Nursing level III

NTQF III

Learning Guide-39

Unit of Competence: Provide Palliative Care and Maintain Mortuary Service

Module Title: Providing Palliative Care and Maintain Mortuary Service

LG Code: HLT NUR3 M08 LO1-LG-37

Code: HLT NUR3 M08 TTLM0919V2

LO 1: Receive bodies at mortuary

Instruction Sheet 1	Learning Guide #1

This learning guide is developed to provide you the necessary information regarding the following **content coverage** and topics:

- Introduction to palliative Care/ end-of-life care
- Physiologic changes ofimpending death
- Completing Checking processes
- Transferringbody is undertaken according to the organizational policy and procedures
- Documentation and registration are processed in accordance with the legal requirements and established procedures.
- Body is stored in accordance with the organizational policy and procedures
- Infection control policy and procedures are strictly followed

This guide will also assist you to attain the learning outcome stated in the cover page. Specifically, upon completion of this Learning Guide, you will be able to:

- Introduction to palliative Care/ end-of-life care
- Physiologic changes
- Complete Checking processes
- Transfer body is undertaken according to the organizational policy and procedures
- Documentation and registration are processed in accordance with the legal requirements and established procedures.
- Body is stored in accordance with the organizational policy and procedures
- Infection control policy and procedures are strictly followed

Learning Instructions:

1. Read the specific objectives of this Learning Guide.
2. Follow the instructions described below 3 to 6.
3. Read the information written in the information “Sheet 1, Sheet 2, Sheet 3, Sheet 4, Sheet 5, Sheet6 and Sheet 7”.
4. Accomplish the “Self-check 1, Self-check t 2, Self-check 3, Self-check 4, Self-check 5, Self-check 6 and Self-check 7” **in page -10, 15, 17, 20, 24, 29, and 33**respectively.
5. If you earned a satisfactory evaluation from the “Self-check” proceedto “Operation Sheet 1, Operation Sheet 2, Operation Sheet 3, Operation Sheet 4, Operation Sheet 5, Operation Sheet 6 and Operation Sheet 7” **in page -34, 35 and 36.**
6. Do the “LAP test” **in page – 38** (if you are ready).

Information Sheet-1	Introduction to palliative Care/ end-of-life care

1.1.Introduction to palliative Care/ end-of-life care

The World Health Organization describes palliative care as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual."

One of the most difficult realities that nurses face is end of life care, despite our very best efforts, some patients will die. Although we cannot change this fact, we can have a significant and lasting effect on the way in which patients live until they die, the manner in which the death occurs, and the enduring memories of that death for the families. Knowledge about end-of-life decisions and principles of care is essential to supporting patients during decision making and in end-of-life closure in ways that recognize their unique responses to illness and that support their values and goals. Education, clinical practice, and research concerning end-of-life care are evolving, and the need to prepare nurses and other health care professionals to care for the dying has emerged as a priority.The national institute for nursing research has taken the lead in coordinating research related to end-of-life care within the national institutes of health. At no time in nursing's history has there been a greater opportunity to bring research, education, and practice together to change the culture of dying, bringing much-needed improvement to care that is relevant across practice settings, age groups, cultural backgrounds, and illnesses.

1.1.2 Definition of terms

- **Autonomy**: self-determination; in the health care context, the right of the individual to make choices about the use and discontinuation of medical treatment.
- **Bereavement**: period during which mourning for a loss takes place.
- **Euthanasia**: Greek word for "good death;" has evolved to mean the intentional killing by act or omission of a dependent human being for his or her alleged benefit.
- **Grief**: the personal feelings that accompany an anticipated or actual loss.
- **Hospice**: a coordinated program of interdisciplinary care and services provided primarily in the home to terminally ill patients and their families.

- **Interdisciplinary** collaboration: members of diverse health care disciplines jointly plan, implement, and evaluate care.
- **Medicarehospicebenefit**: a Medicare entitlement that provides for comprehensive, interdisciplinary palliative care and services for eligible beneficiaries who have a terminal illness and a life expectancy of less than 6 months.
- **Mourning**: individual, family, group, and cultural expressions of grief and associated behaviors.
- **Palliativecare**: comprehensive care for patients whose disease is not responsive to cure; care also extends to patients' families.
- **Palliativesedation**: use of pharmacological agents, at the request of the terminally ill patient, to induce sedation when symptoms have not responded to other management measures. The purpose is not to hasten the patient's death but to relieve intractable symptoms
- **Spirituality**: personal belief systems that focus on a search for meaning and purpose in life, intangible elements that impart meaning and vitality to life, and a connectedness to a higher or transcendent dimension.
- **Terminalillness**: progressive, irreversible illness that despite cure-focused medical treatment will result in the patient's death.

1.2. Sociocultural context:

Although each individual experiences terminal illness uniquely, such illness is also shaped substantially by the social and cultural contexts in which it occurs. In the United States, life-threatening illness, life-sustaining treatment decisions, dying, and death occur in a social environment where illness is largely considered a foe and where battles are either lost or won cure dichotomy has emerged in which health care providers may view cure as the ultimate good and care as second best, a good only when cure is no longer possible. In such a model of health or medical care, alleviating suffering is not as valued as curing disease, and patients who cannot be cured feel distanced from the health care team, concluding that when treatment has failed, they too have failed. Patients and families who have internalized the socially constructed meaning of care as second best may fear that any shift from curative goals in the direction of comfort-focused care will result in no care or poorer-quality care, and that the clinicians on whom they have come to rely will abandon them if they withdraw from the battle for cure.

The reduction of patients to their diseases is exemplified in the frequently relayed message in late-stage illness that "nothing more can be done." This all-too-frequently used statement communicates the belief of many clinicians that there is nothing of value to offer patients who are beyond cure. In a care-focused perspective, mind, body, and spirit are inextricable, and treating the body without attending to the other

components is considered inadequate to evoke true healing. This expanded notion of healing as care, along with and beyond cure, implies that healing can take place throughout life and outside the boundaries of contemporary medicine. In this expanded definition, healing is transcendent and its boundaries are unlimited, even as body systems begin to fail at the end of life.

1. Settings for End-of-Life Care: Palliative Care Programs and Hospice

2.2. Palliative care:

As concerns have grown about the poor quality of life patients experience during progressive illness, ***broadening the concept of palliative care beyond the hospice*** has begun to take hold in health care settings. ***Palliative care*** is an approach to care for the seriously ill that has long been a part of cancer care. Both palliative care and hospice have been recognized as important bridges between the compulsion for cure-oriented care and physician-assisted suicide.

Advocates for improved care for the dying have stated that ***acceptance, management, and understanding of death should become fully integrated concepts in mainstream health care.*** Increasingly, palliative care is being offered to patients with non-cancer chronic illnesses, where comprehensive symptom management and psychosocial and spiritual support can enhance the patient's and family's quality of life. While ***hospice*** care is considered by many to be the "gold standard" for palliative care, the term hospice is generally associated with palliative care that is delivered at home or in special facilities to patients who are approaching the end of life. Palliative care is conceptually broader than hospice care, defined as the active, total care of patients whose disease is not responsive to treatment.

Palliative care emphasizes management of psychological, social, and spiritual problems in addition to control of pain and other physical symptoms. As the definition suggests, palliative care is not care that begins when cure-focused treatment ends. ***The goal of palliative*** care is to improve the patient's and family's quality of life, and many aspects of this type of comprehensive, comfort-focused approach to care are applicable earlier in the process of life-threatening disease in conjunction with cure focused treatment. However, definitions of palliative care, the services that are part of it, and the clinicians who provide it are evolving steadily.

Palliative Care in the Hospital Setting:

Since the advent of diagnosis-related groups (DRGs) as the basis for prospective payment for hospital services in the 1980s, there has been a financial incentive for hospitals to transfer patients with terminal illnesses who were no longer in need of acute-level care to other settings, such as long-term care facilities and home, to receive care. Despite the economic and human costs associated with death in the hospital setting, as many as 50% of all deaths occur in acute care settings (Hogan et al). The landmark Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments documented troubling deficiencies in the care of the dying in hospital settings:

- Many patients received unwanted care at the end of life.
- Clinicians were not aware of patient preferences for life sustaining treatment, even when preferences were documented in the clinical record.
- Pain was often poorly controlled at the end of life.
- Efforts to enhance communication were ineffective.

Hospice Care:

Hospice is not a place, but a concept of care in which the end of life is viewed as a developmental stage. The root of the word hospice is hospes, meaning "***host***." Historically, hospice has referred to ***a shelter or way station for weary*** travelers on a pilgrimage. In the years that followed Kubler-Ross's groundbreaking work, the concept of hospice care as an alternative to depersonalized death in institutions began as a grassroots movement. Her work, and the development of the concept of hospice in England by Dr. Cicely Saunders, resulted in recognition of gaps in the existing system of care for the terminally ill. Hospice care began in response to "noticeable gaps . . .

- Between treating the disease and treating the person
- Between technological research and psycho-social support, and
- Between the general denial of the fact of death in the society and the acceptance of death by those who face it

According to Saunders, who founded the world-renowned St. Christopher's Hospice in London the principles underlying hospice are as follows:

- Death must be accepted.
- The patient's total care is best managed by an interdisciplinary team whose members communicate regularly with each other.
- Pain and other symptoms of terminal illness must be managed.
- The patient and family should be viewed as a single unit of care.
- Home care of the dying is necessary.
- Bereavement care must be provided to family members.
- Research and education should be ongoing**.**

Figure 1:Palliative Care Programs and Hospice

3. Nursing Care of the Terminally Ill Patient

Many patients suffer unnecessarily when they do not receive adequate attention for the symptoms

accompanying serious illness. Careful evaluation of the patient should include not only ***the physical problems but also the psychosocial and spiritual dimensions*** of the patient's and family's experience of serious illness. This approach contributes to a more comprehensive understanding of how the patient's and family's life has been affected by the illness and will lead to nursing care that addresses the needs in every dimension.

3.1. Psychosocial issues

Nurses are responsible for educating patients about the possibilities and probabilities inherent in their illness and their life with the illness, and for supporting them as ***they conduct life review, values clarification, treatment decision making, and end-of-life closure.***

The only way to do this effectively is to try to appreciate and understand the illness from the patient's perspective. To provide effective patient- and family-centered care at the end of life, nurses must be willing to set aside their assumptions so that they can discover what type and amount of disclosure is most meaningful to each patient and family within their unique belief systems.

3.2. Providing culturally sensitive care at the end of life:

Although death, grief, and mourning are ***universally accepted aspects of living, values, expectations, and practices during serious illness, as death approaches,*** and following death are ***culturally bound and expressed.*** Health care providers may share very similar values concerning end-of-life care and may find that they are inadequately prepared to assess for and implement care plans that support culturally diverse perspectives. The nurse's role is to assess the values, preferences, and practices of every patient, regardless of ethnicity, socioeconomic status, or background. The nurse can share knowledge about the patient's and family's cultural beliefs and practices with the health care team and facilitate the adaptation of the care plan to accommodate these practices. In addition, the nurse may assist the patient and family to clarify their goals, expected outcomes, and values as they consider treatment options. The nurse should assess and document the patient's and family's specific beliefs, preferences, and practices regarding end-of life care, preparation for death, and after-death rituals. The nurse needs to work with interdisciplinary colleagues to ensure that the patient and family are referred for continuing psychosocial support, symptom management, and assistance with other care-related challenges (e. g, arranging for home care or hospice support, referrals for financial assistance).

3.3. Spiritual care:

Attention to the spiritual component of the patient's and family's illness experience is not new within the context of nursing care, yet many nurses lack the comfort or skills to assess and intervene in this dimension. Spirituality contains features of religiosity, but the two concepts are not interchangeable. Spirituality involves the "search for meaning and purpose in life and relatedness to a transcendent dimension". For most people, contemplating their own deaths raises many issues, such as the meaning of existence, the purpose of suffering, and the existence of an after life.Hope.

In terminal illness, hope represents patients' imagined future, forming the basis of a positive, accepting attitude and providing their lives with meaning, direction and optimism. When hope is viewed this way, it is not limited to cure of the disease, and instead focuses on what is achievable in the time remaining. Many patients find hope in working on important relationships and creating legacies. The terminally ill patient can be extremely resilient, reconceptualising hope repeatedly as he or she approaches the end of life.

The concept of hope has been delineated and studied by numerous nurse researchers, and its presence has been related to concepts such as spirituality, quality of life, and transcendence. Hope defined as a multidimensional construct that provides comfort to the individual as he or she endures life threats and personal challenges. The nurse can support the patient and family by using effective listening and communication skills and encouraging realistic hope that is specific to the patient's and family's needs for information, expectations for the future, and values and preferences concerning the end of life.

It is important for the nurse to engage in self-reflection and identify her or his own biases and fears concerning illness, life, and death. As nurses become more skilled in working with seriously ill patients, they can become less determined to "fix" and more willing to listen, more comfortable with silence, grief, anger, and sadness, and more fully present with patients and their families. ***Nursing interventions*** for enabling and supporting hope include:

- Listening attentively
- Encouraging sharing of feelings
- Providing accurate information
- Encouraging and supporting patient control over his or her circumstances, choices, and environment whenever possible.

Self-Check -1	Written Test

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

1. Define palliative care.(5 points)
2. What is different between palliative care and hospice.(5 points)

Note: **Satisfactory rating - 3 and 5 points** **Unsatisfactory - below 3 and 5 points**

You can ask you teacher for the copy of the correct answers.

Answer Sheet

Score = _____

Rating: _____

Name: _____ Date: _____

Short Answer Questions

Answer sheet

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Information Sheet-2	Physiologic changes of impending death

1.2. Expected physiologic changes when the patient is close to death:

Observable, expected changes in the body take place ***as the patient approaches death and organ systems begin to fail.*** Nursing care measures aimed at patient comfort should be continued: ***pain medications (administered rectally or sublingually), turning, mouth care, eye care, positioning to facilitate draining of secretions, and measures to protect the skin from incontinence should be continued.*** The nurse should consult with the physician about discontinuing measures that no longer contribute to patient comfort such as ***drawing blood, administering tube feedings, suctioning (in most cases), and invasive monitoring.*** The nurse should prepare the family for the normal, expected changes that accompany the period immediately preceding death. Although the exact time of death cannot be predicted, it is often possible to identify when a patient is very close to death. Hospice programs frequently provide written information for families so they know what to expect and what to do as death nears. ***Noisy, gurgling breathing or moaning is generally most distressing to the family.*** In most cases, the sounds of breathing at the end of life are related to oropharyngeal relaxation and diminished awareness. ***Patient positioning and family reassurance*** are the most helpful responses to these symptoms.

Terminal "Bubbling".

When death is imminent, the patient may become ***increasingly somnolent and unable to clear sputum or oral secretions, which may lead to further impairment of breathing from pooled and/or dried and crusted secretions.*** The ***sound and appearance of the secretions*** are often more distressing to the family than is the presence of the secretions to the patient. Family distress over the changes in patient condition may be eased by ***supportive nursing care.*** Continuation of comfort-focused interventions and reassurance that the patient is not in any distress can do much to ease family concerns.

Gentle mouth care with a moistened swab or very soft toothbrush will help to maintain the integrity of the patient's mucous membranes. In addition, ***gentle oral suctioning, positioning to enhance drainage of secretions, and sublingual or transdermal administration of anticholinergic drugs*** to reduce the production of secretions will provide comfort to the patient and support to the family. Deeper suctioning may cause significant discomfort to the dying patient and is rarely of any benefit, as secretions will reaccumulate rapidly.

The death vigil:

Although every death is unique, it is often possible for the experienced clinician to assess that the patient is "actively" or imminently dying and to prepare the family in the final days or hours leading to death. In any setting, it is unrealistic for family members to be at the patient's bedside 24 hours a day, and it is not unusual for patients to die when the family has stepped away from the bedside just briefly. The nurse can reassure family members throughout the death vigil by ***being present intermittently or continuously, modeling*** behaviors (such as touching and speaking to the patient), providing encouragement in relation to family caregiving, providing

reassurance about normal physiologic changes, and encouraging family rest breaks.

When the patient dies while the family is away from the bedside, the family may express feelings of guilt and profound grief and will need emotional support.

Signs of Approaching Death:

- The person will show less interest in eating and drinking.
- Urinary output may decrease in amount and frequency.
- As the body weakens, the patient will sleep more and begin to detach from the environment.
- Mental confusion may become apparent, as less oxygen is available to supply the brain.
- Vision and hearing may become somewhat impaired and speech may be difficult to understand.
- Secretions may collect in the back of the throat and rattle or gurgle as the patient breathes though the mouth.
- Breathing may become irregular with periods of no breathing (apnea).
- As the oxygen supply to the brain decreases, the patient may become restless.
- The patient may feel hot one moment and cold the next as the body loses its ability to control the temperature.
- Loss of bladder and bowel control may occur around the time of death.
- As people approach death, many times they report seeing gardens, libraries, or family or friendswho have died.

3.4. Managing physiologic responses to illness:

Patients approaching the end of life experience many of the same symptoms, regardless of their underlying disease processes. Symptoms in terminal illness may be caused by the disease, either directly (e.g. dyspnea due to chronic obstructive lung disease) or indirectly (e.g. nausea and vomiting related to pressure in the gastric area), by the treatment for the disease, or by a coexisting disorder that is unrelated to the disease. The importance of believing the patient's report of the pain and its effect, and the importance of systematic assessment of pain. Similarly, symptoms such as ***dyspnea, nausea, weakness, and anxiety should be as carefully and systematically assessed and managed.***

The goals of symptom managementat the end of life are;

- To completely relieve the symptom when possible, or
- To decrease the symptom to a level that the patient can tolerate when it cannot be completely relieved.

Medical interventions: may be aimed at treating the underlying causes of the symptoms. Pharmacologic and non-pharmacologic methods for symptom management may be used in combination with medical interventions to modify the physiologic causes of symptoms. For example, some patients who develop pleural effusion secondary to metastatic cancer may experience temporary relief of the associated dyspnea following thoracentesis, an invasive medical procedure in which fluid is drained from the pleural space.In addition, pharmacologic management with ***low-dose oral morphine*** is very effective in relieving dyspnea, and ***guided relaxation*** may reduce the anxiety associated with the sensation of breathlessness. ***As with pain,*** the principles of pharmacologic symptom management are the smallest dose of the medication to achieve the desired effect,

avoidance of polypharmacy, anticipation and management of medication side effects, and creation of a therapeutic regimen that is acceptable to the patient based on his or her goals for maximizing quality of life.

As with pain management, patients may elect to tolerate higher symptom levels in exchange for ***greater independence, mobility, alertness, or other priorities. Anticipating and planning interventions for symptoms that have not yet occurred is a cornerstone of end-of-life care.*** Both patients and family members cope more effectively with new symptoms and exacerbations of existing symptoms when they know what to expect and how to manage it. ***Hospice programs*** typically provide ***"emergency kits"*** containing ready-to-administer doses of a variety of medications that are useful to treat symptoms in advanced illness. Family members can be instructed to administer a prescribed dose from the emergency kit, often avoiding prolonged suffering for the patient as well as rehospitalization for symptom management.

3.5. Palliative sedation at the end of life:

Effective control of symptoms can be achieved under most conditions, but some patients may experience distressing, intractable symptoms. Although its use remains controversial, ***palliative sedation*** is offered in some settings to patients who are close to death, who have symptoms that do not respond to conventional pharmacologic and non-pharmacologic approaches, and as a result are experiencing unrelieved suffering. Palliative sedation is distinguished from ***euthanasia*** or physician-assisted suicide in that the intent of palliative sedation is to palliate the symptoms, not to hasten the patient's death.

Palliative sedation is most commonly used when the patient exhibits intractable pain, dyspnea, seizures, or delirium. It is generally considered appropriate in only the most difficult cases. Before implementing palliative sedation, the care team should assess for the presence of underlying and treatable causes of suffering, such as depression or spiritual pain. Finally, patients and families should be fully informed about the use of this treatment and alternatives. Palliative sedation is accomplished through infusion of a benzodiazepine or barbiturate in doses adequate to induce sleep and eliminate signs of discomfort. The nurse acts as a collaborating member of the interdisciplinary team, providing emotional support to the patient and family, facilitating clarification of values and preferences, and providing comfort focused physical care. Once sedation has been induced, the nurse will need to continue comfort care, monitor the physiologic effects of the sedation, support the family during the final hours or days of the patient's life, and ensure communication within the care team and between the team and family care. Continuation of comfort-focused interventions and reassurance that the patient is not in any distress can do much to ease family concerns. Gentle mouth care with a moistened swab or very soft toothbrush will help to maintain the integrity of the patient's mucous membranes. In addition, gentle oral suctioning, positioning to enhance drainage of secretions, and sublingual or transdermal administration of anticholinergic drugs to reduce the production of secretions will provide comfort to the patient and support to

the family. Deeper suctioning may cause significant discomfort to the dying patient and is rarely of any benefit, as secretions will reaccumulate rapidly.

3.6. Nursing care of the patient who is close to death

Patients and their families are understandably fearful of the unknown, and ***the approach of death*** may prompt new concerns or cause previous fears or issues to resurface. Families that have always had difficulty communicating or in which there are old resentments and hurts may experience heightened difficulty as their loved one nears death. In contrast, the time at the end of life can also afford the family the opportunity to resolve old hurts and learn new ways of being a family. Regardless of the setting, dying patients can be made comfortable, space can be made for their loved ones to remain present when they wish, and the opportunity to experience growth and healing can be facilitated by skilled practitioners. Likewise, regardless of setting patients' and families' apprehension surrounding the time of death may be diminished if they know what to expect as death nears and how to respond.

Self-Check -2	Written Test

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

1. Which one of the flowing is signs of Approaching Death.
   A. The person will show less interest in eating and drinking.
   B. Urinary output may decrease in amount and frequency.
   C. As the body weakens, the patient will sleep more and begin to detach from the environment.
   D. None
2. What is nursing care of the patient who is close to death(5point)

Note: **Satisfactory rating - 3 points** **Unsatisfactory - below 3 points**

You can ask you teacher for the copy of the correct answers.

Answer Sheet

Score = _____

Rating: _____

Name: _____ Date: _____

Short Answer Questions

Answer sheet

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Information Sheet-3	Completing Checking processes

1.3. Completing Checking processes

Although the process may differ slightly in other hospitals, or departments, the process in our department, the Emergency Department, tends to be as follows:The death must be certified by the Doctor who has been treating the patient. This involves ensuring that there has been cessation of heartbeat, breathing and that there is a lack of pupillary response to light.
If family or friends are in the department, they may be offered the opportunity to spend time with the patient in the Resuscitation area. However, this is a fairly high-activity area and isn't a particularly peaceful place.
Families are able to spend long periods of time in this room, some spend several hours depending on the circumstances.

Procedure for the Verification of Expected Death
It is essential that the nurse takes time to observe the patient for any spontaneous movement or any reaction to the environment e.g. chest movement, swallowing,coughing, nasal flaring and eye movement, whilst in the process of verifying death.The nurse should be accustomed to using a stethoscope and be experienced in listening to healthy heart sounds before assessing the absence of heart sounds.
Death will be verified using the criteria below. These observations should be repeated after 5 minutes.

- Absence of carotid pulses over 1 minute
- Absence of heart sounds over 1 minute
- Absence of respiratory movements and breath sounds over 1 minute
- Pupils not reacting to light
- No response to painful stimuli

e.g. trapezium squeeze

Figure 2: Verification of Expected Death

Self-Check -4	Written Test

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

1. what is the checking process (5 point)

Note: **Satisfactory rating –3 points** **Unsatisfactory - below 3 and 4 points**

You can ask you teacher for the copy of the correct answers.

Answer Sheet

Score = _____

Rating: _____

Name: _____ Date: _____

Short Answer Questions

Answer sheet

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Information Sheet-4	Transferring

1.4. Transferring

1.4.1. Handling thedead

Burial in individual graves is the method of choice, unless the number of dead is exces- sively large, or climatic or other constraints make this impossible. Individual graves can be dug manually, providing work, a sense of purpose, and a ritual element for the com- munity affected by the disaster. If the number is too large, or circumstances demand it, trenches can be dug by mechanical means and bodies placed in them head to foot to save space. If it is expected that the bodies will be disinterred, they should be buried 50 centimetres from thesurface.

Collectionofbodyfromwardin performing the duty to collect body from ward, medical attendants are at risk of in contact with infectious material. The following precautions must be taken:

Bodystorageallbodies must be identified and correctly labeled. Any that cannot be properly identified, and particularly those for which there is no satisfactory medical record, mustbelabeledandtreatedas'dangerofinfection'casesunlessadditionalinformation becomesavailable.Bodies are stored temporarily before post mortem examination or when examination not required in cases where cause of death has been given by clinician and therefore notmedico-legalcasesinabodyfreezerwithtemperaturemaintainedat4^{o}C.

Procedure for post-mortem examination of known or suspected CJD/ Spongiformencephalopathy(referthedocumentfrommortuary)The procedure for examination high risk cases including HIV, hepatitis and tuberculosis, can be used for examination of cases with known or suspected spongiform encephalopathy which is also practiced by the Neurosciences Unit attheQueenElizabethHospitalinBirmingham.

Body cleaning anddisposal Routine autopsy cases after being sawn and clean with running water are given to relatives for lastrites.

ClinicalwasteMost of the waste arising from post mortem examinations is defined as clinical waste andfallsintotwodistinctgroupsandfoursubcategorieswhichare:

VisitorsThose visitors who decide to observe the autopsy may do so in the observation area overlooking the autopsy tables. Access to the area should be via a direct route bypassing the dirty areas inmortuary**.**

QualitycontrolMortuary facilities must undergo regular maintenance and the efficacy of such equipment's i.e. fridge, ventilation systems, local exhaust systems, fume cabinets and PPEs are regularly measured and monitored.

Figure3: transferring the dead body

Self-Check -4	Written Test

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

2. what is the transfer procedure for dead body (5 point)

Note: **Satisfactory rating –3 points** **Unsatisfactory - below 3 and 4 points**

You can ask you teacher for the copy of the correct answers.

Answer Sheet

Score = _____

Rating: _____

Name: _____ Date: _____

Short Answer Questions

Answer sheet

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Information Sheet-5	Body storage

1.5. Body storage

Mortuary is an important integral part of every hospital as it deals with the preservation of the dead body so that the forensic clinicians & pathologists may investigate the cause of death and make scientific investigations. Bodies may be viewed and identified by relatives and friends (unidentified body), and bodies may be kept until burial can be arranged.

The concept of "womb to tomb" in health care of the population in our community health literature clearly indicates that in health care setup, part of doctor's duty is not only caring for the living but also helping in arrange for disposal of that patient who dies.

In general, Mortuary complex consists of Autopsy room/ postmortem room, and preservation room for dead body before disposal arrangement are made(Cold storage room) and ancillary areas. Morgue is pre dominantly used in Northern American English while mortuary is more common in British English.

In Hospital, the effect of death and look at the dead body is great demoralizing factor for the patients and visitors. Similarly, hospitals and physicians prefer to project their success rather than exhibit the dead body. So, it becomes essential for hospital administration that a suitable provision shall be made in an obscure place where the dead body can be placed, pending final disposal or to rule out the cause of death. A carefully planned mortuary complex is of great benefit to all those who come in contact with it. i.e police, doctors, medical students, staffs and relatives of deceased. Provision of mortuary facilities and services in a hospital also has an important bearings in terms of public relation of the hospital. Lots of sentiments value are attached to the dead body of the person with socio and medico legal importance attached to the mortuary of the hospital. Therefore, establishment and proper management of mortuary is of significance of every hospital.

Function of mortuary service

1. To preserve the dead body till the formalities of the handing over of deacesed is completed.

2. To keep the dead body (unclaimed) till the relative claim and take away for final disposal. Usually unclaimed bodies are kept for 72 hours , and if not cliamed till that period, disposal of dead body is done as per existing policy of hospital and as per law of land.

3. To receive and store dead body requiring postmortem examination.

4. To carry out medico legal postmortem work.

5. To impart teaching programs for undergraduates and post graduates.

Planning parameter of mortuary

Location: The location should be in obscure place, in a separate building to where the dead bodies can be transported un obstructively. It should be easily accessible from the wards, Emergency, ICU and OT and pathology department

Functional area

- Parking area & Covered Portico
- Reception & Waiting area
- Trolley area } Storage Chamber
- Post mortem Room
- Office room for record keeping & Processing
- Doctors room
- Store room
- Room for technicians & attendants
- Changing room
- Toilets

Parkingwithcoveredportico: Spacious parking area with a covered area of about 18m2 for vehicles should be provided at entrance to the body store as a protection in wet weather and screen from adjoining area with a exit to subsidiary road or parking area.

Reception : A recption of the mortuary is the place where the bodies are viewed and documents checked. It should have easy assecibility and approchable .

Trolleyarea: A trolly bay is required to keep the trolley fro transportation of dead body.It should be nearby the reception.

Waitingarea: A waiting room of 12-15m2 is recommended for the access to visitors and relatives. It should be pleasantly furnished with provision of WC and drinking water. } In western countries

viewing room(20m2) is adjoined to waiting area to enable bodies to be viewed by relatives. It is treated in such way that it can be used by all regions and denominations.

Storagechamber : Temperature for storage chamber

Negative temperature storage : (-15/-25DC) for unclaimed body/cause of death not identified . At this temperature, body is completely frozen and decomposition is stopped. linen is adhered firmly on tray. Positive temperature storage : (+2/+4) , it does not prevent decomposition which continues at slow rate . For bodies which are to be disposed quickly and with no medicologaldisputes(preservation).

Postmortemroom : The post mortem room is suggested to be treated like an operational theater in all technicality. The major difference between mortuary and OT is that in Operation Theater, utmost care is needed to prevent outside infection entering inside, and in mortuary care is needed to ensure that inside infection does not spread out.

The post mosterm room should

• Be well ventilated, illuminated and cleaned to OT standard.

• Be Fly proof, well lit

• Have proper instrument and specimen storing cupboard

• Have heavy duty exhaust fan

• Have water impervious floor sloping to drain

• Have easily washable floors and walls

• Have proper infection control

• Have running cold and hot water

• Have facilities for collection of specimen

• Be hosed down from floor to ceiling with proper drainage.

Stores: Clean store for clean gown, aprons, gloves, gumboots and towel; Instrument and equipment store for equipment, jars and solutions; linen store for drapes, shroud, towel etc.

Fig 4: refrigerated body storage cabinet.

Self-Check -5	Written Test

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

1. Function of mortuary service is

   A. To preserve the dead body till the formalities of the handing over of deacesed is completed.
   B. To keep the dead body (unclaimed) till the relative claim and take away for final disposal.
   C. To receive and store dead body requiring postmortem examination.
   D. To carry out medico legal postmortem work.
   E. All

2. List functional area of body storage.

Note: **Satisfactory rating –3 points** **Unsatisfactory - below 3 and 4 points**

You can ask you teacher for the copy of the correct answers.

Answer Sheet

Score = _____

Rating: _____

Name: _____ Date: _____

Short Answer Questions

Answer sheet

1_____

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2_____

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3_____

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Information Sheet-6	Documentation and reporting

1.6. Documentation and reporting

Documentation is anything written or printed on which you rely as record or proof of patient actions and activities

A record or chart or client record is a formal, legal document that provides evidence of a client's care and can be written or computer based.

A report is oral, written, or computer-based communication intended to convey information to others.

The process of making an entry on a client record is called recording, charting, or documenting

Each health care organization has policies about recording and reporting client data, and each nurse is accountable for practicing according to these standards.

Purposes Documentation

The patient record is a valuable source of data for all members of the health care team. Client records are kept for a number of purposes including:

- Communication
- Planning client care
- Auditing health agencies
- Research
- Education
- Reimbursement
- Legal documentation
- Health care analysis

Communication The record serves as the vehicle by which different health professionals who interact with a client communicate with each other. This prevents fragmentation, repetition, and delays in client care.

PlanningClientCare Each health professional uses data from the client's record to plan care for that client. Nurses use baseline and ongoing data to evaluate the effectiveness of the using care plan.

Auditing Health Agencies An audit is a review of client records for quality assurance purposes. Accrediting agencies such as The Joint Commission may review client records to determine if a particular health agency is meeting its stated standards.

Researchthe information contained in a record can be a valuable source of data for research. The treatment plans for a number of clients with the same health problems can yield information helpful in treating other clients.

Education Students in health disciplines often use client records as educational tools. A record can frequently provide a comprehensive view of the client, the illness and effective treatment strategies.

Reimbursement Documentation also helps a facility receive reimbursement from the government. For a patient to obtain payment through Medicare or insurance agencies the client's clinical record must contain the correct diagnosis and reveal that the appropriate care has been given.

Legal Documentation The client's record is a legal document and is usually admissible in court as evidence.

Health Care Analysis Information from records may assist health care planners to identify agency needs, such as over utilized and underutilized hospital services. • Records can be used to establish the costs of various services and to identify those services that cost the agency money and those that generate revenue.

GUIDELINES / PRINCIPLES OF RECORDING

Guidelines/ principles:

1. Factual
2. Timing
3. Legibility
4. Permanence
5. Accepted terminology
6. Correct signature
7. Spelling
8. Accuracy
9. Sequence
10. Appropriate

11. Complete
12. Concise
13. Legal prudence

Factual A factual record contains descriptive, objective information about what a nurse sees, hears, feels, and smells. Avoid vague terms such as appears, seems, or apparently because these words suggest that you are stating an opinion, do not accurately communicate facts. Objective documentation includes observations of a patient's behaviors.

DateandTime Document the date and time of each recording this is essential not only for legal reasons but also for client safety. Record the time in the conventional manner (e.g., 9:00 AM or 3:15 PM) or according to the 24-hour clock (military clock), which avoids confusion about whether a time was AM or PM

Legibility All entries must be legible and easy to read to prevent interpretation errors. Hand printing or easily understood handwriting is usually permissible.

PermanenceAll entries on the client's record are made in dark ink so that the record is permanent and changes can be identified. Follow the agency's policies about the type of pen and ink used for recording.

AcceptedTerminology People in the 21st century are often in a hurry and use abbreviations when texting. Even though using abbreviations is convenient, medical abbreviations have been responsible for serious errors and deaths .

CorrectSpelling Use correct spelling while documenting. Correct spelling is essential for accuracy in recording. Avoid spelling mistakes

Signature Each recording on the nursing notes is signed by the nurse making it. The signature includes the name and title; for example, "M.S. REDDY, RN"

Accuracy The client's name and identifying information should be stamped or written on each page of the clinical record. When a recording mistake is made, draw a single line through it to identify it as erroneous with your initials or name above or near the line (depending on agency policy). Do not erase, blot out, or use correction fluid. • The original entry must remain visible

Sequence Document events in the order in which they occur; for example, record assessments, then the nursing interventions, and then the client's responses.

Appropriateness Record only information that pertains to the client's health problems and care. Any other personal information that the client conveys is inappropriate for the record.

Completeness Not all data that a nurse obtains about a client can be recorded. However, the information that is recorded needs to be complete and helpful to the client and health care professionals.

Conciseness Recordings need to be brief as well as complete to save time in communication. Repeated usage of the client's name and the word client are omitted.

LegalPrudence Accurate, complete documentation should give legal protection to the nurse, the client's other caregivers, the health care facility, and the client. Admissible in court as a legal document, the clinical record provides proof of the quality of care given to a client.

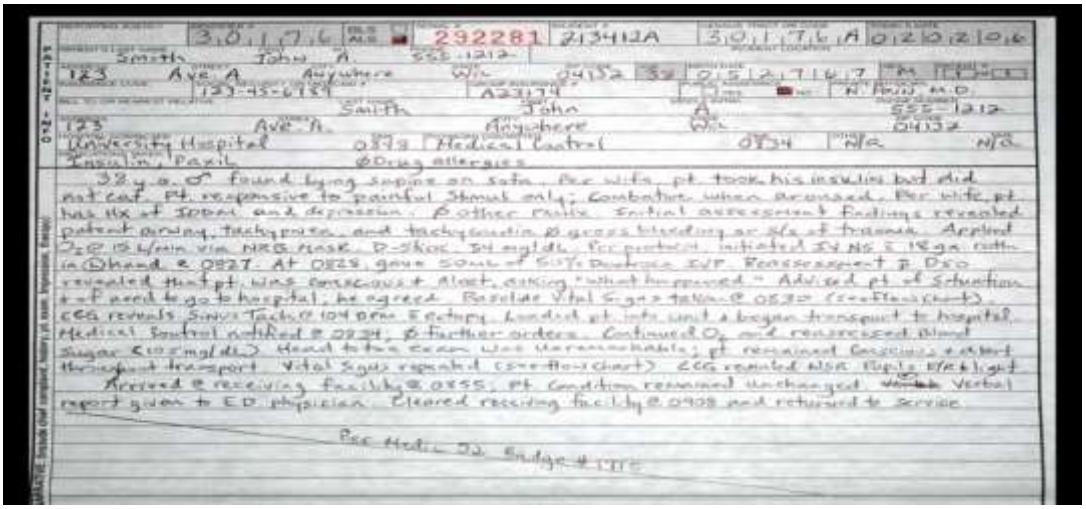

Fig5: This image shows proper documentation

Self-Check -6	Written Test

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

1. Which one of the flowing is not Guidelines/ principles of documentation (3 points)

B. Factual

C. Timing

D. Legibility

E. unaccepted terminology

2. What are the purposes of documentation? (5 points)

Note: **Satisfactory rating –3 points** **Unsatisfactory - below 3 and 4 points**

You can ask you teacher for the copy of the correct answers.

Answer Sheet

Score = _____

Rating: _____

Name: _____ Date: _____

Short Answer Questions

Answer sheet

1_____

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2_____

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3_____

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Information Sheet-7	Infection control policy

1.7. Infection control policy

Infection Control in the Mortuary

Each and every human remains that a funeral service employee comes into contact with must be considered potentially infectious".

Dangerous Communicable Diseases

- Hepatitis B and C
- Rabies
- Invasive group A streptococcal infections
- Transmissible spongiform encephalopathies (e.g. Creutzfeldt-jacob disease or CJD and madcow disease)
- HIV/ AIDS
- Meningiococcemia
- Viral hemorrhagic fever (e.g. African Ebola)
- Other communicable diseases that shall be declared by the department of health

The body shall be placed in a plastic or other durable, airtight container at the point of death and labeled with a biohazard tag. The outside of durable, airtight container shall be immediately and thoroughly disinfected.

Funeral industry infection control guidelines

- Frequent hand washing
- Any skin disease or injury should be adequately protected with gloves or impermeable dressing to avoid contamination with a patient's body fluids.
- Use of PPE (Personal Protective Equipment)/Gloves/Mask/Eye protection/Scrub or Gown and apron/Rubber boots or foot cover.
- Routine cleaning and disinfecting surfaces and instrument
- Immunization
- To minimize any post- mortem growth of microorganisms, all human remains should be placed in a mortuary refrigerator or freezer as soon as possible after death
- All human remains should be well sealed to prevent leakage of blood and body fluids/substances

Standard hand washing procedure:

1. Remove jewellery.

2. Wet hands thoroughly all over.

3. Use pH neutral soap.

4. Lather soap all over hands.

5. Rub hands together vigorously for 15-20 seconds. Pay particular attention to the fingertips, thumbs, wrists, finger webs and the backs of the hands.

6. Rinse under running water.

7. Pat hands dry with paper towels..

Infectious wastes include:

- Sharps (syringes, needles, lancets and scalpel blades)
- Human tissue
- Human blood and body fluids other than urine or feces
- Materials or equipment containing or contaminated with blood and body fluids
- Urine or feces, or materials containing urine or feces Mortuary Cleaning,

Waste Disposal and Laundering

The preparation areas including the preparation table, floor and drains should be washed thoroughly with detergent and water, rinsed and dried. Blood stained fluids and disinfectant solutions should be well diluted before discharge into the sewer. Human tissue and disposable sharps must be disposed of appropriately. Single used PPE must be disposed of as infectious waste. Contaminated re-usable linen should be placed in a laundry bag for routine laundering. On completion of all cleaning and disinfection procedures and the disposal of waste and laundry, employees should remove all PPE,

avoiding contamination of clothing and dispose of it into either a clinical waste or laundry bag before removing gloves.

Cleaning and Disinfection of Equipment

♦ Employees must thoroughly wash and dry hands.

♦ Washing with anti-bacterial soap and disinfection with 70% alcohol

Fig 6: Hand washing

Refer: https://www.youtube.com/watch?v=LUCqzJO_XTI

Self-Check -7	Written Test

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

1. List funeral industry infection control guidelines. (5 point)
2. Define infection control policy. (3 point)

Note: **Satisfactory rating –3 points** **Unsatisfactory - below 3 and 4 points**

You can ask you teacher for the copy of the correct answers.

Answer Sheet

Score = _____

Rating: _____

Name: _____ Date: _____

Short Answer Questions

Answer sheet

1_____

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2_____

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3_____

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Operation Sheet 1	**Nursinginterventionsfor enabling and supporting hope**

Steps 1-Listening attentively

Steps 2-Encouraging sharing feelings

Steps 3-Providing accurateinformation

Steps 4-Encouraging and supporting patient control over his or her circumstances, choices, and environment whenever possible

Operation Sheet 2	Nursing care measures aimed at patient comfort

Steps1- pain medications (administered rectally or sublingually).

Steps2- makemouth care and eye care

Steps 3- position patient to facilitate draining of secretions, and measures to protect the skin from incontinence.

Steps 4- consult with the physician about discontinuing measures that no longer contribute to patient comfort such as drawing blood, administering tube feedings, suctioning (in most cases), and invasive monitoring.

Steps 4- Prepare the family for the normal, expected changes that accompany the period immediately preceding death.

Operation Sheet 3	Death verification technique.

Steps 1-Absence of carotid pulses over 1 minute

Steps 2-Absence of heart sounds over 1 minute

Steps 3-Absence of respiratory movements and breath sounds over 1 minute

Steps 4-Pupils not reacting to light

Steps 5-No response to painful stimuli

Operation Sheet 4	Body Transferring technique

Steps 1-Collectionofbodyfromward

Steps 2-bodies must be identified and correctly labeled

Steps 3-Storagebodytemporarily before post mortem examination

(Bodyfreezerwithtemperaturemaintainedat4^{O}C.)

Steps 4-Body cleaning anddisposal**:** outine autopsy cases after being sawn and clean with running water are given to relatives for lastrites.

Steps 5-allow the visitors who decide to observe the autopsy in the observation area overlooking the autopsy tables.

Operation Sheet 5	post-mortem room preparation procedure

Steps 1-post-mortem room should be well ventilated, illuminated and cleaned to OT standard.

Steps 2-make fly proof, well lit

Steps 3-Have proper instrument and specimen storing cupboard

Steps 4-Have heavy duty exhaust fan

Steps 5-Have water impervious floor sloping to drain

Steps 6-Have easily washable floors and walls

Steps 7-Have proper infection control

Operation Sheet 6	Guidelines of documentation and recording

Steps 1-recording should be Factual

Steps 2- recording should be Timing

Steps 3- recording should be Legibility

Steps 4- recording should be Permanence

Steps 5- recording haveAccepted terminology

Steps 6- recording should have correct signature

Steps 7- recording should be Spelling

Steps 8- recording should be Accuracy

Steps 9- recording should be Sequence

Steps 10- recording should be Appropriate

Steps 11- recording should be Complete

Steps 12- recording should be Concise

Steps 13- recording should be Legal prudence

Operation Sheet 7	Standard hand washing procedure:

Steps 1- Remove jewellery.

Steps 2-Wet hands thoroughly all over.

Steps 3-use pH neutral soap.

Steps 4- lather soap all over hands.

Steps 5- rub hands together vigorously for 15-20 seconds. Pay particular attention to the fingertips, thumbs, wrists, finger webs and the backs of the hands.

Steps 6-Rinse under running water.

Steps 7-Pat hands dry with paper towels..

LAP Test	Practical Demonstration

Name: _____ Date: _____

Time started: _____ Time finished: _____

Instructions: Given necessary templates, tools and materials you are required to perform the following tasks within 8-12hours.

Task 1: perform Nursinginterventionsfor enabling and supporting hope.

Task 2: Nursing care measures aimed at patient comfort.

Task 3: perform death verification technique.

Task 4: perform body transferring technique.

Task 5: perform post-mortem room preparation procedure.

Task 6 :flow Guidelines of documentation and recording.

Task 7 :Standard hand washing procedure.

List of Reference Materials

1. http://www.who.int/cancer/palliative/definition/en/
2. http://www.who.int/cancer/media/FINAL-Palliative%20Care%20Module.pdf
3. http://www.cancer.gov/cancertopics/factsheet/support/palliative-care
4. http://en.wikipedia.org/wiki/Palliative_care
5. http://www.getpalliativecare.org/whatis
6. http://www.nlm.nih.gov/medlineplus/palliativecare.html
7. http://www.nhpco.org/i4a/pages/index.cfm?pageid=5953
8. http://www.liebertonline.com/doi/abs/10.1089/jpm.2005.8.1127
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