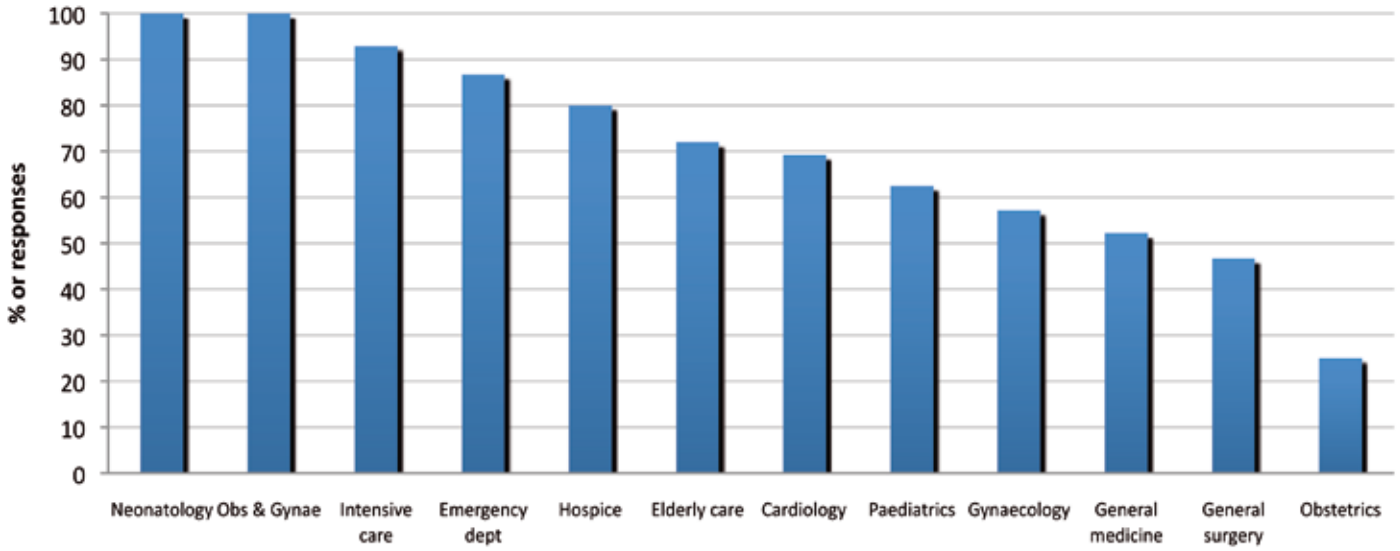


Figure 35: Availability of private areas designated for the use of relatives, as reported by ward managers (n=142)

Staff responses on the availability of private areas designated for the use of relatives are presented in Figure 35. Such areas were available in every neonatal unit and combined obstetrics and gynaecology ward included in the audit, and in over 85% of intensive care units and emergency departments. Appropriate facilities were least likely to be provided in dedicated obstetric wards. General medical wards, where most deaths occur, were rated as having fewer appropriate areas for such purposes as breaking bad news than most other clinical environments.

Difficult discussions with families were reported to take place in six different types of locations, summarised in Figure 36.

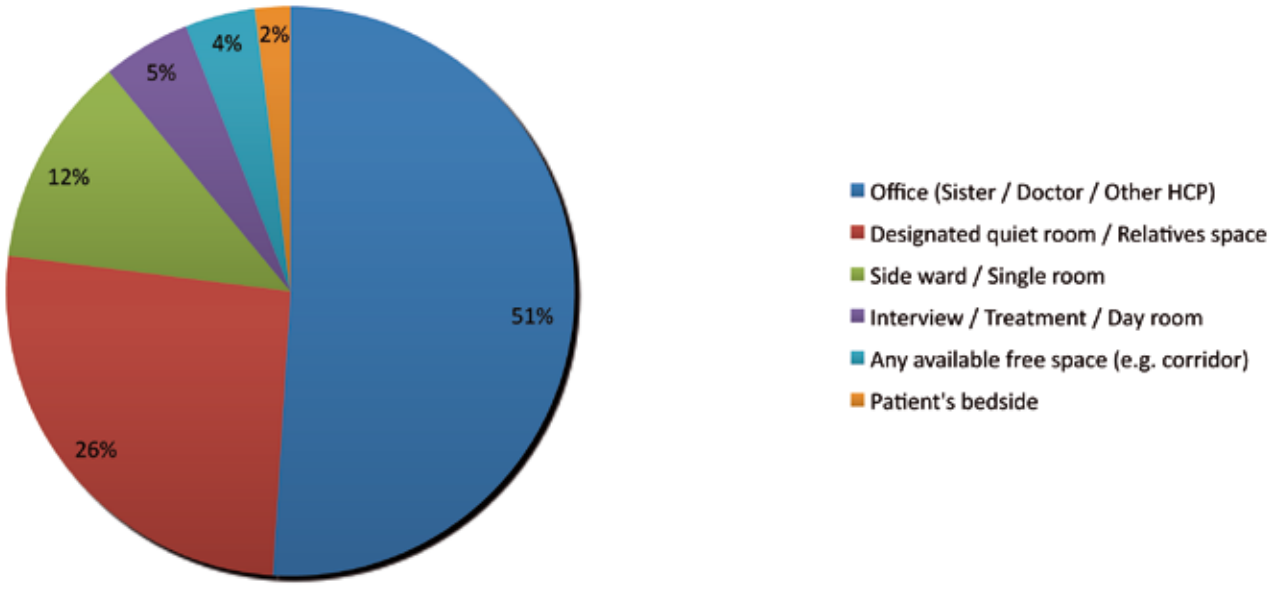


Figure 36: Locations where difficult discussions take place with relatives, as reported by ward managers (n=144)

Offices constituted by far the most common location for difficult discussions, such as those of ward manager, doctor or other health care professional (52%), with sizeable numbers taking place also in either designated quiet rooms or relatives' spaces (26%) or in side wards or single rooms (12%), if available. While staff clearly made efforts to find quiet areas in which to have such difficult discussions with family members, a small number identified that, due to ongoing pressures in acute wards in particular, it was not always possible to identify appropriate locations. As a result, discussions did at times occur in wholly unsuitable places, including corridors and at patients' bedsides.

Given the design of older hospitals in particular, the limited availability of single rooms and also a growing need for isolation rooms for patients with infectious conditions, it is often not possible to care for dying patients in single rooms. Ward managers were therefore asked to indicate the extent to which single rooms were allocated to dying patients. Their responses are summarised in Figure 37, according to clinical speciality.

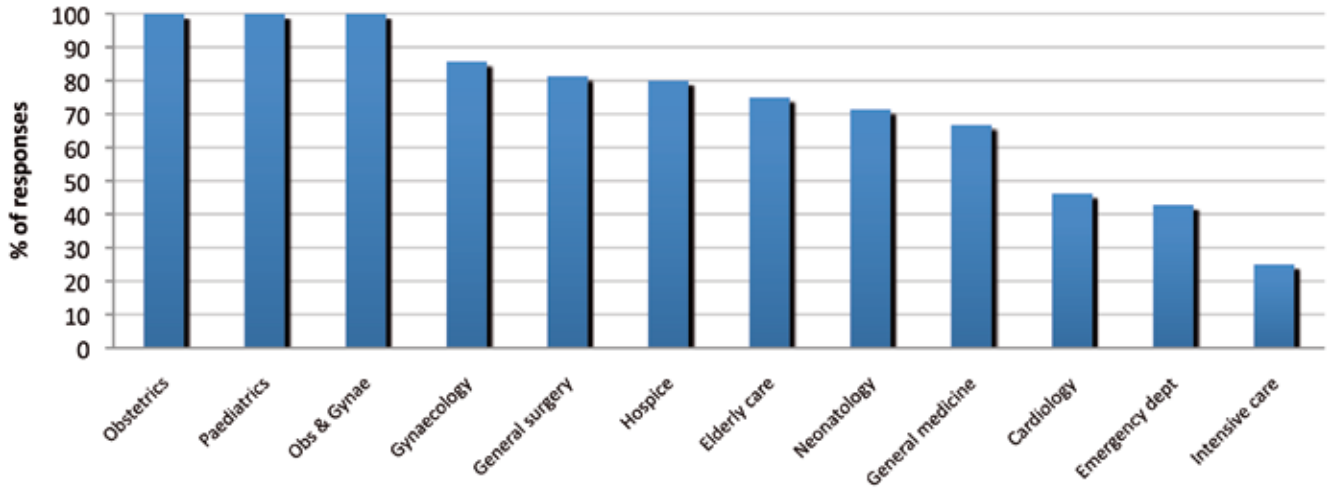


Figure 37: Facilities in which dying patients are cared for in single rooms on more than 75% of occasions, as reported by ward managers (n=133)

Within the hospital sector, there was an inverse relationship between the number of deaths that take place within the speciality and the provision of single rooms, i.e. there was a greater likelihood of a dying patient being cared for in a single room in a speciality where relatively few deaths occur than in areas where deaths are more frequent. However 80% of deaths in hospices occurred in single rooms.

Mortuary staff were asked about their viewing facilities and other environmental factors for relatives. Figure 38 indicates that those mortuaries where post mortems are carried out have a greater range of facilities available.

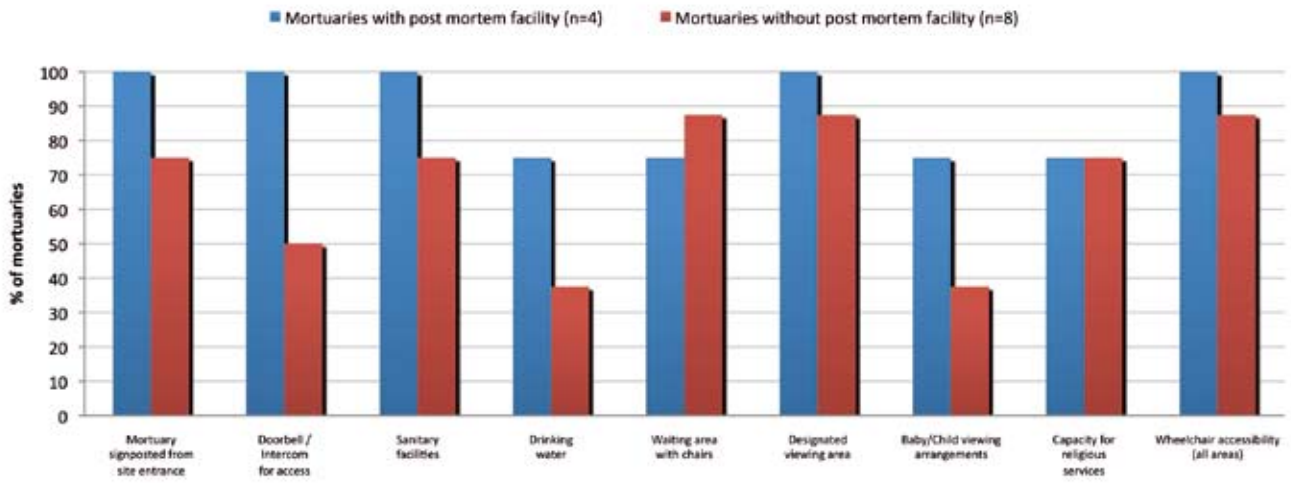


Figure 38: Viewing arrangements and other facilities available at mortuaries

It was evident in discussion with staff that, despite the availability of designated viewing areas in the vast majority of mortuaries, viewing by families was not encouraged in some of the smaller mortuaries. This appeared to be related to the presence of qualified staff.

Some of the most difficult situations that mortuary staff reported they had to deal with included the support of relatives viewing bodies brought directly to the mortuary following accidents and other traumatic incidents.

4.2. Care and support

When engaging in one-to-one contact, patients and families should be enabled to express their needs and preferences through sharing expertise and responsibility and facilitating informed choice (When a Patient Dies, Department of Health 2005).

Given the importance of working in partnership with patients and families, ward managers were asked about whether they explore the wishes and feelings of patients who are dying; figure 39 sets out the results. Every manager from an elderly or a gynaecology ward reported routinely exploring the wishes and feelings of their dying patients, where appropriate. This contrasts with just over 30% of staff from emergency departments reported doing so. The practice in emergency departments may not be unexpected given the higher frequency of sudden deaths that occur. It is recognised that these types of discussions may need to be carried out by experienced staff with advanced communication skills.

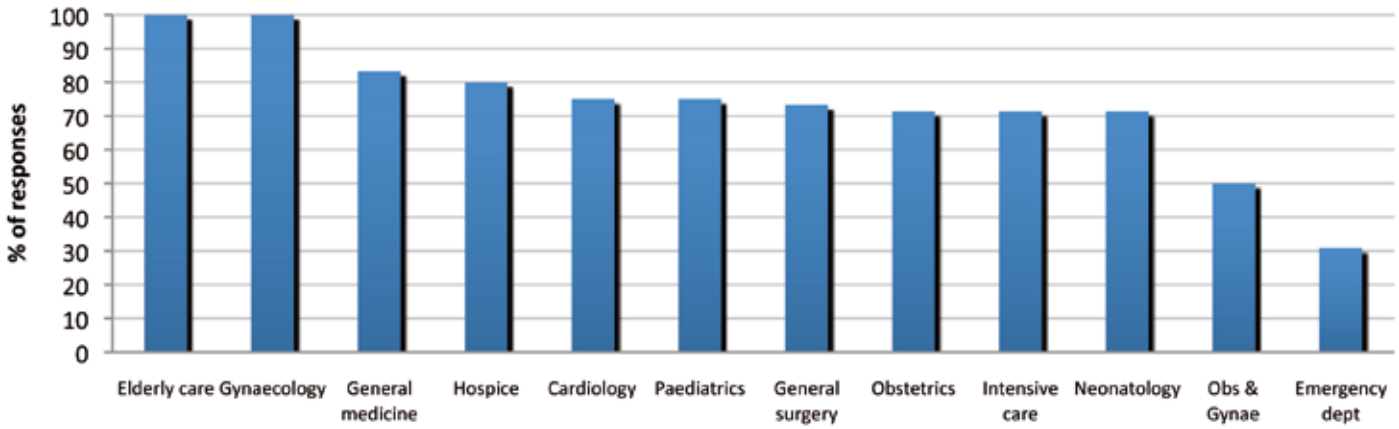


Figure 39: Ward managers from different specialist areas who reported that they routinely explore the wishes and feelings of dying patients (n=137)

All managers were asked during ward visits about the use of a care of the dying pathway in their wards. Currently, only adult wards reported using this system with the development of a separate care of the dying pathway for use within a number of children's services being considered. Only responses from managers of adult wards are reported in Figure 40.

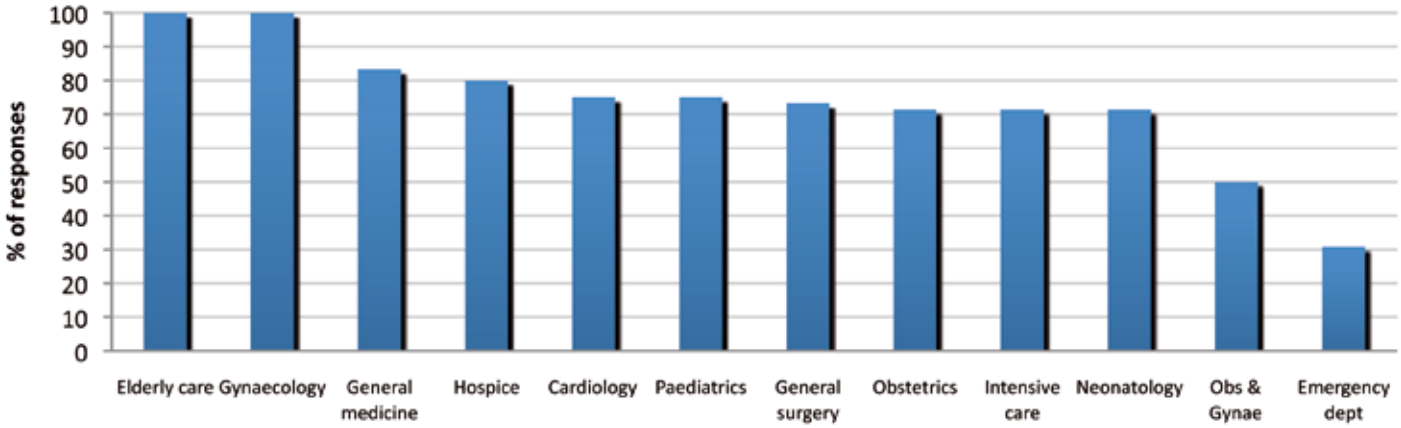


Figure 40: Areas where the care of the dying pathway is operational, as reported by ward managers (n=124)

As expected, general medicine, as the clinical area with the highest number of inpatient deaths, is also the area within which the care of the dying pathway is most frequently used. It is also used extensively in cardiology wards, but rarely in obstetrics or emergency departments. Overall, staff comments were very positive about the benefits of the care of the dying pathway, which they felt helped to ensure a holistic approach to end of life care.

Figure 41 summarises the extent to which ward managers reported that relatives have the opportunity to speak to an appropriate nurse, doctor and/or hospital chaplain. Although staff reported it to be increasingly difficult to give families the amount of time they may need in busy clinical areas, staff were reported to often make themselves available (95-100%).

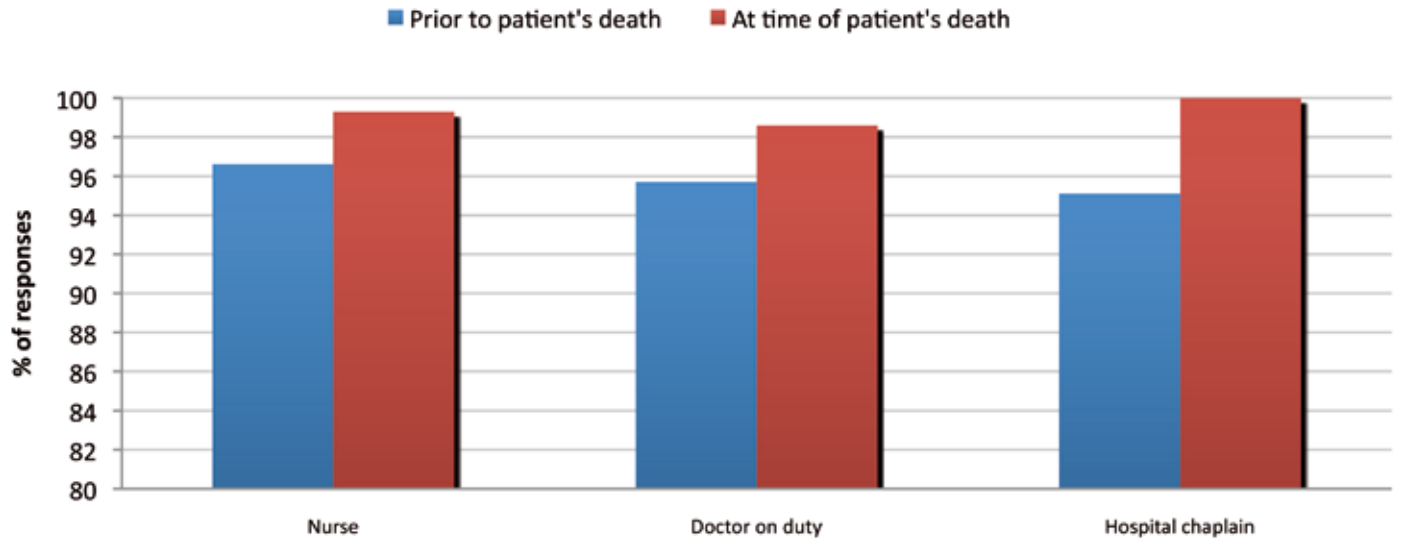


Figure 41: Extent to which relatives were afforded an opportunity to speak to a health care professional about their relative's death, as reported by ward managers (n=145)

Senior staff were asked to identify those individuals and groups, from the statutory or voluntary sector, with a remit for care of the dying, after-death care or support for the bereaved. A total of 23 organisations were identified, the most frequently cited of which are presented in Figure 42.

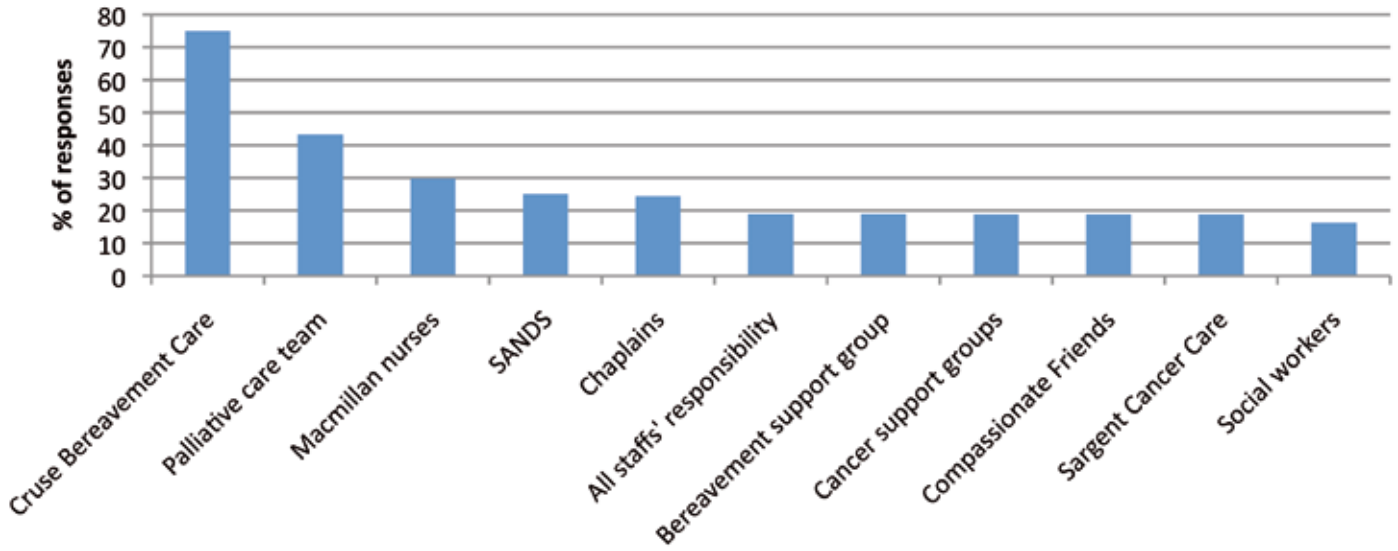


Figure 42: Services most frequently identified by senior managers (n=37) as having a link to bereavement care

Cruse Bereavement Care was by far the most frequently identified organisation, cited by over 70% of the managers. Of the rest, only those services provided by palliative care teams, Macmillan nurses, SANDS and hospital chaplains were identified by more than 20% of respondents. And of the 12 services not included within Figure 42 – care of the dying pathway coordinators, clinical psychologists, Marie Curie services, bereavement volunteers, Bliss for Babies, Child Bereavement Trust, Miscarriage Association, Ulster Cancer Foundation, Area Bereavement Coordinators, community hospice nurses, occupational health services and PSNI Family liaison officers – each was identified by fewer than 10% of managers.

Specialist palliative care and chaplaincy teams were asked about the availability of written information on their respective services. As can be seen from Figure 43, 82% of the former and 67% of the latter indicated that such information is available.

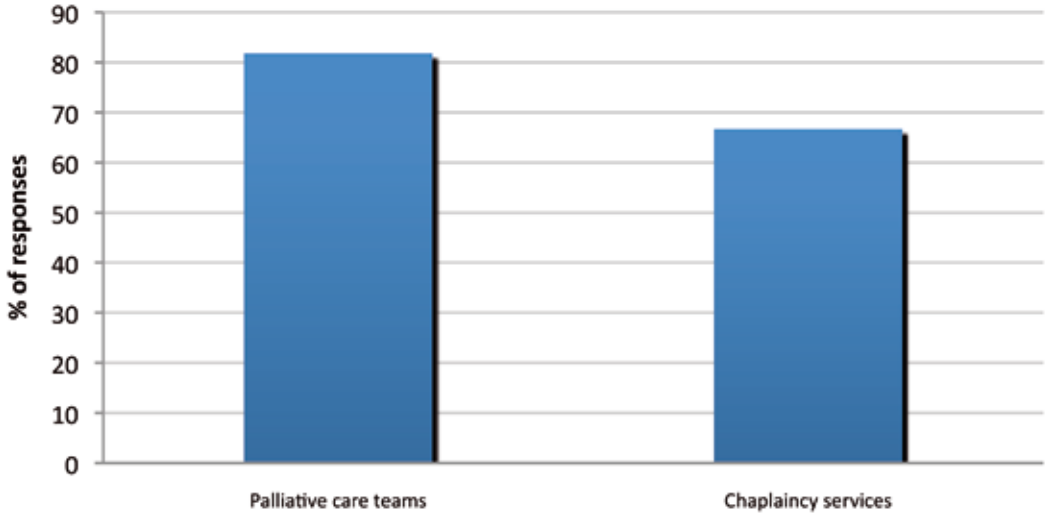


Figure 43: Specialist palliative care teams (n=11) and chaplaincy services (n=33) for which written information was available

Appropriate and timely referral to specialist palliative care teams is essential to ensure that patients and families receive the support and advice they require. Specialist palliative care teams were consequently asked about both the source of their referrals and the nature of the services they provide.

As can be seen from Figure 44, all specialist palliative care teams reported that they received referrals from wards and that, given the nature of their illnesses, on admission some patients were already known to their services.

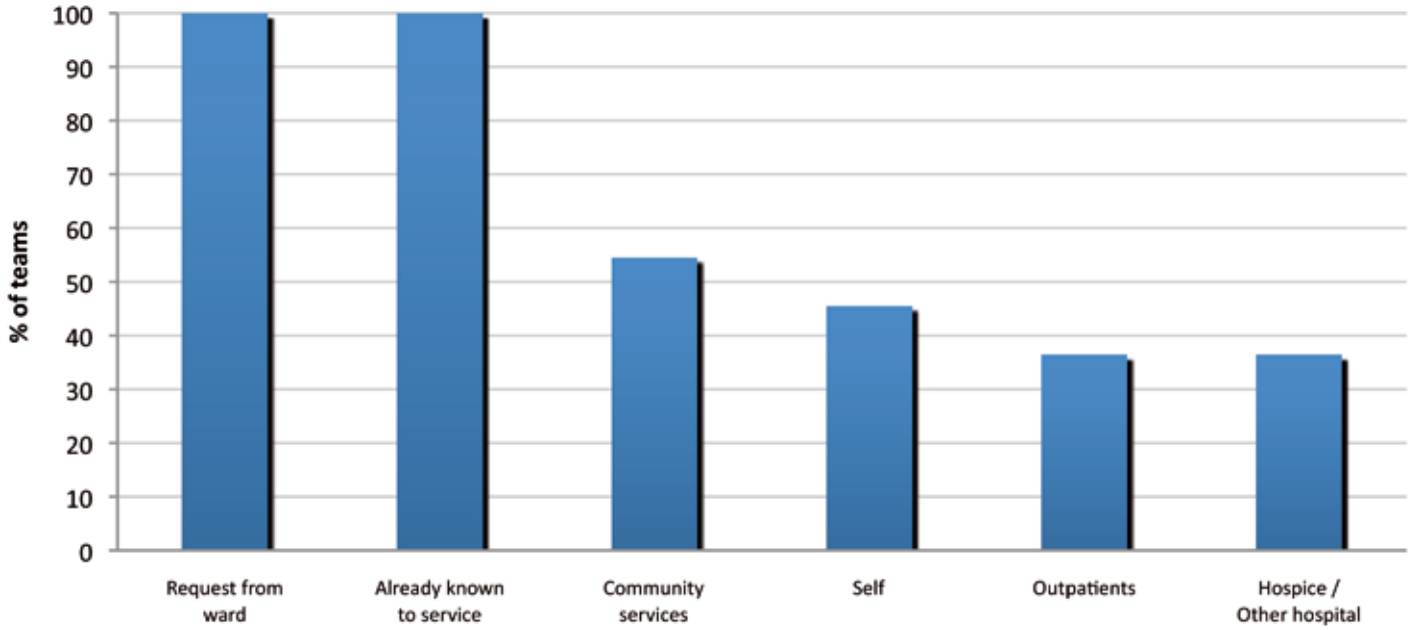


Figure 44: Sources of referral to specialist palliative care teams (n=11)

Figure 45 indicates that symptom management, advice and support were the core services provided by all specialist palliative care teams, followed by education and training, including the promotion of end of life care pathways (73%), referral on to community services (64%) and the provision of follow-up support (55%). It was evident from discussions with ward staff during the audit that the support and advice they received from the palliative care teams on the use of the end of life care pathway was particularly appreciated.

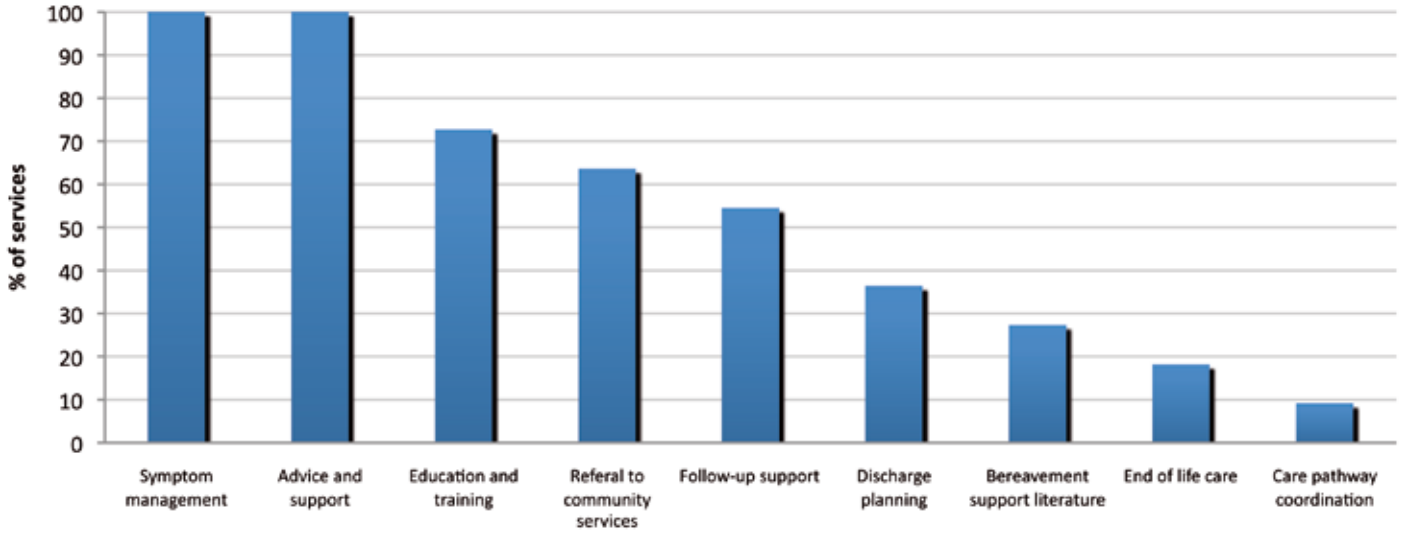


Figure 45: Services provided by specialist palliative care teams (n=11)

Patients are usually informed on admission of the availability of a hospital chaplaincy service and asked if they wish to have their religious denomination recorded and provided to the appropriate chaplain. Efforts are made by chaplains to visit as many patients on their lists as possible, but where this does not occur routinely the chaplains concerned were asked to indicate in what other ways they receive referrals to visit patients.

Figure 46 details the responses provided by the four chaplains concerned. All indicated that they receive requests directly from patients and/or their families, while in three cases the chaplains reported that they were either familiar with patients prior to their admissions or that they were informed of individuals either directly from the wards or during chaplains' ward visits.

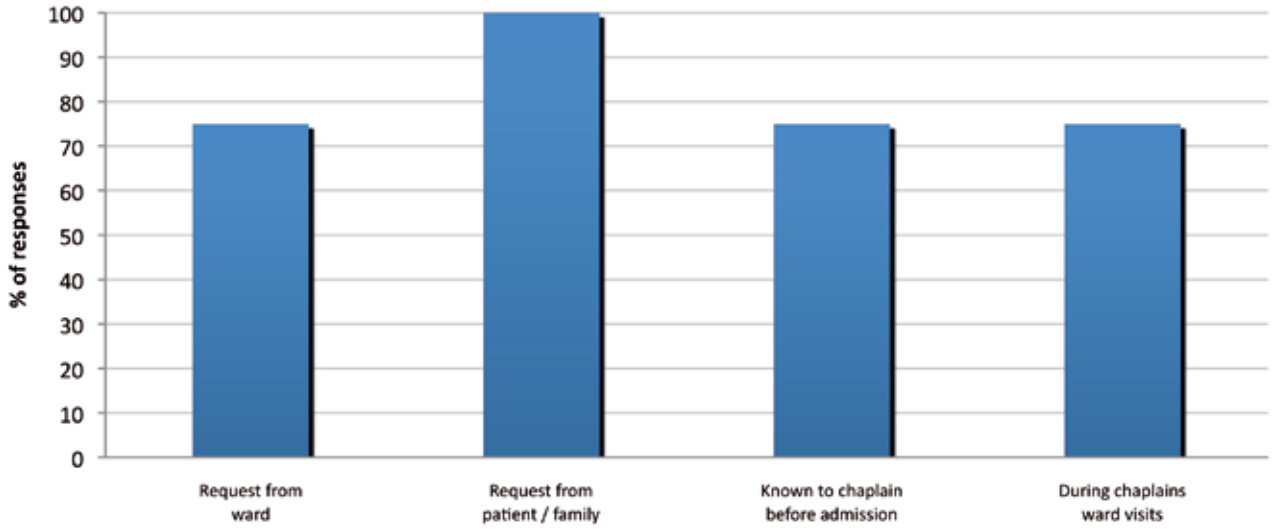


Figure 46: Referrals to chaplains where not all patients are visited (n=4)

The chaplains stressed the importance of timely referrals from ward staff, especially for patients who are dying, and indicated that in some instances they had been notified too late to be able to offer support to the patients, who had already died. The opportunity to build up a relationship with a patient's family prior to his/her death can be of assistance when offering support at the time of the death and afterwards.

The various services which the chaplains provide are summarised in Figure 47.

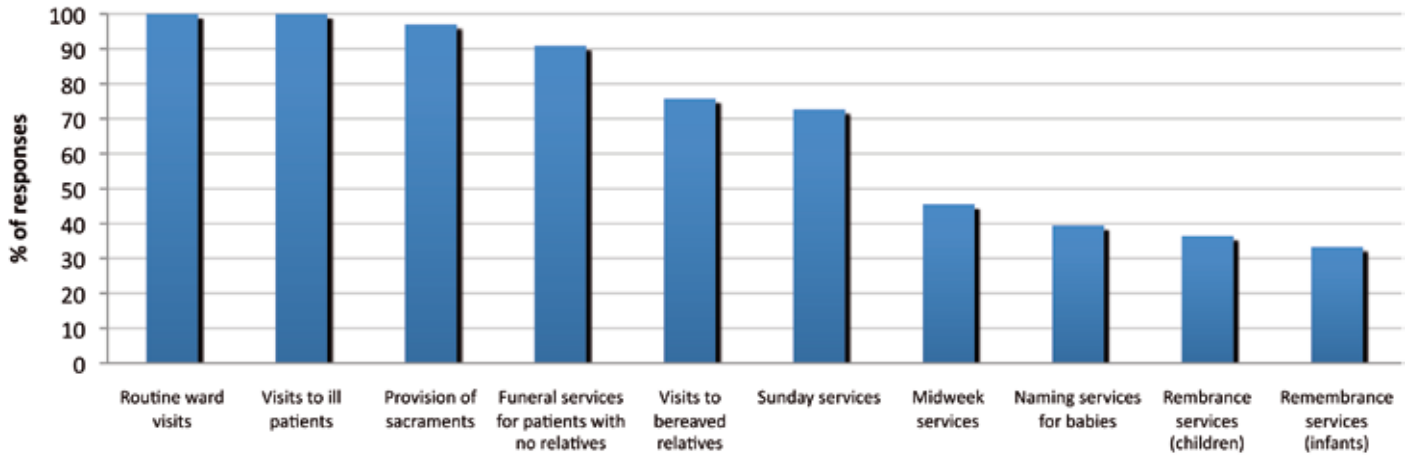


Figure 47: Services provided by chaplains (n=33) to patients and/or their families

All chaplains carry out routine ward visits and visits to ill patients, and the vast majority (90%) provide the sacraments and undertake funeral services for patients without families. Some chaplains (40%) undertake a number of specifically child-related services, such as infants' or children's remembrance services or naming services for babies.

Portering managers and those funeral directors who were contracted to perform portering and mortuary duties were asked both about their duties and responsibilities in relation to hospital mortuaries and about their involvement with families. Figure 48 indicates their key responsibilities, both independently and under the supervision of mortuary staff.

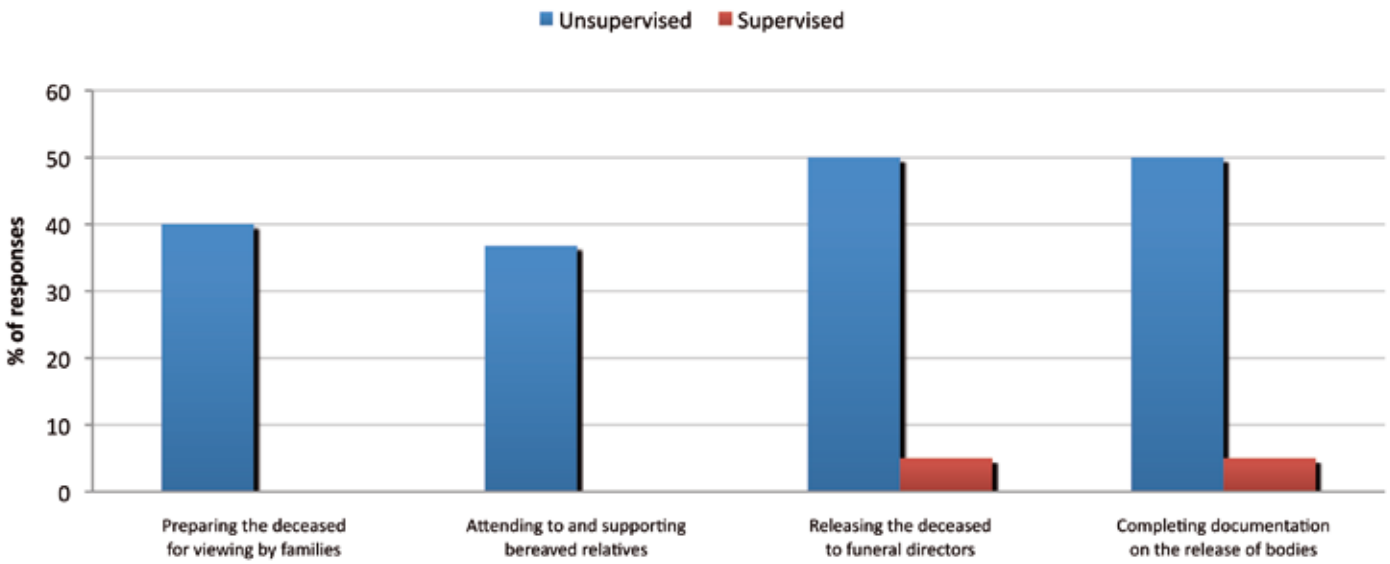


Figure 48: Duties undertaken by portering teams and funeral directors with portering and mortuary duties (n=20)

It is clear that the porters and contracted funeral directors carry out most of their four key duties independently. However, it is also evident that no single duty was performed in any more than 50% of the sites that were audited.

The larger acute hospitals tended to have at least one qualified pathology technician or designated mortuary attendant in post, whereas in a number of smaller hospitals portering staff were responsible for mortuary duties required, in liaison with ward staff and funeral directors. It was notable during the audit that some of the senior portering staff had been carrying out their duties for many years and were very familiar with all the processes involved, as well as with the sensitivities required in dealing with bereaved families.

4.3. Information and communication

The audit identified a range of systems used by wards, departments and hospices to notify other professionals of a patient's death (Figure 49). The most common means was through a senior nurse on duty contacting the patient's GP directly (28%), although 5% of facilities had no recognised system at all in place for the notification of other professionals.

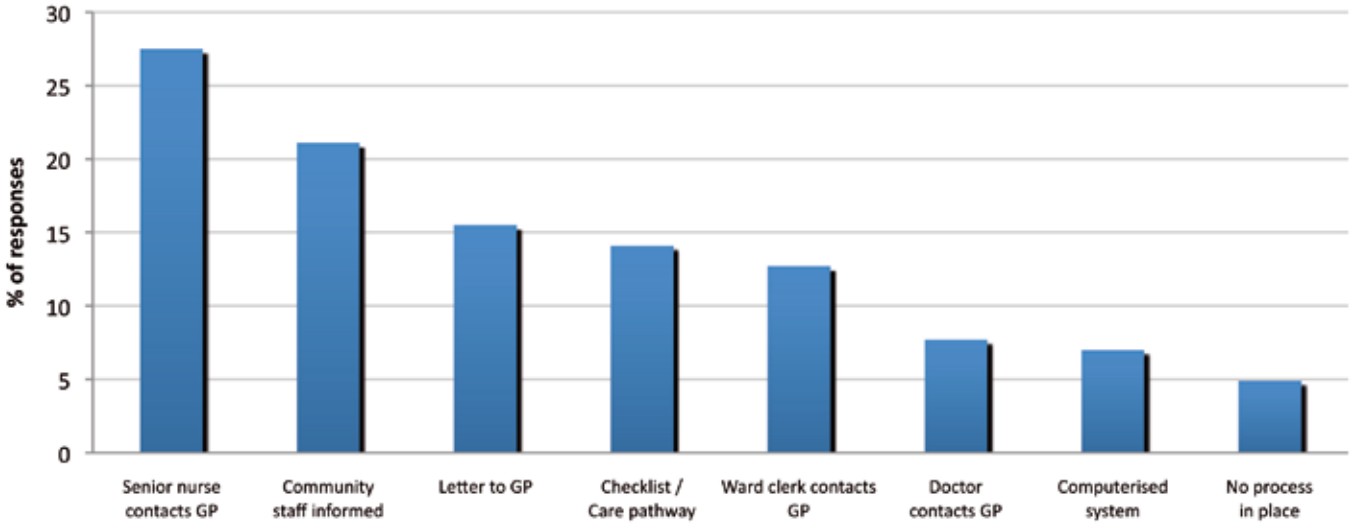


Figure 49: Systems in place for the notification of other professionals, as reported by ward managers (n=142)

It was also identified that no reporting system is entirely robust and that communication can break down at times, resulting in either a delay or the relevant professional not being informed of the patient's death. This has the potential to cause undue upset to bereaved families, such as when they receive a letter offering an appointment to a person who has already died.

Ward staff were asked about the information provided to families at the time of a patient's death (Figure 50). In nearly all cases families were informed if the coroner was contacted or if the Medical Certificate for Cause of Death has been issued. Other information commonly provided to families at the time of a patient's death included potential health and safety risks, the return of the deceased person's property and notification that the remains may be released. It is perhaps surprising, in light of the importance of these latter reasons, that each of them was identified by fewer than 100% of the staff who were audited as information that would routinely be provided to families.

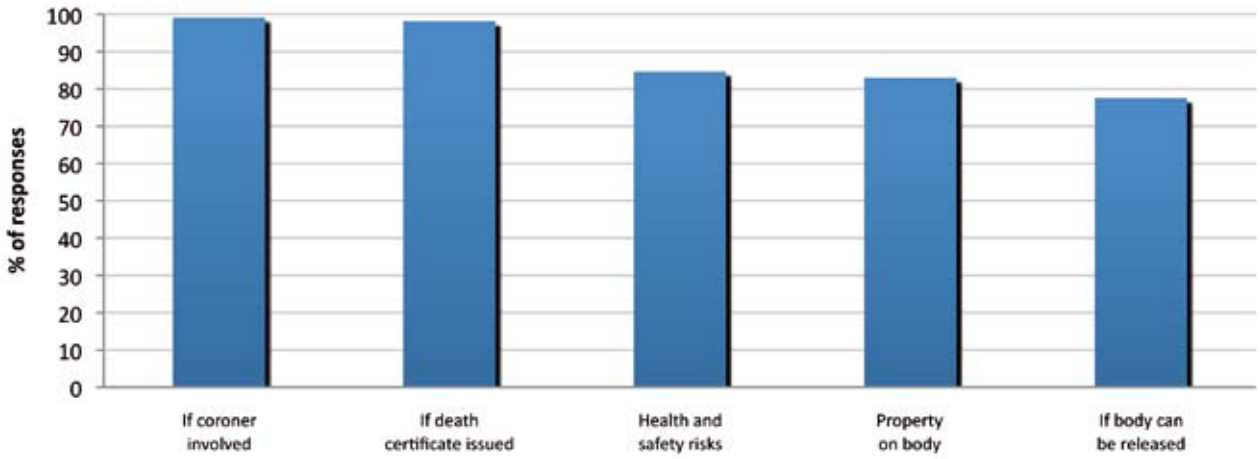


Figure 50: Information given to the family by the ward, as reported by ward managers (n=102–121)

Following the recommendation of the Human Organs Enquiry 2002, the DHSSPS introduced new consent forms to be completed by the deceased's next-of-kin in cases where a hospital post mortem examination is indicated, along with booklets aimed at supporting families through this process. Obtaining consent in such cases involves discussions with families aimed at enabling them to make informed choices. In the case of post mortem examinations directed by the coroner, consent for the procedure is not required, although the families' wishes regarding the disposal of tissue does need to be sought. The Coroner's Service NI has produced a booklet to support these processes.

It is expected that senior doctors and nursing staff will offer information and support to families at such difficult times, and Figure 51 summarises the responses in the audit of ward managers when asked about the information provided to families when a post mortem examination is required.

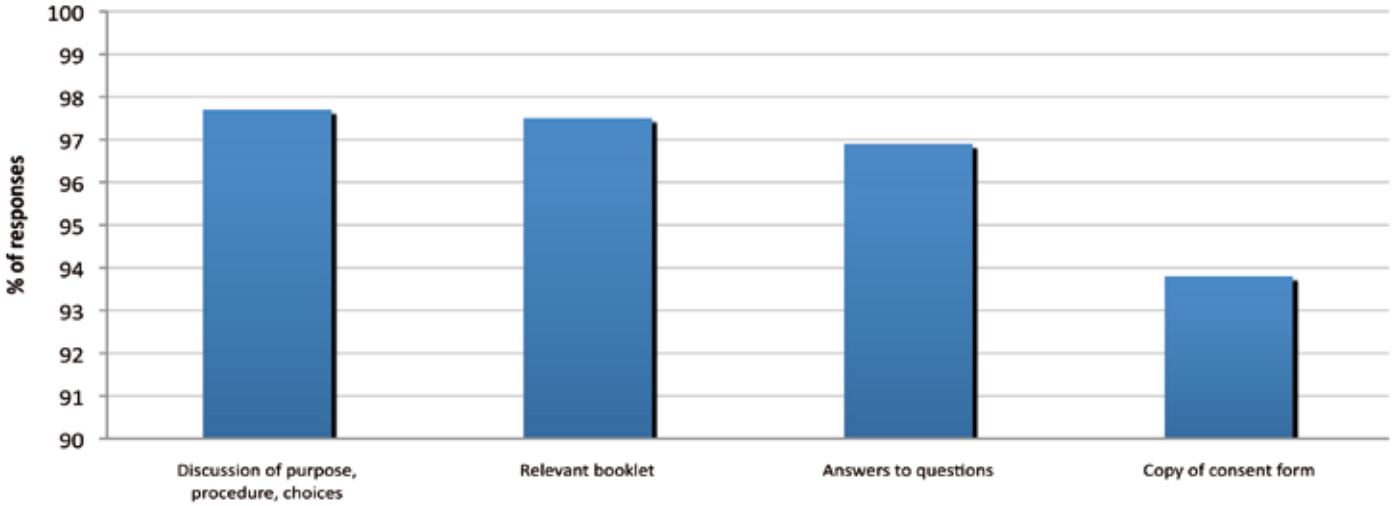


Figure 51: Information provided to families when a post mortem is required, as reported by ward managers (n=113-131)

Explanations and discussions with families, as well as answering their questions and providing them with relevant booklets were all identified practices within at least 97% of wards, although copies of consent forms were provided in only 94% of cases.

The nature of any written information provided to bereaved parents on those wards and departments which may be expected to experience the deaths of babies and/or children is summarised in Figure 52.

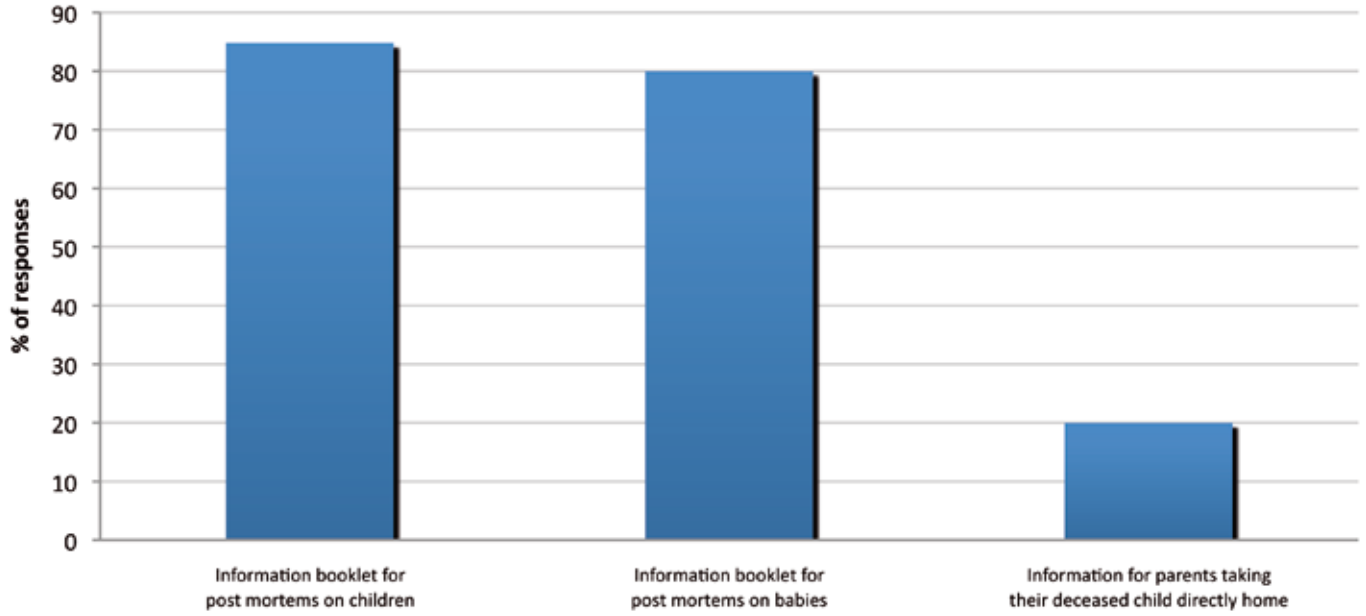


Figure 52: Written information provided to parents of deceased babies or children, as reported by ward managers (n=33-50)

Given that almost half of all children who die in a neonatal unit undergo a hospital post mortem, it is no surprise that information booklets in respect of post mortems on children and babies were the most commonly provided, in at least 80% each of the respective wards and departments. It is increasingly common for parents to take the bodies of their children directly home by car immediately following their deaths, where this was expected; only 20% of the relevant wards and departments had a written policy to support this practice.

Ward managers were asked about other information and resources they provided to bereaved families (Figure 53). There was evidence of families being directed towards a number of voluntary organisations (in particular, Cruse Bereavement Care) in 78% of wards and departments; 74% provided families with forms to assist in registering the death; 62% provided booklets specifically designed to assist bereaved people; and 54% provided information in relation to the arranging of funerals.

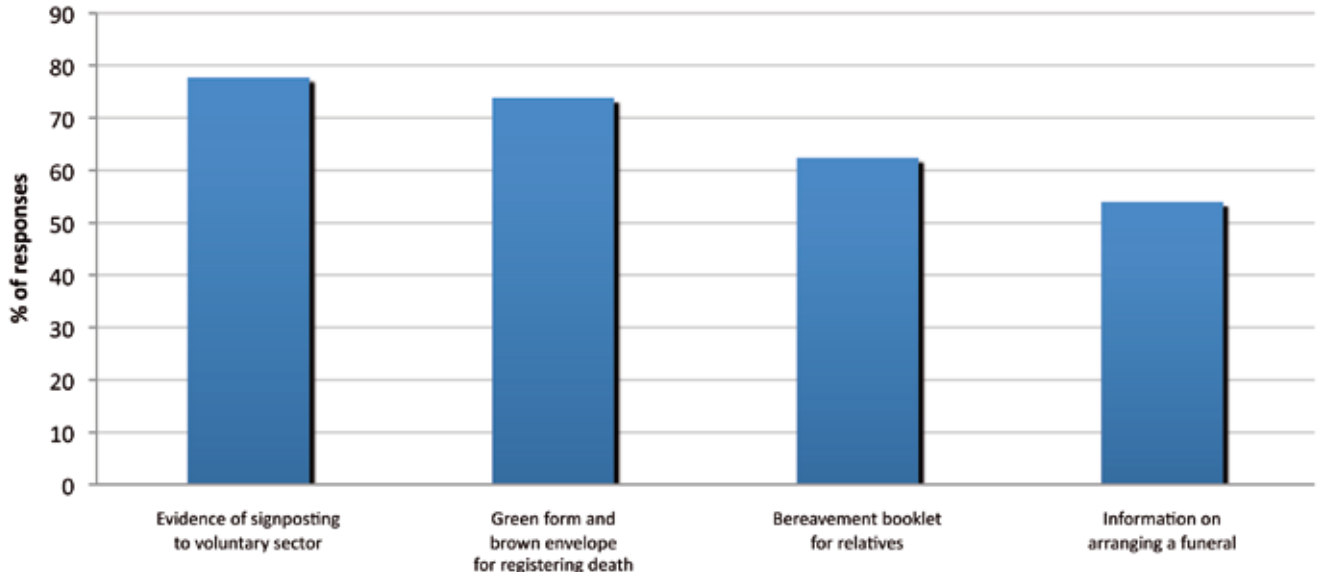


Figure 53: Other information and resources provided to bereaved relatives, as reported by ward managers (n=142)

Ward and hospice managers were also asked about arrangements for the collection of Medical Certificates of Cause of Death in situations where they had not been issued at the time of death. Their responses are provided in Figure 54.

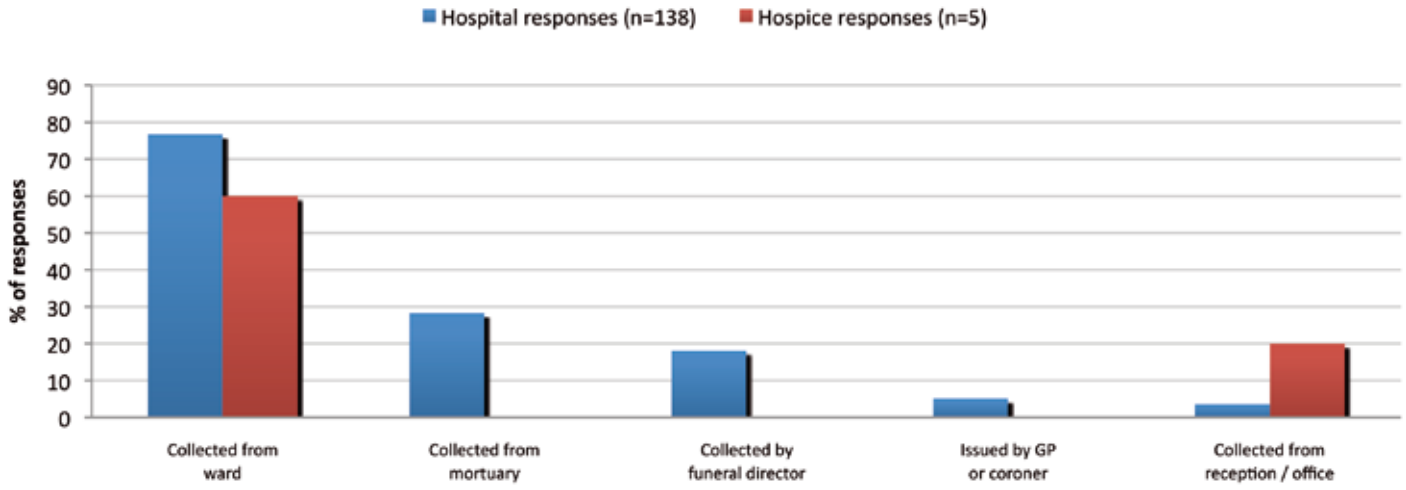


Figure 54: The collection of death certificates in hospital and hospice settings, as reported by ward managers

Within the hospices, certificates were reported to be collected either from the ward (in 60% of cases) or from reception or a general office (20%). Collection from the ward was also reported as the most common procedure within the hospital sector (77%), where a further 28% reported their collection from a mortuary instead. However, it can be difficult for a family member to return to a mortuary or ward in which their relative had died a short time previously and a representative may be able to collect the certificate on a relative's behalf. It is noted that 18% of the hospital ward managers in the audit indicated that death certificates were collected by funeral directors.

To facilitate the customary three-day burial practice in Northern Ireland, it is important for all organisations to ensure the timely issue of death certificates. It is also important that accurate and transparent records regarding the issue and collection of death certificates be maintained.

Ward managers were asked whether or not follow-up meetings to discuss a patient's death were routinely offered to bereaved families. The percentages of units within each clinical area reporting that such follow-up meetings were always offered to families are presented in Figure 55.

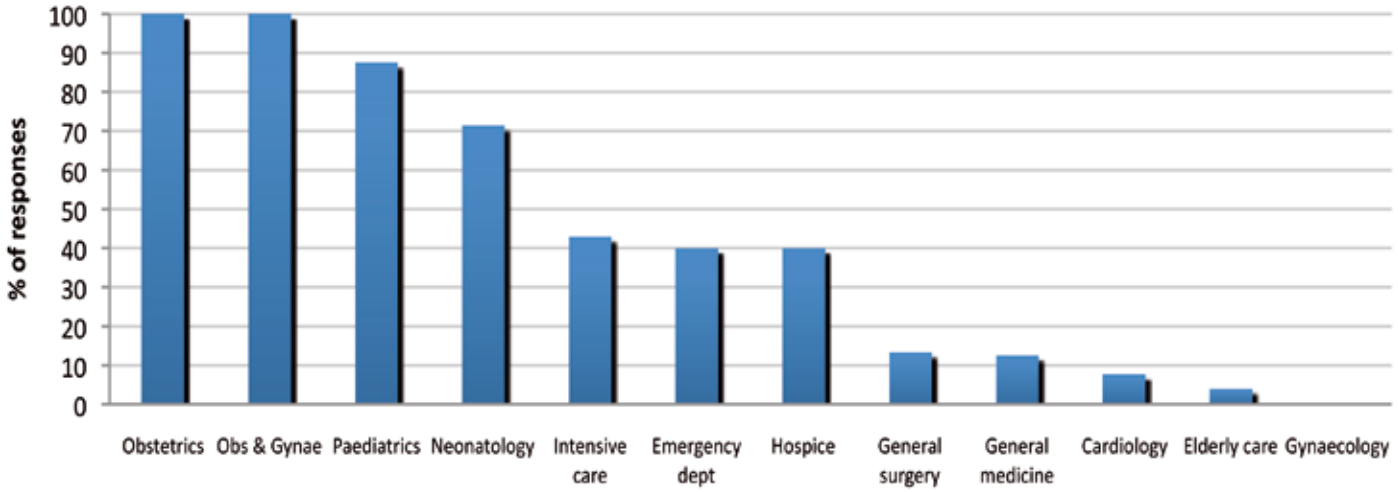


Figure 55: Wards and hospices offering follow-up meetings with bereaved families, as reported by ward managers (n=143)

There were only two clinical areas where every ward concerned provided routine follow-up meetings with families: obstetrics and joint obstetrics and gynaecology services. Follow-up meetings were not routinely offered in the majority of other units, either in the hospital or the hospice sector, such meetings were reported as being provided at the request of families.

When asked about how families were provided with the results of post mortem examinations, the ward managers responded as set out in Figure 56.

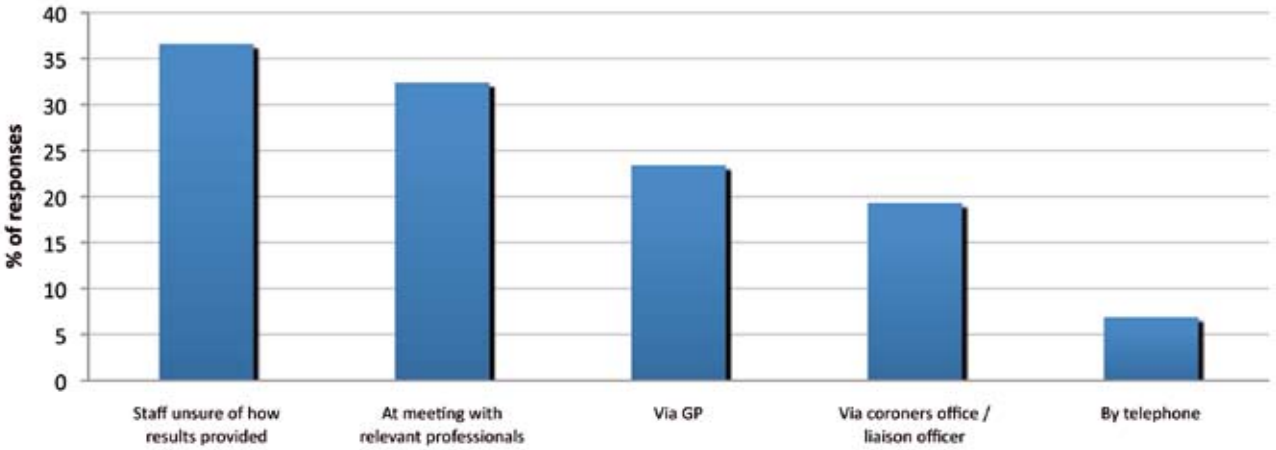


Figure 56: Means of informing families with the results of post mortem examinations, as reported by ward managers (n=145)

The audit findings show that over 35% of ward managers were unable to identify how families received the results of post mortem examinations – suggesting there was often a lack of communication between the various parties involved. Of the others, the most common means was through face-to-face meetings with relevant professionals (identified by 32% of respondents), followed by contact with the patient's GP (23%) and through the coroners office or liaison officer (19%). Seven percent reported that the results of post mortem examinations had been relayed to family members over the telephone.

Ward and hospice managers were also asked to identify any methods they employed to obtain feedback from their service users, with responses summarised in Figure 57.

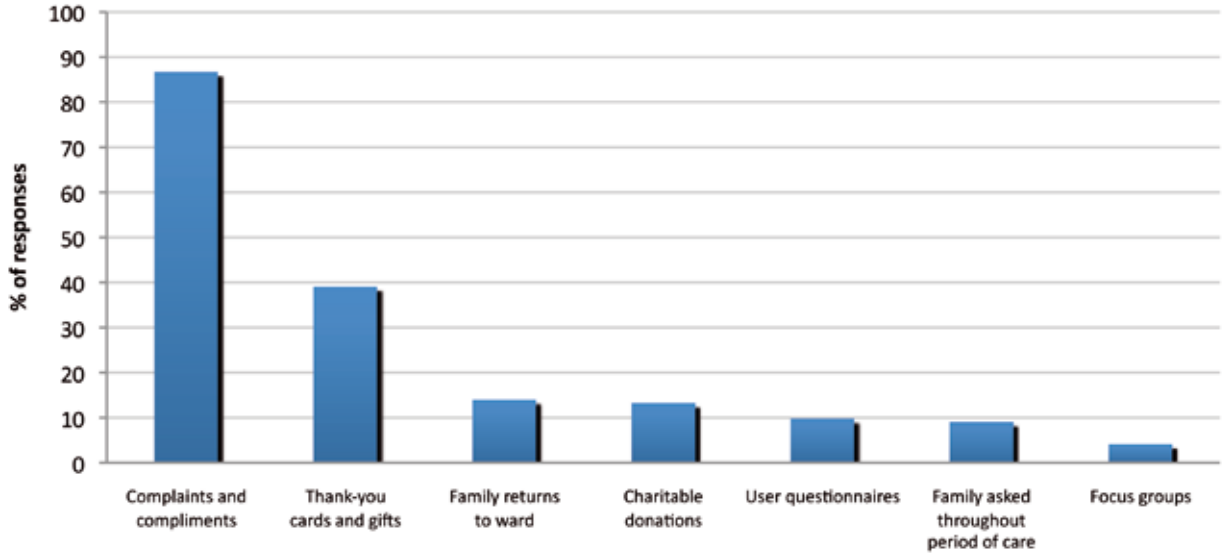


Figure 57 : Methods employed by wards and hospices to secure user feedback, as reported by ward managers (n=143)

By far the most common method employed was through the receipt of complaints and compliments (reported by 87% of the managers audited). Thank you cards and gifts were reported by 39%, with families returning to the ward, charitable donations, and asking family members throughout their relative's stay in the unit each recorded by fewer than 15% of the managers.

Equally small percentages of the managers reported using more formal means of securing service user feedback, including user questionnaires (10%) or focus groups (4%).

No service within the hospital or hospice sector identified a systematic approach of collecting or using user feedback on their services.

5. Recommendations

Results from this audit identified a wide range of services and information across the NI Health and Social Care Services and within Hospices for the care of dying patients and to support bereaved people. There are, however, variations in the standards and organisation of such services. No overarching system or set of policies were in place to ensure appropriate standards. In consequence the following recommendations are set out to improve the quality and organisation of these important services.

1. A strategy for bereavement care within the Health and Social Care Services should be developed to inform the direction of end of life and bereavement care in Northern Ireland.
2. HSC Trusts should develop an overarching policy which incorporates core policies around care of the dying and the management of death. As a minimum this should include written guidance on the following:

    - Last offices (including cultural and religious requirements)
    - All aspects of identification, transfer, storage, viewing and release of bodies
    - A minimum agreed set of information which complies with health and safety requirements should be noted on a mortuary form which accompanies the body.
    - The issue of the Medical Certificate of Cause of Death
    - Reporting deaths to the Coroners Service
    - The management of sudden, unexpected death and the preservation of evidence in forensic cases
    - A clear system for informing other professionals of the death

3. Corporate and local induction should cover issues concerning death and bereavement as relevant to the role of the staff concerned.
4. Trusts must offer training in consent for hospital post mortem examinations to those senior medical staff who may be required to seek consent.
5. Staff should be made aware of support systems available to them.
6. As identified by staff, there should be opportunities for staff development and training in the care of dying patients and bereaved relatives (see Appendix 7).
7. The use of the care of the dying pathway should be promoted as a minimum safe standard.
8. Trusts should have operational policies for chaplains' services.
9. Governance systems should ensure learning from complaints made by bereaved families.
10. Systems should be developed to obtain feedback from bereaved relatives.
11. Information booklets for bereaved relatives should be audited.
12. New capital builds and refurbishment programmes should include areas to promote privacy and dignity for dying patients and bereaved families.

Appendices

Contents

1. Organisational Audit Standards

Audit Criteria	Standard	Achieved	Rationale
1. Chaplains are employed by the organisation	100%	97.5%	"All NHS Trusts provide spiritual support for patients, staff and relatives through chaplains and faith community representatives." - 2 "NHS Trusts may wish to consider how best to provide spiritual care as an integral part of the overall bereavement care they provide." – 1 "Chaplaincy-spiritual care is central to providing support and assistance to the bereaved. All NHS Trusts should ensure that the dying and recently bereaved are able to access chaplaincy services at the appropriate time." – 2
2. The following policies/guidelines concerning death and bereavement are in place:			
a. Accessing interpreting services	100%	90.0%	"Patients should be able to communicate with health workers in the language they feel comfortable with." - 3
b. Advance Directive	100%	52.5%	" Individuals may have an advance directive or living will specifying how they would like to be treated in the case of future incapacity. ……Failure to respect such an advance refusal can result in legal action against the practitioner." - 4
c. Bereavement Care	100%	50.0%	"All NHS Trusts should provide support and advice to families at the time of bereavement." - 5
d. Breaking bad news	100%	80.0%	"Implementation of the Regional Guidelines for Breaking Bad News is the responsibility of each HPSS Trust, HPSS and Voluntary Providers, in partnership with education providers and individual professionals". - 6
e. Burial by hospital (if no next of kin) *hospices not included	100%	62.9%* n=35	"Children Order (NI) 1995, Health and Personal Social Services (NI) Order 1972 (Article25&39), Health and Personal Social Services (NI) Order 1991(Article25) and Welfare Services Act (NI) 1971 (Section 25).
f. Care of the dying pathway:	100%	74.4%	"Provider organisations should ensure that managed systems to ensure best practice in care of the dying patients are implemented by all multidisciplinary teams. This might include the Liverpool Care of the Dying pathway" – 8
g. Care plan for pregnancy loss, stillbirth and neonatal death	100%	75.0% (n=16)	DHSSPS -9
h. Chaplaincy / spiritual care	100%	52.5%	"NHS Trusts may wish to consider how best to provide spiritual care as an integral part of the overall bereavement care they provide. This may be best led through a healthcare chaplain or similar role and Trusts may wish to take into account the NHS guidance for managers and those involved in the provision of chaplaincy/spiritual care issued in 2003". – 2
i. Death certification	100%	82.5%	"Most hospitals will have a written record of procedures to be used following the death of a patient in order to complete a fact of death form (if used), the medical Cause of Death Certificate, a cremation form (if needed) and the documentation necessary to permit the release of the deceased from the hospital, and to pass on the necessary documentation to the next of kin." – 1

Audit Criteria	Standard	Achieved	Rationale
j. Cremation	100%	65.0%	As above.
k. Cultural and religious observances	100%	87.5%	"Adequate arrangements are made for the spiritual, religious, sacramental, ritual and cultural requirements appropriate to the needs, background and tradition of all patients and staff, including those of no specified faith." – 2
l. Do not attempt resuscitation	100%	95.0%	"NHS Trusts chief executives are asked to ensure that the appropriate resuscitation policies which respect patients rights are in place, understood by all relevant staff, and accessible to those who need them, and that such policies are subject to appropriate audit and monitoring arrangements" – 10
m. Identification of the deceased	100%	47.5%	"Mortuary services following good practice will have a policy in place which covers the procedures necessary for the identification of deceased peoples bodies and their possessions" – 12
n. Information for relatives	100%	65.0%	"The provision of written information (listing and describing sources of support, helplines and web-based information, for example) is recommended to help people who are bereaved manage the practical arrangements necessary after a death." – 1
o. Last offices with regard to: i. Manual handling ii. Infection control iii. Cultural & religious practices iv. Transfer of the deceased v. Identification vi. Notification to other departments vii. Removal of implants viii. Return of property and valuables ix. Viewing the deceased	 100% 100% 100% 100% 100% 100% 100% 100% 100%	 82.5% 87.5% 89.7% 62.5% 80.0% 82.5% 45.0% 82.5% 55.0%	"It is recommended that NHS Trusts consider putting in place a written policy ratified by the Trust Board, covering all services relating to death & bereavement." - 1 - 21
p. Post mortem processes	100%	67.5%	11 and 19
q. Reporting cases to the Coroner	100%	92.5%	13, 22
r. Sudden death protocols	100%	37.5%	"Such policies should identify bereavement care pathways for both expected and unexpected deaths" - 1
s. Availability of Memorandum of understanding for investigating patient/client safety incidents…	100%	65.0%	"The memorandum will take effect in circumstances of unexpected death or serious untoward harm requiring investigation by the police, coroners or HSENI separately or jointly." - 14

2. Mortuary Services Audit Standards

Audit Criteria	Standard	Achieved	Rationale
1. The following viewing arrangements are in place:		(n=12)	"…mortuary facilities would ideally need to include at least one private, comfortable room where a body can be seen by relatives and others. Facilities should be designed to cater for all age groups" - 1
a) Relatives can view the deceased in the mortuary	100%	100.0%	
b) Mortuary is clearly sign-posted from the hospital entrance	100%	83.3%	
c) Doorbell or intercom to gain access	100%	66.7%	"Consideration should be given to all approaches, adjacencies and routes (entrances and departures), eg the journey for the bereaved from the place of death to the mortuary" – 1 and 20
d) Access to sanitary facilities	100%	83.3%	
e) Access to drinking water	100%	50.0%	
f) Waiting area with comfortable chairs	100%	83.3%	"A viewing room will usually be decorated and furnished in a way which will help people feel calm and cared for…and easy chairs so that if they wish, relatives can stay with the deceased person for a while in comfort"- 12
g) Designated viewing area	100%	91.7%	
h) Special arrangements for viewing babies/children	100%	50.0%	
i) Capacity to accommodate religious/cultural rituals	100%	100.0%	"Death and bereavement affect individuals in different ways. Their response is also influenced by their beliefs, culture, religion, values, sexual orientation, life-style or social diversity. Mortuary service staff will be alert to individual needs, and be flexible in attempting to meet them." - 12
j) Capacity to hold religious services	100%	75.0%	
k) All areas are wheelchair accessible	100%	93.8%	
2. The following documentation accompanies patient's remains from the ward/department to the mortuary:		(n=12)	"It is recommended that NHS Trusts have in place: secure systems for the identification of bodies, in order to ensure that the correct body is prepared for viewing and/or release for cremation or burial" - 1
a) Patient ID label	100%	75.0%	
b) Wrist/ankle ID band	100%	100.0%	
c) Mortuary form	100%	75.0%	
3. Mortuary staff are informed of the following:		(n=12)	"Mortuary and bereavement services will need to have in place robust mechanisms for communicating information about the deceased patient…this will ensure that any relevant information from the family is passed to mortuary staff." - 12
a) Cultural/religious requirements	100%	91.7%	
b) Health and safety risks	100%	100.0%	
c) Property on body	100%	83.3%	"Mortuary services will have in place facilities, protocols and procedures which enable staff to provide the required service efficiently, effectively and to appropriate clinical standards" - 12
d) Pace maker in situ	100%	66.7%	
e) Tubes/drains etc in situ	100%	75.0%	"Care needs to be taken to identify implanted devices, where appropriate, as these will present a hazard at cremation" - 1
f) If death certificate issued	100%	75.0%	
g) If body is for cremation	100%	66.7%	"Before a deceased persons body is released, mortuary staff should check that all necessary documentation is complete and the deceased person's identity is confirmed both by the mortuary staff and the person to whom the body is released" – 12
h) If remains can be released	100%	75.0%	
i) If body needs to be held:			
I. For hospital post mortem	100%	100.0%	"All post-mortems must be carried out in a premises licenced by the HTA in accordance with the conditions of the licence"- 24
II. For decision of Coroner	100%	100.0%	
j) If Coroner involved	100%	75.0%	"In Coroner's cases, it is important that there is an agreed protocol in place to ensure that there is no confusion about who is responsible for the custody and release of the bodies of the deceased" – 12
4. The following policies are in place:			"Mortuary services will have in place facilities, protocols and procedures which enable staff to provide the required service efficiently, effectively and to appropriate clinical standards" - 12
a) Record keeping	100%	66.7%	
b) Receiving, identifying, securing, storing and releasing bodies, organs and tissues	100%	75.0%	"Mortuary services should have in place a policy on documentation procedures" - 12
c) Lone worker	100%	58.3%	"Mortuary services…will have a policy in place which covers the procedures necessary for the identification of deceased people's bodies and their possessions" - 12
d) Preparation for viewing	100%	66.7%	
e) Supporting relatives	100%	33.3%	"Where families have individual, cultural or religious preferences concerning the storage, handling, transportation or presentation of the deceased person, these need to be carefully documented and accommodated wherever possible." -12
f) Liaison protocols with Coroner Service and PSNI	100%	58.3%	
g) Coroner's post mortems – access to mortuary out of hours	100%	66.7%	"As a result of the isolated location of most mortuaries and the shift patterns maintained by staff, a risk assessment will usually be undertaken and adherence to a Lone Worker policy encouraged among all mortuary staff. - 12
h) Infection control	100%	100.0%	

i) Moving and handling	100%	100.0%	"It is important that the deceased is presented in the best possible way. Mortuary services should have in place a policy on this issue" - 12
j) Removal of the deceased outside working hours	100%	66.7%	"It may be important for bereaved families to see and spend time with the person who has died during the time they are in the mortuary. Mortuaries need to have in place policies to support good practice locally" - 12
k) Disaster planning	100%	75.0%	"Mortuary services should have in place a policy on communicating with bereaved families" - 12
l) Management of mass fatalities	100%	66.7%	"If a death has been referred to the coroner…consideration should be given as to how best arrangements can be made for the family to discuss (or receive) information from the coroner or coroner's officer; close liaison with those agencies is therefore important in this respect" - 1 Health & Safety at Work Act, 1974 - 18
m) Supporting children to view deceased relatives	100%	37.5%	"All staff involved, in whatever role…should have access to a range of formal and informal support" - 1
n) Staff support	100%	58.3%	"The organisation has an effective complaints and representation procedure…" - 15
o) Complaints procedure	100%	83.3%	"Mortuary services should have a system in place to implement security of personal possessions on the deceased's body, or delivery to the mortuary with the deceased." – 12
p) Accessing interpreters	100%	66.7%	
q) Management of personal property of the deceased	100%	66.7%	
5. Staff receive training on the following policies:			
a) Record keeping	100%	41.7%	"All staff involved in delivering mortuary services should participate in education and training that is appropriate to their role. Trusts should, therefore, make training and learning opportunities available to mortuary staff at all levels to enable them to develop: accurate, practical knowledge of hospital policy and procedures, and relevant legislation" - 12
b) Receiving, identifying, securing, storing and releasing bodies, organs and tissues	100%	50.0%	"Where risk assessments indicate a need, systems such as panic alarms and lone worker devices should be in place and underpinned by suitable and sufficient support procedures to protect staff" – 12
c) Lone worker	100%	25.0%	"Staff who work in mortuaries should be trained in the risks of their work and environment and should know how to avoid or minimise these risks" – 12
d) Preparation for viewing	100%	41.6%	
e) Supporting relatives	100%	41.6%	
f) Liaison protocols with Coroner Service and PSNI	100%	50.0%	
g) Coroner's post mortems – access to mortuary out of hours	100%	50.0%	
h) Infection control	100%	58.3%	
i) Moving and handling	100%	66.7%	
j) Removal of the deceased outside working hours	100%	50.0%	
k) Disaster planning	100%	41.6%	
l) Management of mass fatalities	100%	41.6%	
m) Supporting children to view deceased relatives	100%	41.6%	
n) Staff support	100%	25.0%	
o) Complaints procedure	100%	33.3%	
p) Accessing interpreters	100%	25.0%	
q) Management of personal property of the deceased	100%	41.7%	
6. The following support systems are available for staff:			"This area of work can be particularly demanding, and it is important that staff should have access to a range of formal and informal support. Time should be allocated to ensure that staff are able to access the support they need" - 12
a) Peer support	100%	100.0%	
b) Case review	100%	50.0%	
c) Support and counselling	100%	50.0%	
d) Reflective practice	100%	25.0%	"All staff should also have opportunities to develop their understanding and practice through mechanisms such as clinical supervision, case review, critical incident analysis and risk management meetings"- 1
e) Referral to Occupational Health	100%	100.0%	
f) Confidential counselling	100%	66.7%	

3. Chaplaincy Services Audit Standards

Audit Criteria	Standard	Achieved	Rationale
1. Named co-coordinator/lead chaplain of the chaplaincy service	100%	63.6% (n=33)	"The chaplaincy service is headed by a dedicated member of the chaplaincy team" - 2
2. Policy for the chaplaincy service	100%	42.4% (n=30)	"Clear lines of accountability/management are established to enable a consistent standard and quality of service for all patients and staff" -2
3. Job description for chaplains	100%	84.8% (n=33)	"Appointments to chaplaincy- Hospital chaplaincy appointments are NHS trust appointments. HR departments within trusts will advise on trust appointment procedures…Panel of assessors…should be identified to provide advice on such issues as job descriptions…" - 2 HSS (TC7) 8/2004 Code Of Conduct For NHS Healthcare Chaplains states that NHS employers incorporate the code into contracts of employment - 23
4. Written information is available about the chaplaincy service	100%	66.7% (n=33)	See above reference "Trusts may inform patients about the availability of chaplaincy services for example through information leaflets and welcome packs" - 2
5. The following verbal/written information is provided by the chaplaincy service:		(n=33)	"Adequate arrangements are made for the spiritual, religious, sacramental, ritual and cultural requirements appropriate to the needs, background and tradition of all patients and staff including those of no specified faith" - 2
a) Spiritual support booklet for patients	100%	63.6%	
b) Record of visit in patient notes	100%	30.3%	
c) Record of administration of sacraments in patient notes	100%	63.6%	
d) Record of visit in chaplains notes			
e) Record of administration of sacrament in chaplains notes	100%	54.5%	
f) Visiting card left if appropriate	100%	42.4%	
g) Notification of admission to patients' own faith leader			
	100%	93.9%	
	100%	97.0%	
6. The following services are provided by chaplains:		(n=33)	
a) Routine ward visits			
b) Visits to ill patients	100%	100.0%	
c) Visits to bereaved relatives	100%	100.0%	
d) Provision of sacraments	100%	75.8%	"Trusts should ensure that the Dying and recently bereaved are able to access chaplaincy services at the appropriate time" - 2
e) Naming service for babies	100%	97.0%	
f) Sunday services	100%	39.4%	
g) Mid-week services	100%	72.7%	"Chaplains are the trust experts on arranging and providing liturgies and ceremonies to meet the needs of the bereaved, especially in the case of neonatal, child death and in annual services for the bereaved" - 2
h) Remembrance services for children	100%	45.5%	
i) Remembrance services for infants	100%	36.4%	
j) Remembrance services for staff	100%	33.3%	
k) Funeral services for patients with no relatives	100%	30.3%	"Chaplaincy teams should be involved in Trust emergency plans…. and their roles clearly defined" Useful contributors to debrief. - 2
l) Input to multidisciplinary team meetings	100%	90.9%	
m) Input to disaster plan			
n) Input to clinical debriefing sessions	100%	42.4%	
o) Staff support			
p) Staff training	100%	48.5%	
	100%	27.3%	
	100%	69.7%	
	100%	51.5%	

Audit Criteria	Standard	Achieved	Rationale
7. Funeral services can be provided on site	100%	50.0%	
8. The following training is provided for chaplains by the Trust:			"Trusts are responsible for training and development…appropriate training and development investment should be made to available to all members of the chaplaincy team. - 2
a) Child protection	100%	51.5%	
b) Manual handling	100%	27.6%	
c) Infection control	100%	72.4%	
d) Fire prevention	100%	44.8%	
e) Trust induction	100%	62.1%	
f) Data protection	100%	48.3%	
9.The chaplaincy service has access to the following support:			"The annual appraisal process should identify training needs and ways to meet them" -2
a) Allocated time for chaplains to meet together	100%	85.7%	
b) Meetings with Director	100%	78.6%	
c) Interpreting services	100%	67.9%	
d) Administrative staff	100%	53.6%	
e) Appraisal/development review	100%	32.1%	
f) Corporate information via circulation lists	100%	92.9%	
10. The following facilities are available to chaplains:			"Trusts should provide accessible and suitable spaces for prayer, reflection and religious services which are open to patients and staff 24 hours a day. - 2
a) Chaplaincy office	100%	90.6%	
b) Telephone	100%	81.3%	
c) Answer machine	100%	21.9%	
d) Computer	100%	50.0%	
e) Pager/bleep	100%	59.4%	
f) Multi-faith worship room	100%	43.8%	
g) Chapel	100%	65.6%	
h) Quiet room for confidential support of clients	100%	71.9%	
i) Dedicated car parking for emergency calls	100%	37.5%	

4. Palliative Care Services Audit Standards

Audit Criteria	Standard	Achieved	Rationale
1. Policy for specialist palliative care service in place	100%	63.6%	" Clear referral pathways to specialist palliative care services will be in place within each trust/provider" - 16 "Those providing generalist medical and nursing services should have access to specialist advice at all times" - 8 " Specialist palliative Care services must be provided by an appropriately qualified and experienced multiprofessional team, normally lead by a consultant in palliative medicine" - 16 "Each multidisciplinary team or service should implement processes to ensure effective inter-professional communication within teams and between them and other service providers…" - 8
2. Written information is provided about the specialist palliative care services	100%	81.8%	"Commissioners and provider organisations should ensure that patients and carers have easy access to a range of high quality information materials." – 8
3. Palliative care team has access to the following support: (a) Allocated time for team to meet together (b) Administrative support (c) Appraisal/development review	 100% 100% 100%	 (n=11) 81.8% 90.9% 100.0%	"All providers of palliative care should have mechanisms in place to ensure staff have access to regular support, e.g. multiprofessional case discussions, clinical supervision and a range of systems for personal support" - 16
4. Additional Training (a) Indicate if team members have undertaken additional training and development in bereavement care (free text listing)	100%	100% (free text responses indicated all teams had additional training)	"Provider organisations should identify staff who may benefit from training and should facilitate their participation in training and ongoing development. Individual practitioners should ensure they have the knowledge and skills required for the roles they undertake" 8 " Specialist palliative care: All staff should have experience in the palliative care environment and have an accredited, recognised or specialist qualification, appropriate to their specialist group in palliative care/medicine" – 16
5. Palliative care team contribute to bereavement care (a) Indicate way(s) in which team contribute to bereavement care (free text listing)	100%	100% (free text responses indicated all teams made various contributions to bereavement care)	"Assessment and discussion of patients' needs for physical, psychological, social, spiritual and financial support should be undertaken at key points (such as at diagnosis, at commencement, during, and at the end of treatment; at relapse; and when death is approaching). - 8 "This can be distressing time for families and friends and retaining verbal information may be difficult. It is important that they are made aware of bereavement issues, both about the grieving process and about how to access help and support locally" – 17

5. Porters and Funeral Directors Services Audit Standards

Audit Criteria	Standard	Achieved	Rationale
1. The following information if given when portering team is contacted to remove a body from the ward:			Managing the receipt, storage and release of deceased people and their property safely, securely, efficiently, effectively and appropriately is the core business of mortuary services. - 12
a) Name of the deceased	100%	70.0%	
b) Health and safety issues:			
(i) Infection control	100%	70.0%	
(ii) Weight	100%	70.0%	
c) Cultural/religious requirements	100%	73.3%^	
d) Property on body	100%	44.4%^^	
e) Tubes/drains in situ	100%	55.0%	
f) If Death Certificate issued	100%	57.1%^^^	
g) If remains can be released	100%	61.5%^^^^	
h) If Coroner involved	100%	50.0%	

Audit Criteria	Standard	Achieved		Rationale
2. Portering team have received the following training to help increase skills and confidence:		SLA (n=5)	Porters (n=15)	All mortuary staff will need to be aware of current health and safety legislation and guidance and will receive training to enable them to work safely. Trusts should make training and learning opportunities available to mortuary staff at all levels to enable them to develop.- 12
a) Death, grief and bereavement (to the appropriate level)	100%	100%	0.0%^	
b) Interpersonal and communication skills	100%	100%	0.0%^	
c) Roles and services provided by other members of the multi-disciplinary team e.g. mortuary services, chaplains	100%	100%	0.0%^	
d) Multi-cultural and religious practices	100%	100%	7.1%^	
e) Manual handling	100%	100%	86.7%	
f) Infection control	100%	100%	80.0%	

Audit Criteria	Standard	Achieved	Rationale
3. **The following mechanisms are currently in place or would like to be seen developed to support the portering team to care for dying patients and their relatives:**			This area of work can be particularly demanding and it is important that staff should have access to a range of formal and informal support. – 12
a) Informal support from peers	100%	100%	
b) Confidential one to one support from manager/designated colleague/mentor to talk through the experience	100%	90.0%	
c) Dedicated 'de-briefing' time with peers following particularly traumatic situations (as determined by the staff)	100%	55.0%	
d) Dedicated 'de-briefing' time with the multi-professional team following particularly traumatic situations (as determined by the staff)	100%	45.0%	
e) Confidential one to one support from member of staff external to the ward/department	100%	55.0%	
f) Access to external support or counselling services	100%	65.0%	

^ Total out of 15 as the 5 SLA services responded that 1 (c) was not applicable.
^^ Total out of 18 as 2 services responded that 1 (d) was not applicable.
^^^Total out of 14 as 4 SLA services and 2 portering services stated that 1 (f) was not applicable.
^^^^Total out of 13 as 5 SLA services and 2 portering services stated that 1 (g) was not applicable.

6. Ward Manager Questionnaire Results

Audit Criteria	Expected %	Achieved %	Number of responses Total n=145
1. Respondents rated the following aspects of the ward environment excellent/good:	100% (overall)	53.7%	n=1419[a]
a. Space	100%	45.5%	n=145
b. Privacy	100%	56.5%	n=145
c. Noise levels	100%	40.4%	n=141[b]
d. Telephone access	100%	82.5%	n=143[c]
e. Availability of food	100%	57.2%	n=145
f. Rest facilities	100%	48.9%	n=141[b]
g. Bathroom facilities	100%	43.8%	n=144[d]
h. Quiet spaces for prayer or contemplation	100%	51.0%	n=145
i. Parking facilities	100%	47.5%	n=145
j. Mortuary facilities*	100%	64.8%	n=125[e,f]
*Exception: No mortuary on site			
2. Respondent indicated that areas detailed in quality measure 1 needed improved	0%	80.6%	n=139a
3. Respondent indicated that the following information is provided to patients and relatives in either written or verbal form:			
a. Location of public phones	100%	92.3%	n=143
b. Location of toilets	100%	95.8%	n=143
c. Car parking arrangements	100%	71.0%	n=138
d. Chaplaincy service	100%	93.6%	n=141
e. Access to food/beverages	100%	97.6%	n=140
4. Respondent indicated that there is 24 hr access to food / beverages	100%	70.6%	n=143
5. Respondent indicated that food and beverages are located within a five minute walk from the ward	100%	93.0%	n=100
6. Respondent indicated that there is a private area designated for relatives on the ward	100%	66.9%	n=142
7. Respondent indicated that single rooms are always prioritised for dying patients	100%	63.4%	n=134
8. Respondent indicated that dying patients are cared for in a single room 51 – 100% of times	100%	79.9%	n=134
9. Respondent indicated that patients are always asked if their religious affiliation can be documented	100%	86.6%	n=142
10. Respondents indicated that patients are asked if this information can be passed to the chaplaincy service	100%	79.4%	n=141
11. Respondent indicated that the patients initial decision about contact with the chaplaincy service is revisited	100%	95.7%	n=92
12. Respondent indicated that the care of the dying pathway is operational within the department ***Exception: paediatric wards (8)**	100%	58.1%	n=131

13. Respondent indicated that staff members routinely explore the wishes and feelings of dying patients regarding their death	100%	76.6%	n=137
14. Parents are offered the opportunity to take their deceased child or baby from the ward to home in their own car *Exception: adult wards (107)	100%	68.4%	n=38
15. Respondent indicated that elements of the removal process could be improved	0%	42.2%	n=90
16. Respondent indicated that the following documentation/identification routinely accompanies the patients' remains from the ward/dept:	100%		
a. Patient ID Label		a. 85.0%	a. n=127
b. Wrist/ankle ID band		b. 97.9%	b. n=140
c. Mortuary/ID form		c. 85.3%	c. n=136
d. Death Certificate		d. 57.8%	d. n=135
e. Cremation form		e. 41.3%	e. n=126
17. The following information is provided to families of the deceased when a post mortem is required:			
a. Discussion covering purpose, procedures and their choices	100%	a. 99.2%	n=129
b. Relevant booklet	100%	b. 99.2%	n=122
c. Copy of consent form	100%	c. 97.2%	n=109
18. Respondents indicated that relatives are given the opportunity to speak to the following professionals prior to their relative's death:			
a. Consultant/Reg/Staff Grade	100%	a. 99.3%	n=138
b. Doctor on duty	100%	b. 97.8%	n=137
c. Nurse	100%	c. 100%	n=140
d. Hospital Chaplain	100%	d. 97.1%	n=139
19. Respondents indicated that relatives are given the Death Certificate at the time of their relatives death at least approximately 51% of the time	100%	56.8%	n=139
20. Respondents indicated that a follow-up meeting is always offered to the family to discuss the patient's death	100%	30.1%	n=143
21. Respondent indicated that they receive the following feedback from families regarding the care provided before, at the time and after the relative's death:			
a. User questionnaires	100%	a. 9.7%	n=145
b. Focus groups	100%	b. 4.1%	n=145
c. Complaints/compliments	100%	c. 85.5%	n=145
d. No feedback	100%	d. 14.5%	n=145
e. Other	100%	e. 37.9%	n=145
22. Respondents indicated that they can refer relatives directly to another service (statutory or voluntary) for information or support	100%	79.4%	n=141

7. Individual Staff Questionnaire Results

GENERAL INFORMATION

Total number of responses = 1632 Response rate 40%

1. **Current organisation of employment**

Belfast HSC Trust	24.0% (388)
Northern HSC Trust	21.2% (342)
South Eastern HSC Trust	16.4% (265)
Southern HSC Trust	18.2% (294)
Western HSC Trust	16.5% (266)
Hospice	3.7% (59)

(Total number of respondents = 1614)

2. **Specific speciality/role within current hospital/hospice?**

Medical	8.4% (136)
Registered Nurse	61.5% (997)
Registered Midwife	0.7% (11)
Social Worker (Acute)	3.1% (50)
Allied Health Professional	9.3% (151)
Healthcare Assistant	9.8% (159)
Administrative	2.8% (45)
Domestic/Hotel Services	4.4% (72)

(Total number of respondents = 1621)

3. **Length of time employed within the health and social care sector:**

Less than 1 year	4.5% (73)
1 – 5 years	30.2% (490)
6 – 10 years	14.0% (228)
More than 10 years	51.3% (834)

(Total number of respondents = 1625)

4. **How often in your day to day work do you have contact (e.g. face to face over the telephone or written correspondence) with the following:-**

a) Patients who are dying

Never	7.6% (121)
Less than once a month	31.7% (505)
1-3 times a month	31.0% (472)
More than 4 times a month	29.6% (834)

(Total number of respondents = 1592)

b) Recently bereaved family members

Never	6.2% (97)
Less than once a month	41.7% (649)
1-3 times a month	29.3% (456)
More than 4 times a month	22.7% (353)

(Total number of respondents = 1555)

c) Staff who have cared for dying patients

Never	4.4% (68)
Less than once a month	27.0% (421)
1-3 times a month	23.3% (364)
More than 4 times a month	45.3% (707)

(Total number of respondents = 1560)

ENVIRONMENT AND FACILITIES

Audit Criteria	Expected Percentage	Actual Percentage Achieved
5a.The following aspects of the hospital environment/facilities provided for dying patients and their families are excellent/good:-		
a) Space	100%	33.6% (542)
b) Privacy	100%	35.9% (582)
c) Noise levels	100%	19.1% (309)
d) Telephone access for families	100%	47.5% (720)
e) Availability of food for families	100%	30.2% (488)
f) Rest facilities for families	100%	21.0% (338)
g) Bathroom facilities for families	100%	20.5% (330)
h) Parking facilities	100%	33.7% (545)
i) Mortuary facilities	100%	32.9% (527)
j) Quiet places for contemplation and prayer	100%	42.5% (686)
k) Written guidance / information	100%	41.9% (676)
5b. **Hospital environment/facilities provided requires improvements**	0%	91.8% (1133)

TREATMENT AND CARE

Audit Criteria	**Expected Percentage**	**Actual Percentage Achieved**
6a. Care given before death could be improved for:-		
i) Patients	0%	42.9% (682)
ii) Families	0%	54.4% (855)
b. Care given at time of death, could be improved for:-		
i) Patients	0%	32.6% (511)
ii) Families	0%	41.8% (648)
c. Care given after death, could be improved for:-		
i) Patients	0%	29.4% (450)
ii) Families	0%	43.0% (659)

STAFF SKILLS, TRAINING & SUPPORT

Audit Criteria	Expected Percentage	Actual Percentage Achieved
7. **Respondents stated they are comfortable with the following;-**		
a) Breaking, or being present at the delivery of bad news	100%	24.1% (339)
b) Meeting the following needs of patients who are dying and their family: i) Physical needs	100%	45.6% (663)
ii) Emotional needs	100%	29.9% (441)
iii) Spiritual needs	100%	27.7% (385)
iv) Social needs	100%	30.6% (427)
c) Discussing death and dying	100%	22.2% (325)
d) Talking to people who have been recently bereaved	100%	24.0% (369)
e) Supporting a child whose relative is dying	100%	11.8% (143)
f) Supporting people from different cultures	100%	9.5% (139)
g) Participating in follow-up meetings should relatives wish to return to the hospital or discuss aspects of the patient's care	100%	20.3% (238)
8. **The following additional education/training to increase skills and confidence in caring for the dying and their relatives has been previously received:**		
a) Death, grief and bereavement (to the appropriate level)	100%	19.5% (295)
b) Interpersonal and communication skills	100%	28.2% (427)
c) The roles and services provided by other members of the multi-disciplinary team e.g. mortuary services, chaplains	100%	11.0% (163)
d) Multi-cultural and religious practices	100%	4.7% (71)
e) Ethical issues relating to end of life care for example advance directives, do not resuscitate orders, patient autonomy versus relatives wishes and withholding/withdrawal of treatment	100%	13.1% (192)
f) Spiritual support at the end of life	100%	11.0% (157)
g) Delivering bad news to patients and their relatives	100%	23.1% (318)
h) Equality and human rights	100%	14.6% (220)
i) Other	100%	12.7% (13)

Breakdown of question 8

The following table is a breakdown of training received, training required/not required as indicated by respondents (in relation to additional education/training to increase skills and confidence in caring for the dying and their relatives):

		Have received training	Would be helpful	Would not be helpful
a)	Death, grief and bereavement (to the appropriate level)	19.5% (295)	70.1% (1144)	2.9% (44)
b)	Interpersonal and communication skills	28.2% (427)	60.9% (923)	7.1% (107)
c)	The roles and services provided by other members of the multi-disciplinary team e.g. mortuary services, chaplains	11.0% (163)	77.4% (1145)	7.0% (104)
d)	Multi-cultural and religious practices	4.7% (71)	87.2% (1316)	3.9% (59)
e)	Ethical issues relating to end of life care for example advance directives, do not resuscitate orders, patient autonomy versus relatives wishes and withholding/withdrawal of treatment	13.1% (192)	79.8% (1167)	3.1% (45)
f)	Spiritual support at the end of life	11.0% (157)	75.0% (1075)	7.4% (106)
g)	Delivering bad news to patients and their relatives	23.1% (318)	69.4% (954)	4.1% (57)
h)	Equality and human rights	14.6% (220)	72.7% (1096)	6.8% (103)
i)	Other	12.7% (13)	44.1% (45)	3.9% (4)

Audit Criteria		Expected Percentage	Actual Percentage Achieved
9. **The following aspects of support when participating in the care of dying patients and their families are currently in place**			
g)	Informal support from your peers	100%	67.6% (1064)
h)	Confidential one to one support from manager/designated colleague/mentor to talk through the experience	100%	38.1% (588)
i)	Clinical Supervision	100%	41.6% (645)
j)	Case review/critical incident analysis	100%	26.5% (403)
k)	Dedicated “de-briefing” time with your peers following particularly traumatic situations (as determined by the staff)	100%	21.2% (331)
l)	Dedicated “de-briefing” time with the multi-professional team following particularly traumatic situations (as determined by the staff)	100%	14.0% (220)
m)	Confidential one to one support from member of staff external to the ward/department to talk through the experience	100%	17.2% (268)
n)	Access to external support or counselling services	100%	24.7% (386)

Breakdown of Question 9

The table below is a breakdown of that which is currently in place or would be helpful, when participating in the care of dying patients and their relatives as indicated by respondents:

Audit Criteria	Currently in place	Would be helpful	Don't know
a) Informal support from your peers	67.6% (1064)	26.7% (421)	5.7% (90)
b) Confidential one to one support from manager/designated colleague/mentor to talk through the experience	38.1% (588)	46.0% (710)	16.0% (247)
c) Clinical Supervision	41.6% (645)	34.3% (532)	24.1% (374)
d) Case review/critical incident analysis	26.5% (403)	50.1% (761)	23.4% (356)
e) Dedicated "de-briefing" time with your peers following particularly traumatic situations (as determined by the staff)	21.2% (331)	65.6% (1025)	13.2% (206)
f) Dedicated "de-briefing" time with the multi-professional team following particularly traumatic situations (as determined by the staff)	14.0% (220)	67.7% (1065)	18.3% (287)
g) Confidential one to one support from member of staff external to the ward/department to talk through the experience	17.2% (268)	50.7% (790)	32.1% (501)
h) Access to external support or counselling services	24.7% (386)	50.8% (792)	24.5% (382)

8. Standards Documents

No.	Document
1	Department of Health (2005) When a Patient Dies; Advice on Developing Bereavement Services in the NHS. DOH
2	Department of Health (2003) NHS Chaplaincy: Meeting the Religious and Spiritual Needs of Patients and Staff. DOH
3	Department of Health (2003). Social Services and Public Safety Racial Equality in Health and Social Care Good Practice Guide. DOH
4	Department of Health, Social Services and Public Safety (2003) Reference Guide to Consenting for Examination, Treatment or Care. DHSSPSNI
5	Department of Health (2001) The Removal Retention and Use of Human Organs and Tissue from Post Mortem Examinations. Advice from the Chief Medical Officer D.O.H.
6	Department of Health, Social Services and Public Safety (2003) Breaking Bad News Guidelines. DHSSPSNI
7	Health and Personal Social Services (NI) Order 1991 (Article 25) and Welfare Services Act (NI) 1971 (Section 25). Burial or Cremation of the Dead. The Children (Northern Ireland) Order 1995, Article 34. Children Looked After by an Authority.
8	National Institute for Clinical Excellence (2004) Improving Supportive and Palliative Care for Adults with Cancer. NICE
9	Department of Health, Social Services and Public Safety (2005) Care plan for Women Who Experience a Miscarriage, Stillbirth or Neonatal Death. DHSSPSNI
10	Resuscitation Guidelines 2005. Resuscitation Council (UK), London
11	Department of Health, Social Services and Public Safety (2005) Post Mortem Examinations - A Code of Good Practice: Rights of Patients and Relatives: Responsibilities of Professionals. DHSSPSNI
12	Department of Health (2006) Care and Respect in Death: Good Practice Guidance for NHS Mortuary Staff. DOH
13	Coroners Act (1959) Northern Ireland Section 7 The Coroners Service Northern Ireland: Information leaflets (2006) 1) Coroners Service 2) Coroners Inquest 3) Coroners post mortem Examination: Information for Relatives 4) The Coroners Liaison Officer
14	Department of Health, Social Services and Public Safety, Police Service (NI), Court Service NI, Health and Safety Executive (NI) (2006) Memorandum of Understanding: Investigating Patient or Client Safety Incidents (Unexpected Death or Serious Untoward Harm) (DHSSPSNI)
15	Department of Health, Social services and Public Safety (2006) The Quality Standards for Health and Social Care. DHSSPSNI
16	Department of Health, Social Services and Public Safety (2000) Partnerships in Caring: Standards for Service. A Review of Palliative Care. DHSSSNI
17	Liverpool Care Pathway – Goal 18 Bereavement Leaflet, Data Dictionary 2006 – Marie Curie Palliative Care Institute, Liverpool
18	Health and Safety At Work Act 1974
19	Department of Health and Social Services and Public Safety (2005) Care plans, Consent Forms and Information for Relatives for a Hospital Post Mortem Examination of I. A baby II. A child II. An adult IV. Histopathological examination and disposal of early miscarriages (DHSSPSNI)
20	NHS Estates 2005: A place to die with dignity: Creating a Supportive Environment. DOH
21	Royal Marsden Hospital Manual of Clinical Nursing Procedures (2004) 6th ed. Last Offices Procedure. Blackwell Publishing Ltd. Oxford
22	Births and Deaths Registration (Northern Ireland) Order 1976
23	Department of Health, Social Services and Public Safety (2004) Circular HSS (TC7) 8/2004 Code Of Conduct For NHS Healthcare Chaplains
24	Human Tissue Authority (2006) Code of Practice 3: Post Mortem Examination. HTA

References

Births and Deaths Registration (Northern Ireland) Order. 1976.
http://www.opsi.gov.uk/RevisedStatutes/Acts/nisi/1976/cnisi_19761041_en_3

Coroners Act (1959) Northern Ireland Section 7.
http://www.opsi.gov.uk/RevisedStatutes/Acts/apni/1959/capni_19590015_en_1

Coroners Service Northern Ireland (2006) Information leaflets

1) Coroners Inquest
2) Coroners Post Mortem Examination: Information for Relatives
3) Coroners Service
4) The Coroners Liaison Officer

http://www.coronersni.gov.uk/publications.htm

Department of Health (2000) NHS Executive Resuscitation Policy. HSC 2000/028. DOH.
http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4004244

Department of Health (2001) The Removal Retention and Use of Human Organs and Tissue from Post Mortem Examinations. Advice from the Chief Medical Officer D.O.H.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4064942

Department of Health (2003) NHS Chaplaincy: Meeting the Religious and Spiritual Needs of Patients and Staff. DOH.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4073108

Department of Health (2005) When a Patient Dies; Advice on Developing Bereavement Services in the NHS. DOH.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4122191

Department of Health (2006) Care and Respect in Death: Good Practice Guidance for NHS Mortuary Staff. DOH.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137969

Department of Health and Social Services and Public Safety (2005) Care plans, Consent Forms and Information for Relatives for a Hospital Post Mortem Examination. DHSSPSNI.
http://www.dhsspsni.gov.uk/index/hss/hoi-home/hoi-postmortem.htm

Department of Health Social Services and Public Safety (2003). Racial Equality in Health and Social Care: Good Practice Guide. DHSSPSNI.
http://www.dhsspsni.gov.uk/raceeqhealth_contents.pdf

Department of Health, Social Services and Public Safety (2000) Partnerships in Caring: Standards for Service. A Review of Palliative Care. DHSSSNI.
http://www.dhsspsni.gov.uk/pallcare.pdf

Department of Health, Social Services and Public Safety (2003) Breaking Bad News Guidelines. DHSSPSNI.
http://www.dhsspsni.gov.uk/breaking_bad_news.pdf

Department of Health, Social Services and Public Safety (2003) Reference Guide to Consenting for Examination, Treatment or Care. DHSSPSNI.
http://www.dhsspsni.gov.uk/consent_referenceguide.pdf

Department of Health, Social Services and Public Safety (2004) Circular HSS (TC7) 8/2004 Code of Conduct for NHS Healthcare Chaplains. DHSSPSNI.

Department of Health, Social Services and Public Safety (2005) Care plan for Women Who Experience a Miscarriage, Stillbirth or Neonatal Death. DHSSPSNI.
http://www/dhsspsni.gov.uk/hoi-careplan.pdf

Department of Health, Social Services and Public Safety (2005) Post Mortem Examinations - A Code of Good Practice: Rights of Patients and Relatives: Responsibilities of Professionals. DHSSPSNI.
http://www.dhsspsni.gov.uk/postmotrem.pdf

Department of Health, Social Services and Public Safety (2006) The Quality Standards for Health and Social Care. DHSSPSNI.
http://www.dhsspsni.gov.uk/qpi_quality_standards_for_health_social_care.pdf

Department of Health, Social Services and Public Safety, Police Service NI, Court Service NI, Health and Safety Executive NI (2006) Memorandum of Understanding: Investigating Patient or Client Safety Incidents (Unexpected Death or Serious Untoward Harm). DHSSPSNI.
http://www.dhsspsni.gov.uk/mou_investigating_patient_or_client_safety_incidents.pdf

Department of Health, Social Services and Public Safety. (2002). Human Organs Inquiry: Report from Inquiry Chair; John O'Hara QC. DHSSPSNI.
http://www.dhsspsni.gov.uk/hoi-mainreport.pdf

Health and Personal Social Services (NI) Order 1991 (Article 25) Provision of Accommodation.
http://www.opsi.gov.uk/si/si1991/Uksi_19910194_en_9.htm#mdiv25

Health and Safety At Work Act 1974.
http://www.opsi.gov.uk/RevisedStatutes/Acts/ukpga/1974/cukpga_19740037_en_1

Human Tissue Act (2004)
http://www.opsi.gov.uk/acts/acts2004/ukpga_20040030_en_1

Human Tissue Authority (2006) Code of Practice 3: Post Mortem Examination. HTA.
http://www.hta.gov.uk/guidance/codes_of_practice.cfm

Liverpool Care Pathway – Goal 18 Bereavement Leaflet, Data Dictionary 2006 – Marie Curie Palliative Care Institute, Liverpool.
http://www.mcpcil.org.uk/liverpool_care_pathway/view_the_lcp_and_associated_documentation/goal_definitions

National Institute for Clinical Excellence (2006) Clinical Guideline 43: Obesity; guidance on prevention, identification, assessment and management of overweight and obesity in adults and children. NICE.
http://www.nice.org.uk/nicemedia/pdf/word/CG43NICEGuideline.doc

National Institute for Clinical Excellence (2004) Improving Supportive and Palliative Care for Adults with Cancer. NICE.
http://www.nice.org.uk/nicemedia/pdf/csgspmanual.pdf

NHS Estates 2005: Improving the Patient Experience series; A place to die with dignity: Creating a Supportive Environment. Design Brief Working Group.
http://195.92.246.148/nhsestates/knowledge/knowledge_content/home/home.asp

Northern Ireland Statistics and Research Agency (2006) Registrar General Northern Ireland 2005 Annual Report. NISRA.
http://www.nisra.gov.uk/archive/dempgraphy/publications/annual_reports/2005/chpt1.pdf

Resuscitation Guidelines (2005) Resuscitation Council (UK)
http://resus.org.uk/pages/bls.pdf

Royal Marsden Hospital Manual of Clinical Nursing Procedures (2004) 6th ed. Last Offices Procedure. Blackwell Publishing Ltd. Oxford

The Children (Northern Ireland) Order 1995, Article 34. Children Looked After by an Authority.
http://www.opsi.gov.uk/si/si1995/uksi_19950755_en_1

Welfare Services Act (NI) 1971 (Section 25). Burial or Cremation of the Dead.
http://www.opsi.gov.uk/RevisedStatutes/Acts/apni/1971/capni_19710002_en_1

Acknowledgements

The Northern Ireland Health and Social Care Bereavement Network would like to acknowledge the work of the Audit Department South Eastern Health and Social Care Trust who provided the lead for this regional audit and in particular Debbie Schofield in her role as audit lead, whose patience direction and support has greatly enhanced the quality of this audit.

We would like to thank the members of the steering group at the Department of Health, Social Services and Public Safety NI, chaired by Mr Martin Bradley Chief Nursing Officer, who provided the network with invaluable support and direction.

We would also like to thank former members of the network who inspired us in the early stages of the project. Sharon McCloskey, Area Bereavement Coordinator, Southern Trust, Ruth Smith, Assistant Director Surgery, South Eastern Trust, John Mone, Director of Nursing And Quality, Craigavon Area Hospital Group Trust, Ann McVey, Assistant Director of Nursing, Craigavon Area Hospital Group Trust, Irene Duddy, Director of Nursing, Altnagelvin Hospital Trust and Alice McParland, Interim Deputy Director of Nursing, United Hospitals Trust.

This audit was undertaken at a time of great change within health and social care in Northern Ireland. The co-operation of staff at all levels throughout the legacy trusts during this time was greatly appreciated.

Finally the Network would like to acknowledge the leadership, inspiration and commitment of Dr Patricia Donnelly, Divisional Director Clinical Services, Belfast Trust, to this project.

NI Area Bereavement Coordinators Contact Details

Name	Address	Telephone Numbers	E-mail
Barbara Bankhead **Phyllis Tweed (secretary)** **Northern HSC Trust**	Bush House Bush Road Antrim BT41 2QB	Work (028) 9442 4992 Trust mobile: 07841 468 824 Phyllis (028) 9442 4000 Ext 2191 Fax No: (028) 9442 4675	Barbara.Bankhead@northerntrust.hscni.net
Carole McKeeman **Cathy McCartney (secretary)** **Western HSC Trust**	Medical Directorate Room 2 Centrepoint Building Altnagelvin Area Hospital Glenshane Road Derry BT47 6SB	Work (028) 7134 5171 Ext 5545 Work mobile 07841 970 715 Cathy (028) 7134 5171 Ext 5548	Carole.McKeeman@westerntrust.hscni.net Cathy.McCartney@westerntrust.hscni.net
Paul McCloskey **Lucille Crossley (secretary)** **South Eastern HSC Trust**	Home 3 The Ulster Hospital Upper Newtownards Road Dundonald Belfast BT16 1RH	Work (028) 9048 4511 Ext 2398 Work mobile 07841 103 955 Lucille (028) 9048 4511 Ext 3674	Paul.McCloskey@setrust.hscni.net Lucille.Crossley@setrust.hscni.net
Anne Coyle **Marina Hamilton (secretary)** **Southern HSC Trust**	The Rowans Craigavon Area Hospital 68 Lurgan Road Portadown BT63 5QQ	Work (028) 3861 3861 Work mobile 07702 923 161 Marina (028) 3861 3862	Anne.Coyle@southerntrust.hscni.net MarinaR.Hamilton@southerntrust.hscni.net
Heather Russell **Julie McQuillan (secretary)** **Belfast HSC Trust**	Clinical Services Division 1st Floor, Bostock House Room 104 Royal Victoria Hospital Grosvenor Road Belfast BT12 6BA	Work (028) 9063 3904 Work mobile 07920 186 935 Julie (028) 9063 3193	Heather.Russell@belfasttrust.hscni.net Julie.McQuillan@belfasttrust.hscni.net

For further information regarding this Audit, please contact the relevant Bereavement Coordinator for your Trust.