1.0. POLICY:

In the last phase of life people seek peace and dignity. The hospital shall provide the following elements of care from physicians, health care institutions, and the community at the time of end of life of patients

2.0. PURPOSE:

- To provide skilful nursing, gentle handling and utmost care to the body after death.
- To fulfill Patients cultural beliefs or personal wishes relating to death and dying; these must be respected & the spiritual needs of the patients are respected
- To ensure Infection risks do not increase after death.
- Death in hospital may necessitate by law to involve the respective legal authorities as and when required
- To ensure that healthcare workers comply with legislation, the wishes of patients/relatives continue to follow Standard Precautions will be followed
- To minimize Transmission based infections and any risk of cross-infection

3.0. SCOPE: All Death Patients at the Hospital

4.0. ABBREVIATIONS:

IP No.: In-Patient Number

5.0. RESPONSIBILITY: Consultants, Junior Residents, Nurses & Housekeeping staff

6.0. DISTRIBUTION:- All Inpatient Areas

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Anesthesiologist	Medical Director	Managing Director

7.0. PROCESS DETAILS:

7.1. DESCRIPTION OF THE PROCESS

Core Principles for End-of-Life Care

I. PAIN and PALLIATIVE CARE:

- **P**hysician **O**rders for **L**ife **S**ustaining **T**reatment
- Comprehensive approach to end-of-life planning.
- Gives seriously ill patients and their families more control over their end-of-life care.
- Legal document (actionable medical order) that must be signed by both the physician and patient. May also be signed by nurse practitioners and physician assistants within their scope of practice.
- Prevents unwanted or ineffective treatments.
- Reduces patient and family suffering.
- Pain is one of the most prevalent symptoms near the end of life the adequate management of pain at the end of life is imperative.

- opioid analgesics are the standard of care for treating moderate to severe pain in patients with advanced illness, the false fear that opioids induce respiratory depression and hasten death is a major barrier to their use at the end of life.

- clinicians who care for the chronically ill and for those at the end of life should acquire competency in pain management.

II. AUTOPSY AND ORGAN DONATION (OUTSOURCED)

Autopsy:

a. Autopsies are **not conducted at Inodaya Hospital**.
b. Families requiring autopsy must be guided to **authorized government or forensic centers**.
c. Staff should provide **information and support** for legal and procedural requirements.

Organ Donation:

d. Organ donation is **actively encouraged** in line with **Transplantation of Human Organs and Tissues Act**.
e. Hospital staff provide **counseling and support** to families of potential donors.
f. Only **certified organ transplant centers** are involved in donation and retrieval.
g. Staff ensure **informed consent** is obtained and documented.
h. Hospital promotes awareness among patients, families, and the community regarding the **benefits and process of organ donation**.
i. Ethical and legal standards are strictly followed during all interactions related to organ donation.

III: Patient values, Religion and cultural preferences:

- If the patient has any cultural or religious beliefs which necessitate alternative procedures to nurses undertaking Last Offices. If this is the case then follow the instructions for the specific religion guidelines.
- If the body of the deceased is likely to leak after death, a body bag will be required.
- If any special requests made before death, e.g. the keeping on of jewellery, clothes to be worn.
- If the eyes have been donated for corneal grafting.

III. Clinical policy of care at the end of life should:

1. Respect the dignity of both patient and caregivers;
2. Be sensitive to and respectful of the patient's and family's wishes;
3. Use the most appropriate measures that are consistent with patient choices
4. Access and manage **psychological, social, and spiritual/religious problems**;
5. Provide access to any therapy which may realistically be expected to improve the patient's quality of life, including alternative or non-traditional treatments;
6. Provide access to palliative care and hospice care;
7. Respect the right to refuse treatment;
8. Respect the physician's professional responsibility to discontinue some treatments when appropriate, with consideration for both patient and family preferences;

9. Promote clinical and evidence-based research on providing care at the end of life.

IV: involving patient and family in aspects of care

- Family members (FMs) play important roles in the care of patients including contribution to decision-making, assisting the health-care team in providing care, improving patient safety and quality of care, assisting in home care, and addressing expectations of patient's family and society at large.
- Building rapport with patients and family caregivers.
- Managing patients' symptoms, distress, and functional status (eg, pain, dyspnea, fatigue, sleep disturbance, mood, nausea, or constipation) to improve quality of life.
- Educating patients about their illness and prognosis.
- If the next of kin attend the ward following the death of the patient, return the patient's personal possessions to them ensuring that the appropriate documentation is completed for patient's property and valuables.

V. Psychological, emotional, spiritual, and cultural concerns of the Family.

- people should be offered support at the time of death that is culturally and spiritually appropriate, immediate, and available shortly afterwards. Bereavement support may not be limited to immediately after death, but may be required on a longer-term basis and, in some cases, may begin before death.
- **A stepped approach to emotional and bereavement support may be appropriate, which could include but is not limited to:-**
  - ✓ information about local support services like ambulance
  - ✓ practical support such as advice on arranging a funeral, information on who to inform of a death, help with contacting other family members and information on what to do with equipment and medication

- ✓ general emotional and bereavement support, such as supportive conversations with the spiritual care team or support from the voluntary, community and faith sectors
- ✓ referral to more specialist support from trained bereavement counselors if necessary

PROCEDURAL STEPS:

- Condition of the dead body is to be verified and recorded properly, before keeping the dead body inside the dead body bag.

8.0. ACTIVITY AND RESPONSIBILITY

S. No	Procedure Steps	Responsibility
	PHYSICAL PREPARATION OF DEAD BODY	
1.	Eyes should be closed immediately as in sleep. If relatives have consented to	Primary nurse/ Housekeeping staff
2.	If the eyes are for donation, gently tape close the eyelids using Transpore tape	Primary nurse/ Housekeeping staff
3.	Body to be straightened with arms placed according to the spiritual needs of the patient/attenders	Primary nurse / attendant/ Housekeeping staff
4.	Mouth should be closed immediately.	Primary nurse / attendant/ Housekeeping staff
5.	Remove all support equipments	Primary nurse / attendant/ Housekeeping staff
6.	Give thorough sponging to the patient.	Primary nurse / attendant

7.	To change patient clothes.	Primary nurse / attendant
8.	Keep the head & chin in position.	Primary nurse / attendant
9.	Bandages may be used if necessary.	Primary nurse / attendant
10.	Plug nose and ears with cotton plug.	Primary nurse / attendant
11.	Cover the patient with new white bed sheet.	Primary nurse / attendant
12.	Attach an identity card to the dead body having name & IP No.	Primary nurse / attendant
13.	Allow the relatives to be with the body for a while. Arrange to meet the religious rites if possible.	Primary nurse/ Housekeeping staff
14.	Primary Nurse to follow the routine discharge procedure as per Discharge policy.	Primary nurse/ Housekeeping staff
15.	Primary Nurse to arrange for Mortuary / Dead body van if required.	Primary nurse/ Housekeeping staff
16.	If the deceased has dentures ensure they are in right place.	Primary nurse/ Housekeeping staff
17.	If the lower jaw drops down significantly, consider putting on a chin support by applying bandages.	Primary nurse/ Housekeeping staff
18.	Place an adult incontinence pad/diaper under the deceased.	Primary nurse/ Housekeeping staff
19.	If the deceased is to be viewed by relatives on the ward ensure there is no blood or body Wrap the patient carefully in a sheet and fasten with tape.	Primary nurse/ Housekeeping staff
20.	Close all the orifices of the body with cotton plug.	Primary nurse

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21.	Place the deceased in a body bag if the body is likely to leak, or if the patient has an infection / alert organism and it is indicated in table 1.	Primary nurse
22.	If there is a risk of leakage or infection the porters will use gloves regardless of whether the body is in a bag. The attendees will wash their hands after handling a wrapped body. Complete nursing documentation. AFTER CARE Ensure all notes, laboratory reports and X rays are gathered together.	Primary nurse/ Housekeeping staff
23.	Completion of all legal formalities of End of life care	Consultants, Junior Residents & Medical Superintendent

9.0. RECORDS AND FORMATS:

Nominal registers and death certificate