Infection Prevention and Control

Precautions to be taken with the bodies of those who have died with a known or suspected infection
<table>
<thead>
<tr>
<th>Policy Title:</th>
<th>Guidelines on the Precautions to be taken with the bodies of those who have died with a known or suspected infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary:</td>
<td>Guides staff on the types of infections or infectious diseases that require extra precautions when dealing with a body.</td>
</tr>
<tr>
<td>Supersedes:</td>
<td>V5  2015</td>
</tr>
<tr>
<td>Description of Amendment(s):</td>
<td>Minor Wording</td>
</tr>
<tr>
<td>This policy will impact on:</td>
<td>clinical practices, employees and health &amp; safety</td>
</tr>
<tr>
<td>Financial Implications:</td>
<td>None</td>
</tr>
<tr>
<td>Policy Area:</td>
<td>Infection Control Trust Wide</td>
</tr>
<tr>
<td>Document Reference:</td>
<td>BKSlv6.17</td>
</tr>
<tr>
<td>Version Number:</td>
<td>5</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>06.2017</td>
</tr>
<tr>
<td>Issued By:</td>
<td>Director of Infection Prevention and Control</td>
</tr>
<tr>
<td>Review Date:</td>
<td>07.2019</td>
</tr>
<tr>
<td>Author:</td>
<td>Lead Nurse Infection Prevention and Control</td>
</tr>
<tr>
<td>Impact Assessment Date:</td>
<td>06.2017</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>APPROVAL RECORD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committees / Group</td>
</tr>
<tr>
<td>Consultation:</td>
</tr>
<tr>
<td>Approved by Director:</td>
</tr>
<tr>
<td>Section</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>9</td>
</tr>
<tr>
<td>10</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Appendix 1</td>
</tr>
<tr>
<td>Appendix 2</td>
</tr>
<tr>
<td>Appendix 3</td>
</tr>
<tr>
<td>Appendix 4</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
1. **Introduction**

The purpose of this policy is to detail the precautions to be taken with the bodies of those who have died with a known or suspected infection. It is important that staff have the appropriate knowledge to ensure that any hazards are controlled, whilst ensuring that the policy is applied sensitively. For example, the indiscriminate use of body bags may cause needless anxiety for the bereaved family, friends and also among the hospital staff.

Grieving is essential for the healing process and in some religions and cultures it may require special rituals including washing and/or kissing the body. Not allowing these last rites to be performed before placing the body in a plastic bag or sheet may cause deep distress and/or resentment. Relatives should be consulted about their wishes before body preparation is commenced.

The safety of all persons who may come into contact with the body of a person who have died with a known or suspected infection must always be given high priority. This requirement is covered by various Acts of Parliament and by regulations established under these Acts. There should be a balance between what is required for safety, and ensuring that the dignity of the bereaved person is maintained.

Good clear communication regarding the possibility of an infection risk must be maintained between healthcare staff, mortuary attendants and funeral directors at all times to ensure effective infection prevention and control measures are implemented.

Not all cases of infection will have been identified before death and for this reason it is strongly recommended that universal precautions are adopted for the handling of deceased patients as they would be in life.

2. **Responsibilities**

- **The Chief Executive** has ultimate responsibility for the implementation and monitoring of policies used in the Trust, and for ensuring sufficient resources are made available to facilitate the prevention and control of healthcare associated infections. This responsibility may be delegated.

- **The Director of Nursing, Performance and Quality, Director of Infection Prevention and Control (DIPC)** will take the lead responsibility for the development and implementation of this policy with support of the Lead Nurse Infection Prevention and Control and the Infection Prevention and Control Doctor.
  - Challenging poor standards and holding to account as appropriate.
  - Providing assurance to the board that systems and process are in place to ensure compliance with agreed standards

- **The Infection Prevention and Control Team (IPCT)** will have responsibility for:
  - Ensuring the Policy is implemented and monitored throughout the Trust
  - Ensure the Policy is updated to reflect any changes to the National or local guidelines.
  - Provide education and support to clinical staff
  - Provide education and advice on the management of patients who have died with a known or suspected infection within the organisation
  - Refer to the Consultant Microbiologist / Infection Control doctor where appropriate

- **Matrons / Ward Senior Sister/ Departmental Managers** are responsible for ensuring that all staff:
- Are aware of and adhere to this policy
- Are aware of their roles and responsibilities with regard to reducing HealthCare Associated Infections
- Are aware of patients considered high risk who may need additional precautions in death
- Demonstrate appropriate & effective infection control practices
- Alert the Infection Prevention & Control team as appropriate of patients who have known or suspected infection
- Inform the patient’s relatives as appropriate of controls required following the patient’s death.
- Communicate patient(s) status to the portering/ mortuary (as appropriate).

### 3. Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cadaver</td>
<td>Is a deceased person or body that may be used by physicians and other scientists to identify disease sites or determine cause of death</td>
</tr>
<tr>
<td>Hand hygiene</td>
<td>The process used to decontaminate hands with soap and water or alcohol gel (as per standard precautions policy)</td>
</tr>
<tr>
<td>Last Offices</td>
<td>Is the term used to describe the care given to the deceased person which is focused on fulfilling religious and cultural beliefs as well as legal requirements</td>
</tr>
<tr>
<td>Patient Confidentiality</td>
<td>Staff should maintain confidentiality in death as in life</td>
</tr>
<tr>
<td>PPE</td>
<td>Personal Protective Equipment e.g. Gloves, Aprons</td>
</tr>
<tr>
<td>Standard Precautions</td>
<td>All blood and bodily fluids are potentially infectious; therefore all staff involved in care of the deceased person must follow the Standard Precautions Policy.</td>
</tr>
<tr>
<td>Bagging</td>
<td>Placing the body in a plastic Cadaver bag</td>
</tr>
<tr>
<td>Viewing</td>
<td>Facilitating the opportunity for the bereaved to see, touch and spend time with the body before disposal</td>
</tr>
<tr>
<td>Embalming</td>
<td>Injecting chemical preservations into the body to slow the process of decay this may also incorporate cosmetic work.</td>
</tr>
<tr>
<td>Hygienic Preparation</td>
<td>Cleaning and tidying the body so it presents a suitable appearance for viewing (an alternative to embalming).</td>
</tr>
</tbody>
</table>

### 4. Infection Prevention and Control Precautions

Patients who have specific infectious conditions/pathogens may pose a risk in death these risks include:
- Tuberculosis (TB)
- Group A streptococcal Infection
- Agents causing Transmissible Spongiform encephalopathy’s (TSE/CJD)
- Hepatitis B and C
- Human Immunodeficiency Virus (HIV)

Transmission may occur via the following routes:

a. Needle-stick injuries with a contaminated instrument or sharp fragment of bone.

b. Contaminated aerosols or splashes from body cavities or wounds.

c. Aerosol from lungs, e.g. tubercle bacilli when condensation could possibly be
forced out through the mouth.

d. Intestinal pathogens from anal and oral orifices.

e. Abrasions, wounds and sores on skin.

f. Splashes or aerosols onto the conjunctivae

The principles of the Standard Precautions policy must be followed as in life by all staff who handles cadavers including Hand Hygiene, the correct use of PPE.

Further advice on the staff precautions staff regarding bodies suspected of being infective are detailed in Appendix 1.

5. Communication

If a person has died with a known or suspected infection, it is an essential legal responsibility that all persons who may be involved in handling the body are informed of the potential risk of infection. They should be told of the risks, but not the specific diagnosis as this remains confidential, even after death. The persons who need to know include:

- **In Hospital:** Ward staff, porters, mortuary staff, the bereaved relatives and the funeral directors
- **At Home:** The nurse laying out, bereaved relatives and the funeral directors
- **Elsewhere:** emergency services staff must use universal precautions for handling all bodies
- The funeral directors should inform the relatives, in writing, of any risks of infection.

To prevent the risk of transmission of infection after death it is important that good liaison is maintained between:

- staff on the wards
- microbiology and histopathology laboratories
- portering department
- mortuary departments
- the funeral director
- The next of kin.

6. Last Offices

The final act of care for a patient is that of laying out. It is essential to be mindful of any infection risks and implement the precautions necessary to protect others.

Mortuary staff and/or funeral directors must be informed if the patient was receiving specific infection control nursing other than for antibiotic resistant organisms or protective isolation e.g. MRSA. Use the notification form (see Appendix 3) as part of the last offices.

Nursing staff performing the last offices must adhere to all working practices as stated in the Infection Prevention & Control Standard Precautions Policy and Post Death Procedures.

When preparing the deceased person consideration must be given to control the loss of blood and/or bodily fluids. Last offices should therefore include:
• Cleaning the body of any soiling and body fluids, including nasal and oral cleansing

• Observing the body for wounds and puncture sites and applying waterproof pressure dressings wherever practicable

• If the death is to be referred to the coroner, newly introduced drains, intravenous lines, catheters, etc. must be left in situ. Tubing must be clamped, spigotted or drainage bags attached to prevent syphoning. Urinary catheters / stoma bags must be emptied prior to transfer to the mortuary.

7. Body Bags

Plastic body bags are used for cases thought to be infective to handlers, or to transport leaking or otherwise offensive bodies.

Bodies cool more slowly inside a body bag, facilitating decomposition and making hygienic preparation more difficult. It may only be possible to display the head for viewing and this may cause additional distress to the bereaved.

Body bags should be reserved for cases where a risk assessment indicates its use is necessary. A black and yellow biohazard label should be attached to the shroud and the bag, in addition to the identification labels (see Appendix 3).

A risk assessment must be made on the infectivity of the deceased person prior to leaving the ward/department.

A body bag must be used prior to transfer of the body to the mortuary where there is:

1. A high risk of infection (see Appendix 1)

2. Uncontrollable loss of blood or body fluids.

3. No known medical history.

4. No means of identifying the body.

Whenever body bags are used a biohazard label must be attached to the body bag and the body and the accompanying Notification Form (see appendix 3) for the mortuary staff.

Sheets MUST NOT be used on bodies placed in bags.

Ensure that the relevant form is completed and placed in a sealed envelope (to ensure confidentiality) for the attention of the mortuary technicians.

Body bags and forms are available from the mortuary by request to the portering staff.

There are two sizes of body bag, please request large or small according to need.

Ensure the zip closure is left at the head end of the bag.

Porters must be informed by the nursing staff of infected bodies. On collection of
trolley from Mortuary, portering staff must put on gloves. They do not need to wear special clothing when transporting the body, but after moving the body to the mortuary and removing their gloves, they must WASH THEIR HANDS - this is the greatest safety factor.

In some cultures and religious groups, relatives expect to carry out the ritual preparation before burial and, in most cases, this can be permitted but where a risk of infection exists, the hazard has to be assessed and appropriate advice given (see Appendix 1). This may mean only partial preparation and the use of gloves and protective clothing and should be supervised.

When the hygienic preparation is not done by nursing staff, funeral staff will do as much as they can and this often includes at least partial embalming.

8. Hospital Ward staff

Nursing staff performing the last offices should adopt the same universal routine protective precautions as when the patient was alive, plus also wear gloves and a disposable plastic apron when handling the deceased. Staff must ensure that:

- Any surface contamination should be removed by washing
- Any wounds or leaking openings should be covered with occlusive dressings
- Care must be taken to avoid contamination of any wounds or skin lesions on the workers hands; and hands must be washed thoroughly at the end of the procedure
- If the death is not to be reported to the Coroner, then all drains, catheters and intravenous lines should be removed
- Ensure that adequate occlusive dressings are applied to prevent leakage of body fluids.

The ward nurse will inform the relatives on any restrictions, emphasising that the body may be enclosed in a bag once it leaves the ward.

Relatives may be ignorant of the true nature of the infection and an individual's right to confidentiality continues after death but, nevertheless, the bereaved relatives must be advised on how to avoid risk of infection themselves. The certifying doctor should discuss the precautions that are advised with the relatives.

If relatives wish to carry out ritual preparation of the body themselves, it should be done under supervision, observing the universal precautions advised.

Porters must be informed by nursing staff that they are transporting an infected body. They must put on gloves but no other special clothing is required. The mortuary staff must also be advised of the risk of infection. After removal to the mortuary is completed, gloves must be removed and disposed of into the Waste system (yellow bag) and hands thoroughly washed.

9. Specific Infections

The Advisory Committee on Dangerous Pathogens (ACDP) in the publication Containment of biological agents according to hazard and categories of containment (4th ed. 1995), contains guidance on the biological agents referred to in the control of Substances Hazardous to Health Regulations 1994.

The four categories of classification of biological agents are:
Group 1 – Low Risk – Unlikely to cause human disease.

Group 2 – Medium Risk – can cause human disease and may be a hazard to employees; it is likely to spread to the community and there is usually effective prophylaxis or treatment available.

Group 3 – High Risk – can cause severe human disease and may be a serious hazard to employees; it may be spread to the community, but there is usually effective prophylaxis or treatment available.

Group 4 – Very High Risk – causes human disease and is a serious hazard to employees; it is likely to spread to the community and there is usually no effective prophylaxis or treatment available.

Group 1 – 3 will normally be covered by policies already established by the Infection Prevention & Control Team and will be available through the Trust Intranet.

Group 4 will require extra ordinary precautions and will generally NOT be admitted or nursed at the MDGH, unless absolutely unavoidable. In ALL cases of suspected Group 4 patients, the Infection Prevention & Control Team MUST BE INFORMED IMMEDIATELY. During normal working hours, contact via extensions 1597, 1417 or bleep 3034, 3449.

Once the Team have been notified they will respond to the ward or department and give support and guidance to management and staff.

NB. The Health Protection Agency categorise cadavers as Low, Medium, High and High (rare). For completeness, both Groups 1 – 4 and categories Low to High (rare) have been included in the table (Appendix 1).

It must always be remembered that anybody has the potential to be infectious and Standard precautions MUST always be used.

10. Monitoring Compliance
Compliance with this policy will be audited as part of the Infection Prevention and Control Team audit programme as appropriate. In addition monitoring will be undertaken as part of:

- Infection Prevention and Control Environmental audit peer review.
- Post infection/ Incident review meetings

Non-compliance with the policy will be managed via the staff disciplinary route; this will be supported by the Director of Nursing, Quality, Performance, DIPC, and the Medical Director.

This policy should be read in conjunction with as a minimum but not exclusively

- Standard Precautions Policy
- Specific Microorganisms policy e.g. Clostridium difficile
- Isolation Policy.
- Outbreak Policy.
- Hand Hygiene Policy.
LEGISLATION, GUIDANCE AND REFERENCES

Advisory Committee on Dangerous Pathogens (1995) Protection Against Blood borne Infections in the Workplace – HIV & Hepatitis

Control of Substances Hazardous to Health Regulations 2002 (COSHH)

Available at: https://www.gov.uk/dh
Guidelines for handling cadavers (deceased bodies) with some infections which are not notifiable in England and Wales

<table>
<thead>
<tr>
<th>Degree of Risk</th>
<th>Infection</th>
<th>Bagging</th>
<th>Viewing</th>
<th>Embalming</th>
<th>Hygienic Preparation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Chicken Pox/shingles</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Cryptosporidiosis</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Dermatophytosis</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Legionellosis</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Lyme disease</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Orf</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Psittacosis</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>MRSA</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Tetanus</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Medium</td>
<td>HIV/AIDS</td>
<td>ADV</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Haemorrhagic fever with renal syndrome</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Q Fever</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>High</td>
<td>Transmissible Spongiform encephalopathies (CJD)</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Invasive group A streptococcal infection</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
Guidelines for handling cadavers (deceased bodies) with some infections which are notifiable in England and Wales

<table>
<thead>
<tr>
<th>Degree of Risk</th>
<th>Infection</th>
<th>Bagging</th>
<th>Viewing</th>
<th>Embalming</th>
<th>Hygienic Preparation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Acute encephalitis</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Leprosy</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Measles</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Meningitis (except meningococcal)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Mumps</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Ophthalmia neonatorum</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Rubella</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Tetanus</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Whooping cough</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Medium</td>
<td>Relapsing fever</td>
<td>Adv</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Food poisoning</td>
<td>No/Adv</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Hepatitis A</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Acute poliomyelitis</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Diphtheria</td>
<td>Adv</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Dysentery</td>
<td>Adv</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Leptospirosis (Well’s disease)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Malaria</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Meningococcal septicaemia (with or without meningitis)</td>
<td>Adv</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Paratyphoid fever</td>
<td>Adv</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Cholera</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Scarlet fever</td>
<td>Adv</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Tuberculosis</td>
<td>Adv</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Typhoid fever</td>
<td>Adv</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Typhus</td>
<td>Adv</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>High</td>
<td>Hepatitis B,C</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>High(Rare)</td>
<td>Anthrax</td>
<td>Plague</td>
<td>Rabies</td>
<td>Smallpox</td>
<td>Viral Haemorrhagic fever</td>
</tr>
<tr>
<td>----------------------------</td>
<td>---------</td>
<td>--------</td>
<td>--------</td>
<td>----------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Adv</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Other conditions requiring body bags with restriction of contact (except touching the face) but should not be removed from the bag include:

- Death in dialysis unit
- Large pressure sores
- Leakage & discharge of body fluids likely
- Known intravenous drug misuser
- Severe secondary infection
- Gangrenous limbs & infected amputation sites
- Post mortem
- Incipient decomposition
APPENDIX 3
ACTION TO BE TAKEN WHERE A DEATH OCCURS & A RISK OF INFECTION IS KNOWN OR SUSPECTED

IN HOSPITAL/COMMUNITY

DEATH

↓

RISK OF INFECTION TO OTHERS

ASSESSED BY CLINICIAN

MAY CONSULT CONSULTANT MICROBIOLOGIST

AGREE RISK OF INFECTION

AT HOME/COMMUNITY

ASSESSED BY GENERAL PRACTITIONER

MAY CONSULT CCDC OR CONSULTANT MICROBIOLOGIST

AGREE RISK OF INFECTION

<table>
<thead>
<tr>
<th>CATEGORY 4</th>
<th>CATEGORY 3</th>
<th>CATEGORY 2</th>
<th>CATEGORY 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>BODY BAG TO BE USED</td>
<td>YES</td>
<td>ADVISED</td>
<td>ADVISED</td>
</tr>
<tr>
<td>BODY MAY BE REMOVED FROM BAG</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>EMBALMING PERMITTED</td>
<td>NO</td>
<td>NOT ADVISED</td>
<td>YES</td>
</tr>
<tr>
<td>VIEWING BODY BY BEREAVED</td>
<td>FACE ONLY</td>
<td>FACE ONLY</td>
<td>YES</td>
</tr>
<tr>
<td>TOUCHING BODY BY BEREAVED</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>

INFORMATION TO BE PASSED ON

- PATIENT DIED WITH A KNOWN OR SUSPECTED INFECTION (NOT THE DIAGNOSIS)
- ADVICE ON PRECAUTIONS REQUIRED
- WHERE FURTHER INFORMATION CAN BE OBTAINED FROM

FUNERAL DIRECTORS STAFF
RELATIVES/BEREAVED
HEALTH CARE STAFF

NB. More detailed information, in confidence, about the risk of infection may be necessary for nursing and mortuary staff.
APPENDIX 4

THE MORTUARY STAFF MUST BE INFORMED OF THE INFECTION RISKS ASSOCIATED
WITH THIS BODY.

Please complete the following:

Patients Name ........................................................................................................

D.O.B. .............................................

Hospital Number ..........................................

Ward/Department .................................................................................................

Risk of Infection ....................................................................................................

REASON FOR USE OF BODY BAG (Please tick the relevant section)

 NOTE Ensure that attempts have been made to control blood loss prior to placing
body in the bag.

DO NOT USE A SHEET INSIDE THIS BAG.

ONCE IT IS SEALED IT OUGHT NOT BE RE-OPENED.

1. Risk of infection – see Appendix 1. □

2. Uncontrollable loss of blood/body fluids. □

3. No known medical history. □

4. Unable to identify patient. □

Signature ............................................ Print Name .............................................

Date ............................................................

PLACE THIS FORM IN A SEALED ENVELOPE MARKED FOR THE ATTENTION OF THE
MORTUARY TECHNICIAN AND GIVE TO PORTERS REMOVING THE BODY OR PLACE
IN POCKET ON BODY BAG
Equality Analysis (Impact assessment)
Please START this assessment BEFORE writing your policy, procedure, proposal, strategy or service so that you can identify any adverse impacts and include action to mitigate these in your finished policy, procedure, proposal, strategy or service. Use it to help you develop fair and equal services. Eg. If there is an impact on Deaf people, then include in the policy how Deaf people will have equal access.

1. What is being assessed?

Precautions to be taken with the Bodies of those who have died with a known or suspected infection

Details of person responsible for completing the assessment:

- Name: Anita Swaine
- Position: Lead Nurse
- Team/service: Infection Prevention and Control

State main purpose or aim of the policy, procedure, proposal, strategy or service:
(usually the first paragraph of what you are writing. Also include details of legislation, guidance, regulations etc. which have shaped or informed the document)

Information for staff on the management/handling of bodies with a known or suspected infection

2. Consideration of Data and Research

To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it. Think about the information below – how does this apply to your policy, procedure, proposal, strategy or service

2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document

Cheshire East (CE) covers Eastern Cheshire CCG and South Cheshire CCG.
Cheshire West & Chester (CWAC) covers Vale Royal CCG and Cheshire West CCG.
In 2011, 370,100 people resided in CE and 329,608 people resided in CWAC.

Age: East Cheshire and South Cheshire CCG’s serve a predominantly older population than the national average, with 19.3% aged over 65 (71,400 people) and 2.6% aged over 85 (9,700 people).

Vale Royal CCGs registered population in general has a younger age profile compared to the CWAC average, with 14% aged over 65 (14,561 people) and 2% aged over 85 (2,111 people).

Since the 2001 census the number of over 65s has increased by 26% compared with 20% nationally. The number of over 85s has increased by 35% compared with 24% nationally.
Race:
- In 2011, 93.6% of CE residents, and 94.7% of CWAC residents were White British.
- 5.1% of CE residents, and 4.9% of CWAC residents were born outside the UK – Poland and India being the most common.
- 3% of CE households have members for whom English is not the main language (11,103 people) and 1.2% of CWAC households have no people for whom English is their main language.

Gender:
- In 2011, c. 49% of the population in both CE and CWAC were male and 51% female. For CE, the assumption from national figures is that 20 per 100,000 are likely to be transgender and for CWAC 1,500 transgender people will be living in the CWAC area.

Disability:
- In 2011, 7.9% of the population in CE and 8.7% in CWAC had a long term health problem or disability.
- In CE, there are c.4500 people aged 65+ with dementia, and c.1430 aged 65+ with dementia in CWAC. 1 in 20 people over 65 has a form of dementia.
- Over 10 million (c. 1 in 6) people in the UK have a degree of hearing impairment or deafness.
- C. 2 million people in the UK have visual impairment, of these around 365,000 are registered as blind or partially sighted.
- In CE, it is estimated that around 7000 people have learning disabilities and 6500 people in CWAC.
- Mental health – 1 in 4 will have mental health problems at some time in their lives.

Sexual Orientation:
- CE - In 2011, the lesbian, gay, bisexual and transgender (LGBT) population in CE was estimated at18,700, based on assumptions that 5-7% of the population are likely to be lesbian, gay or bisexual and 20 per 100,000 are likely to be transgender (*The Lesbian & Gay Foundation*).
- CWAC - In 2011, the LGBT population in CWAC is unknown, but in 2010 there were c. 20,000 LGB people in the area and as many as 1,500 transgender people residing in CWAC.

Religion/Belief:
The proportion of CE people classing themselves as Christian has fallen from 80.3% in 2001 to 68.9% In 2011 and in CWAC a similar picture from 80.7% to 70.1%, the proportion saying they had no religion doubled in both areas from around 11%-22%.
- Christian: 68.9% of Cheshire East and 70.1% of Cheshire West & Chester
- Sikh: 0.07% of Cheshire East and 0.1% of Cheshire West & Chester
- Buddhist: 0.24% of Cheshire East and 0.2% of Cheshire West & Chester
- Hindu: 0.36% of Cheshire East and 0.2% of Cheshire West & Chester
- Jewish: 0.16% of Cheshire East and 0.1% of Cheshire West & Chester
- Muslim: 0.66% of Cheshire East and 0.5% of Cheshire West & Chester
- Other: 0.29% of Cheshire East and 0.3% of Cheshire West & Chester
- None: 22.69%of Cheshire East and 22.0% of Cheshire West & Chester
- Not stated: 6.66% of Cheshire East and 6.5% of Cheshire West & Chester
Carers:

- In 2011, nearly 11% (40,000) of the population in CE are unpaid carers and just over 11% (37,000) of the population in CWAC.

2.2 Evidence of complaints on grounds of discrimination: (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the policy, procedure, proposal, strategy or service or its effects on different groups?)

| None |

2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?

| None |

3. Assessment of Impact

Now that you have looked at the purpose, etc. of the policy, procedure, proposal, strategy or service (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the policy, procedure, proposal, strategy or service on each of the strands listed below.

**RACE:**

From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, racial groups differently?

- Yes  
- No  

**Explain your response:** In order to explain the requirements of the policy to people whose first language is not English, e.g. family members caring for a patient, staff will follow the interpretation policy. The policy details actions required to respect an individual’s cultural beliefs.

**GENDER (INCLUDING TRANSGENDER):**

From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, different gender groups differently?

- Yes  
- No  

**Explain your response:** No impacts identified.

**DISABILITY**

From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, disabled people differently?

- Yes  
- No  

**Explain your response:** No impacts identified.
**AGE:**
From the evidence available does the policy, procedure, proposal, strategy or service, affect, or have the potential to affect, age groups differently?  
Yes ☐ No ☒

**Explain your response:** No impact identified.

---

**LESBIAN, GAY, BISEXUAL:**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, lesbian, gay or bisexual groups differently?  
Yes ☐ No ☒

**Explain your response:** No impact identified.

---

**RELIGION/BELIEF:**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, religious belief groups differently?  
Yes ☐ No ☒

**Explain your response:** The policy covers appropriate measures to respect patients’ and families’ religious/cultural requirements.

---

**CARERS:**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, carers differently?  
Yes ☐ No ☒

**Explain your response:** Information will be provided to carers (in an appropriate format using appropriate communication methods to support any communication/disability issues) about any additional requirements to care. Clinical staff will ensure that information is given to the carers to ensure they understand measures required, this can be both verbal and written.

---

**OTHER:** EG Pregnant women, people in civil partnerships, human rights issues.  
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect any other groups differently?  
Yes ☐ No ☒

**Explain your response:** No other impacts identified.

---

4. Safeguarding Assessment - CHILDREN

<table>
<thead>
<tr>
<th>a. Is there a direct or indirect impact upon children?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ☐ No ☒</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual</th>
</tr>
</thead>
</table>
children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people:

c. If no please describe why there is considered to be no impact / significant impact on children. No impact identified

5. Relevant consultation

Having identified key groups, how have you consulted with them to find out their views and that the made sure that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc.?

Consultation has occurred through the Infection Prevention and Control group which is multidisciplinary and includes a member of the public.

6. Date completed: 14.07.2017 Review Date: 16/7/2019

7. Any actions identified:

Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Date to be Achieved</th>
</tr>
</thead>
</table>

8. Approval:

At this point, you should forward the template to the Trust Equality and Diversity Lead lynbailey@nhs.net
Approved by Trust Equality and Diversity Lead:

Date: 17.7.17