East Lancashire Hospitals
NHS Trust

Care after Death and Bereavement Care During COVID-19

Guidance to Aid Care

15th July 2020

Safe | Personal | Effective

Originally collated for the Northern Care Alliance NHS Group and the Association for Palliative Medicine of Great Britain and Ireland by:
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Please Note:

The COVID-19 outbreak currently being experienced around the world is unprecedented and requires everyone to work together to contribute to the health and well-being of populations as well as ensure that appropriate guidance and sharing of good practice occurs. This is essential in order to support the care of patients at the end of their lives or who are significantly unwell as the result of both COVID-19 and other possibly life-limiting illnesses.

This guidance, which is been prepared for secondary care initially and is not intended to be comprehensive, has been prepared and collated locally by the Northern Care Alliance NHS Group and the Association for Palliative Medicine of Great Britain and Ireland. While it is not nationally endorsed by the National Health Service, it may be useful to colleagues throughout the country when preparing their own guidance. This has been adapted for local use in ELHT.

This will be a 'live' document that will be updated, expanded and adapted as further contributions are received and in line with changing national guidance. The most current version of the guidance document will be available on the public-facing pages of the Association for Palliative Medicine website (https://apmonline.org/). It is advised that you always check that you are referring to the most current version. **Please do not share the guidance on social media, as it contains some information that may be distressing to the public if not presented in a sensitive way with appropriate opportunity for discussion and explanation.**

Staff should be aware that this guidance is subject to change as developments occur. Every effort will be made to keep this guidance up to date. Additional information can be found at https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response**. The Bereavement Nurse, Bereavement Care Office, Mortuary team and Coroners' Office can be contacted for additional support and guidance.**

The utmost consideration and care must be given to the safety of other patients, visitors and staff by maintaining infection control procedures at all times.

As far as is possible in such a short period of time, the information contained within this document has been checked by experts from across the palliative care profession. However, neither the Northern Care Alliance NHS Group nor the Association for Palliative Medicine of Great Britain and Ireland can accept any responsibility for errors or omissions in this document.

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****The information provided in this guidance was accurate at the time of print. As this is a developing situation, it is possible that processes could change accordingly. Please ensure you access the latest version on OLI.**

Contact Information for Trust-Wide including Community

This guidance is aimed at all professionals who provide care after death to patients who are suspected or confirmed to have died of COVID-19 and who are supporting bereaved families in ELHT

Primary Support Contacts

Bereavement Care Helpline for Families Available for bereavement support and advice for ALL families no matter what the cause of death. This service is available Monday-Friday 9am-5pm. There will be an answerphone out of hours which will allow voicemails to be left and will also have the details of the National Covid-19 helpline number	**01254 725 287** **(Ext. 85287)**
Bereavement Questions and Queries for Staff	**AskBereavement@elht.nhs.uk**
Spiritual Care Available 08.30-1600, 7 days. For out of hours, please contact switchboard and ask them to page the On-Call Chaplain	**01254 733 632** **(Ext. 83632)**
ELHT Family Liaison Service This is a dedicated phone line available 9am - 5pm Mon-Fri and 10am-4pm on Saturdays, to enable liaison between patients, hospital staff, relatives and carers. Please use this service during busy times when relatives may struggle to get through to the appropriate ward or department to find out information about their loved ones. Patients or ward staff can also use this service to get information or messages to relatives	**01254 735287** **(Ext. 85435)**
National COVID-19 Helpline **8am-8pm 7 days a week**	**0800 2600 400**
Support with Zoom / iPAD Virtual Visits Please contact the Chaplains (David/Andrew) or Out of Hours page via Switchboard	**01254 733632** **(Ext. 83632)**

Additional Contacts	
Bereavement Nurse Tina Woods	**Mon-Fri 0900-1700** 01254 832 825 (Ext.82825) Mobile - 07944 190 622 Answerphone available out of hours
Hospital Specialist Palliative Care Team	**Mon-Fri 0830-1630** 01254 732318 (Ext.82318) **Out of Hours** 07730 639 399
Community Specialist Palliative Care Team	**Mon-Fri 0900-1700** 01254 736 329 (Ext.86329) **Out of Hours** 07730 639 399
ELHT Staff Pastoral Support Line Available to offer confidential emotional support and advice to staff	**Mon-Fri 0830-1600** 01254 732 264 (Ext.82264) Answerphone available out of hours
NHS People A confidential staff support line, operated by the Samaritans and free to access You can call for support, signposting and confidential listening	**7 days, 0700-2300** 0300 131 7000 Alternatively, you can text **FRONTLINE** to 85258 for support 24/7 via text
Pendleside Hospice Family Support Team Still taking referrals for bereavement counselling but providing telephone counselling sessions rather than 1-1. **ANYONE** can call this family support team number if they are affected by Covid-19 or if they wants to access support about this	01282 440 102
Rossendale Hospice Still taking referrals for bereavement counselling but providing telephone counselling sessions rather than 1-1	01706 253 633
East Lancs Hospice Still taking referrals for bereavement counselling but providing telephone counselling sessions rather than 1-1	01254 287 000
Bereavement Midwife Kathryn Sansby	**Mon-Fri 0800-1600** 01282 804 665 (Ext.14665) 07595 090617

Background: COVID-19

Coronaviruses are mainly transmitted by large respiratory droplets and direct or indirect contact with infected secretions. They have also been detected in blood, faeces and urine and, under certain circumstances, airborne transmission is thought to have occurred from aerosolised respiratory secretions and faecal material.

As coronaviruses have a lipid envelope, a wide range of disinfectants are effective. PPE and good infection prevention and control precautions are effective at minimising risk but can never eliminate it.

As COVID-19 has only been recently identified, there is currently limited information about the precise routes of transmission. This guidance is based on knowledge gained from experience in responding to coronaviruses with significant epidemic potential such as Middle East Respiratory Syndrome Coronavirus (MERS-CoV) and Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV).

COVID-19 is classified as an airborne, high consequence infectious disease (HCID) in the UK.

Emerging information from these experiences has highlighted factors that could increase the risk of nosocomial transmission, such as delayed implementation of appropriate infection prevention and control measures combined persistence of coronavirus in the clinical setting.

How long any respiratory virus survives in the environment will depend on a number of factors, for example:

- the surface the virus is on
- whether it is exposed to sunlight
- environmental conditions such as temperature and humidity
- exposure to cleaning products

Under most circumstances, the amount of infectious virus on any contaminated surfaces is likely to have decreased significantly by 72 hours.

In the absence of effective drugs or a vaccine, control of this disease relies on the prompt identification, appropriate risk assessment, management and isolation of possible cases, and the investigation and follow up of close contacts to minimise potential onward transmission.

Effective infection prevention and control measures, including transmission-based precautions (airborne, droplet and contact precautions) with the recommended PPE are essential to minimise these risks. Appropriate cleaning and decontamination of the environment is also essential in preventing the spread of this virus.

The Guidance

It is important to remember that most people infected with COVID-19 virus have mild disease and recover. Of the laboratory confirmed patients, about:

- 80% have had mild to moderate disease
- 15% require admission to hospital for severe disease
- 5% require admission to an intensive care unit and are critically ill

Chaplaincy / Spiritual Care Teams

Spiritual care is a core element of palliative care (Weissman and Meier, 2009) and routinely provides emotional and spiritual support to patients and those close to them (Vanderwerker *et al*, 2008; Handzo *et al*, 2008; Flannelly *et al*, 2003; Fogg *et al*, 2004; Galek *et al*, 2009). Chaplains will regularly be involved in the support of patients' families pre-bereavement and in many instances will play a significant role in bereavement care, including the conduct of patients' funerals and the organisation and conduct of memorial services and related events. As members of the multi-disciplinary team chaplains will often be responsible for supporting staff, especially in difficult circumstances.

The individual needs of the patients, relatives, carers and members of staff should be fully assessed as part of a Spiritual Needs Assessment to take into consideration their religious, spiritual and cultural requirements. This will ensure that the safety of staff and patients is maintained and will enable a full risk assessment to be undertaken before each visit.

Chaplaincy teams should continue to work alongside relevant clinical staff, Specialist Bereavement Nurse, Specialist Palliative Care Team, Equality and Inclusion Leads and to liaise with community partners to provide faith-related advice and resources around end of life issues, death and bereavement.

Advance Care Directives (Living Wills) for Staff Information

A patient's advance decision to refuse treatment lets the healthcare team know of their wishes if they are not able to communicate them.

What is an advance decision?

An advance decision (sometimes known as an advance decision to refuse treatment, an ADRT, or a living will) is a decision that someone can make now to refuse a specific type of treatment at some time in the future.

It lets family, carers and health professionals know the person's wishes about refusing treatment if they're unable to make or communicate those decisions themselves.

The treatments that the person is deciding to refuse must all be named in the advance decision.

The person may want to refuse a treatment in some situations, but not others. If this is the case, they need to be clear about all the circumstances in which they want to refuse this treatment. An advance decision is not the same as an advance statement. For more information visit - https://www.nhs.uk/conditions/end-of-life-care/advance-decision-to-refuse-treatment/

Spiritual Care - COVID-19 Outbreak

ALL ROUTINE VISITS SUSPENDED

If Religious, spiritual or cultural needs are identified, a response is required from the Chaplaincy Team. Chaplaincy & Spiritual Care support accessed via normal routes: -

Urgent / Out of Hours – Ring Switchboard

Non Urgent – Tel: 83632

Chaplain to contact clinical staff to confirm COVID-19 status and response required

No COVID-19 Suspected

New / Ongoing / Urgent Support

Triaged and reviewed in partnership with ward / unit / IC staff

Spiritual Needs Assessment completed

Consider appropriate and safe response:

- Is telephone / Skype / Face Time response possible?
- What infection control measures are necessary?
- Is generic of faith specific response required?
- Is urgent response required?

Urgent / EOL	**Non-Urgent**
Visit and respond as agreed with clinical staff	Arrange appropriate response; consider telephone contact or ward visit

Confirmed/Suspected COVID-19

New / Ongoing / Urgent Support

Triaged and reviewed in partnership with ward / unit / IC staff

Spiritual Needs Assessment completed

Consider appropriate and safe response:

- Is telephone / Skype / Face Time response possible?
- Discuss infection control measures and requirements
- Is generic of faith specific response required?
- Is urgent response required?

Urgent / EOL	**Non-Urgent**
If visit agreed as urgent and necessary, appropriately trained staff should utilise PPE. **OR** Prayer sheet for staff to use with patient if available	Spiritual care support pack issued to patient. Visit not appropriate unless urgent. Utilise remote support options – **See Appendix 1**

- The individual needs of the patients, relatives, carers and members of staff will be appropriately assessed as part of a Spiritual Needs Assessment to take into consideration their religious, spiritual, pastoral and cultural wishes.
- An initial risk assessment will be undertaken with a review before each subsequent visit.
- Chaplaincy teams to work alongside relevant clinical staff, Specialist Bereavement Nurses, Equality and Inclusion Leads and to liaise with community partners to provide faith related advice and resources around end of life issues, death and bereavement.

Visiting Patients in the Last Days of Life - COVID-19 Outbreak

The public will be asked to limit visiting patients in hospital and to consider other ways of keeping in touch with those close to them, through phone calls and using facilities such as text, FaceTime and WhatsApp. All patients are now able to make FREE phone calls via their bedside phones.

Visitors in clinical areas must be immediate family members or carers.

General Principles

Members of the public should not attend any health or care setting if they:

are unwell, especially with a high temperature or a new persistent cough

vulnerable as a result of medication, have a chronic illness or are over 70 years of age

all visitors should be advised of, and adhere to, local and national guidance regarding handwashing and use of alcohol hand gel when visiting patients

Negative COVID-19 Patients

End of life visiting and care continues as normal practice, this includes the performance of mementos in care after death)

Consideration regarding the number of visitors at the bedside at any one time should be guided by the individual situation, the facility and appropriate risk assessments

The number of visitors at the bedside is limited to one close family contact or somebody important to the dying person. However, where it is possible to maintain social distancing throughout the visit, a second additional visitor (including a child) could be permitted.

Suspected or Confirmed COVID-19 Patients

Visitors will wear PPE in the same way as the staff caring for the patient

The number of visitors at the bedside is limited to one close family contact or somebody important to the dying person. However, where it is possible to maintain social distancing throughout the visit, a second additional visitor (including a child) could be permitted. Visits to Critical Care will be coordinated by senior staff on the department and will be facilitated following a robust risk assessment.

There should be no time limit on how long visitors can stay with a patient and relatives can, if they wish to do so, be involved in providing care

For all other care after death guidance please refer to the appropriate flowchart

For guidance on visiting for Maternity, Paediatrics, NICU and Patients with Learning Disabilities please see the guidance here

A clinical guide for supporting compassionate visiting arrangements for those receiving care at the end of life can be found here

Essential visitors are parents or carers of a paediatric patient, or an affected patient's main carer. Visiting should also be restricted to those assessed as able to wear PPE. Visitors should be permitted only after completion of a local risk assessment which includes safeguarding criteria as well as the infection risks.

Visitors should be advised not to go to any other departments or locations within the hospital or healthcare facility after visiting.

The risk assessment must assess the risk of onward infection from the visitor to healthcare staff, or from the patient to the visitors. The risk assessment should include whether it would be feasible for the visitor to learn the correct usage of PPE (donning and doffing under supervision) and should determine whether a visitor, even if asymptomatic, may themselves be a potential infection risk when entering or exiting the unit.

This must be clear, documented and reviewed.

Important Considerations for Care Immediately Before and After Death - COVID-19 Outbreak

THIS ADVICE IS FOR CASES WHERE A COVID-19 IS SUSPECTED OR CONFIRMED

The utmost consideration and care must be given to the safety of other patients, visitors and staff by maintaining infection control procedures at all times. The Specialist Bereavement Nurse, Bereavement Office, Mortuary team and Coroners Office can be contacted for additional support and guidance.

ALWAYS

1. Ensure clear and complete documentation
2. Provide open, honest and clear communications with colleagues and the deceased's family / significant others
3. Be considerate of emotional/spiritual/religious needs of the deceased's family / significant others

Before Death

1. Decisions regarding escalation of treatment made on a case-by-case basis
2. If death is imminent and family wish to stay with their loved one, staff must advise them that they should wear full PPE
3. Faith death – discuss with Chaplaincy Team for information

At the Time of Death

1. Inform and support family and / or next of kin
2. Appropriately trained professional completes Verification of Death process wearing required PPE and maintaining infection control measures
3. Appropriate doctor to complete MCCD as soon as possible

- COVID-19 is an acceptable direct or underlying cause of death for the purposes of completing the Medical Certificate of Cause of Death
- COVID-19 is not a reason on its own to refer a death to a coroner under the Coroners and Justice Act 2009
- COVID-19 is a notifiable disease under the Health Protection (Notification) Regulations 2010 – this does not mean referral to a coroner is required by virtue of its notifiable status
- If the deceased is to be cremated, doctors will not be able to physically see the deceased due to risk. There is now no need for a second confirmatory medical certificate for a cremation to take place (see appendix 1)
- Documents to certify the death can now be presented electronically rather in person https://nafd.org.uk/2020/03/27/changes-to-cremation-forms-information-from-the-ministry-of-justice/person. These changes apply to all deaths not just COVID-19 related deaths
- If referral to HM Coroner is required for another reason, a telephone conversation should take place as soon as possible with HM Coroner's Office and guidelines within Care after Death policy should be followed alongside this guidance

THIS ADVICE IS FOR CASES WHERE A COVID-19 IS SUSPECTED OR CONFIRMED

If the patient has been tested and you are awaiting results, treat as high risk during care after death

ALWAYS

1. Ensure clear and complete documentation
2. Provide open, honest and clear communications with colleagues and the deceased's family / significant others
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Care after Death

1. Mementoes (e.g. locks of hair) should be offered and taken at the time of care after death. These cannot be offered or undertaken at a later date. Mementoes in care after death can be provided on the ward. Mementoes should be placed in a sealed bag and the relatives must not open these bags for 7 days

2. Full PPE should be worn for performing physical care after death. Refer to current PPE guidance via OLI

3. Moving a recently deceased patient onto a hospital trolley for transportation to the mortuary might be sufficient to expel small amounts of air from the lungs and thereby present a minor risk. A body bag/envelope should be used for transferring the body and those handling the body at this point should use full PPE (see above). Place the patient in a sheet before placing in the body bag. For patients who are wrapped in a sheet and placed in a body bag/envelope there should not be a need for transfer personnel to wear PPE. If the bag is cleaned on the outside and wrapped then it is safe.

4. Registered nurses on ward to complete electronic Notification of Death forms fully including details of COVID-19 status and place in pocket on body bag along with body bag form, ID band with patient demographics placed through loops in body bag zip, body bag wiped over with, for example Antichlor, and arrange transfer to mortuary

5. The deceased's property should be handled with care as per policy by staff using PPE and items that can be safely wiped down such as jewellery should be cleaned with, for example, Antichlor. Clothing, blankets, etc., should ideally be disposed of. Any hospital linen should be treated as per ELHT policy.
   Patient valuables, for example jewellery, should be doubled bagged in appropriate clear plastic bags, sealed and secured and cleaned with Antichlor with the items visible. The bag should be identifiable to the patient.
   All patient property, for example clothes or personal possessions AND patient valuables, including cash and jewellery which have been accumulated on the ward during the patient's stay in hospital, should go to the MORTUARY where they will be collected by the Undertaker for return to the patient's family. The family should be advised not to open the property for a period of 7 days. The night safe is currently NOT available for use and is sealed.

6. Consider bereavement support for the family and all carers of any confirmed or suspected Covid-19 deaths and refer to the bereavement nurse

7. **Organ / tissue donation is highly unlikely to be an option as per any other active systemic viral infection**

Mortuary Transfer and Care - COVID-19 Outbreak

THIS ADVICE IS FOR CASES WHERE A COVID-19 IS SUSPECTED OR CONFIRMED

If the patient has been tested and you are awaiting results, treat as high risk during care after death

ALWAYS

1. Ensure clear and complete documentation
2. Provide open, honest and clear communications with colleagues and the deceased's family / significant others
3. Be considerate of emotional/spiritual/religious needs of the deceased's family / significant others

Mortuary Transfer and Care

1. Transfer personnel will not need to wear PPE if previous guidance is followed. The normal process for transfer to the mortuary should be adhered to

2. Follow usual booking-in procedures at the Mortuary

3. The trolley used to transfer the deceased to the mortuary and the electric trolley used in the mortuary must both be cleaned with, for example, Antichlor on receipt of the deceased

4. If a pacemaker or defibrillator is in situ, arrangements can be made for a COVID-19 positive patient to have this removed. This is normally undertaken by the funeral director but if necessary can be facilitated by the mortuary staff

5. No visits to reduce any risk to staff and family

6. Mortuary Technicians to do checks on the name tags on body bag tag, body bag **NOT** to be opened

7. On release of the deceased, Funeral Director to bring coffin into Mortuary, deceased to be placed into coffin and coffin sealed and cleaned prior to being placed in Funeral Director's transport

8. The trolley and fridge tray that the deceased has been on must be cleaned after release to funeral directors with, for example, Antichlor

9. **If a post mortem examination is required, staff to follow Royal College of Pathologists guidelines** *(Osborn et al, 2020)*

Registering a Death - COVID-19 Outbreak

THIS ADVICE IS FOR CASES WHERE A COVID-19 IS SUSPECTED OR CONFIRMED

ALWAYS

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2. Provide open, honest and clear communications with colleagues and the deceased's family / significant others
3. Be considerate of emotional/spiritual/religious needs of the deceased's family / significant others

Registering a Death

1. The new Coronavirus (Emergency) Act 2020, which forms part of the UK Government's response to managing the Covid-19 pandemic, has now passed through Parliament. The provisions within the Act relating to death registration have now been commenced.

2. The emergency provisions allows for the electronic transfer of documents relating to the death certification and registration process and allows the MCCD to be scanned and emailed directly to the registrar rather than issuing it to relatives.

3. From 31st March 2020 both the Blackburn and Lancashire Registration Services will cease face to face registrations and will be registering all deaths by telephone.
   Therefore MCCD's should no longer be given to families but scanned and emailed directly to the Registration Office, so that the death can be registered by telephone and the funeral then take place. There will be no need for the family to make an appointment with the Registration Office as registrars will contact them on receipt of the MCCD and contact details to arrange a time for the registration to take place.

4. Funeral directors are an addition to the existing list of qualified informants rather than a replacement; family members are still allowed (and may be preferred).
   Where the deceased's NOK or a possible informant are following self-isolation procedures, ill or unavailable, a funeral director can act as informant on behalf of the family.

5. The provisions also allow for the electronic transfer of documents relating to the certification and registration process (e.g. transfer of the MCCD from the medical practitioner to the registrar and the form for burial or cremation (the Green), from the registrar to the relevant authority).

USEFUL CONTACT INFORMATION AND RESOURCES

Public Health England - https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response
Public Health Wales - https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/
Health Protection Scotland - https://www.hps.scot.nhs.uk/a-to-z-of-topics/covid-19/
HSC Public Health Agency Northern Ireland - https://www.publichealth.hscni.net/news/covid-19-coronavirus
Public health declaration of Covid-19 as a notifiable disease - https://www.legislation.gov.uk/nisr/2020/23/made
Mental capacity legislation - www.legislation.gov.uk/nisr/2019/190/pdfs/nisr_20190190_en.pdf

Community Care after Death Policy - Covid-19 Outbreak

THIS ADVICE IS FOR CASES WHERE A COVID-19 IS SUSPECTED OR CONFIRMED

If the patient has been tested and you are awaiting results, treat as high risk during care after death

ALWAYS

1. Ensure clear and complete documentation
2. Provide open, honest and clear communications with colleagues and the deceased's family / significant others
3. Be considerate of emotional/spiritual/religious needs of the deceased's family / significant others

Community Care after Death

1. Those handling bodies should be aware that there is likely to be a continuing risk of infection from body fluids where coronavirus infection is confirmed or suspected.

2. Any equipment used in the Verification of Death process should be either disposed of or fully decontaminated with Sani AF wipes (order code VJT 640). Full PPE should be worn for performing physical care after death.

3. If someone has died within a care setting the deceased's property must be handled with care as per policy. All staff should wear PPE. Items that can be safely wiped down such as jewellery should be cleaned with Sani AF wipes and securely bagged before returning to families.

4. Clothing, blankets etc. should ideally be disposed of or treated as per local policy. If they must be returned to families they should be double bagged and securely tied and families informed of the risks. Mementoes/keepsakes e.g. locks of hair etc. must be offered and obtained during physical care after death by person/s wearing full PPE, as they will not be able to be offered at a later date. They should be placed in a sealed plastic bag and families advised to NOT open for 7 days.

5. Ensure that anyone involved in moving the body is aware of confirmed or suspected COVID-19. If the deceased is being care for by the District Nurse team – please contact them. If Out of Hours please contact the Out of Hours District Nurse Team. From 16:30 pm weekdays until 7:30 am, weekends and BH's, patients wanting to get through to district nurses should call the out of hours number - 01282 805958. At 21:45 each night the telephones in the district nursing hub are forwarded to the night's duty mobile phone. The number for the night duty mobile which is 07984600288

6. Consider bereavement support for the family and/or carers of any confirmed or suspected COVID-19 deaths and refer on as appropriate – link in with ELHT Bereavement support pathway

7. Please contact the nominated Funeral director & ensure to advice re. the deceased COVID status.

Looking After Yourself and Colleagues

In order to care effectively for our patients and their families, we must care for the physical, social, psychological and spiritual needs of our colleagues and ourselves. Firstly, we need to recognise our own vulnerabilities and the effect of our emotions upon our behaviours. It is important to develop within our team safe spaces, psychologically and physically, to talk about these and the effect upon our wellbeing. We must develop mindful and deliberate compassion towards each other which involves noticing and being present in each other's suffering as well as creating flexible time to cope with suffering, buffering each other from overload as outlined in the GMC document, "Caring for doctors, Caring for patients". https://www.gmc-uk.org/-/media/documents/caring-for-doctors-caring-for-patients_pdf-80706341.pdf

We all will have anxieties, we will feel the burden of risk, we will be faced with suffering and death and at times will be limited in what we are able to do. We will feel tired and overwhelmed. We will not be failing our patients or our teams by feeling these things.

We will need to come alongside each other in our daily teams, or virtually, to identify with others who will be feeling the same. At times we will be able to be steady and calm in the face of the great suffering. At times we will seek this compassion from others. It is a time to show we value each other and confer dignity to each other. We need to be reaching out and establishing these networks of support now. Start by asking someone you work with how they really are.

Staff Support Line

In the current climate of increasing pressures on our healthcare system, it has been acknowledge that we are facing significant stresses. This is on both a personal and professional level.

In response, NHS People have introduced a confidential staff support line, operated by the Samaritans and free to access from 7.00 am – 11.00 pm, seven days a week.

You can call for support, signposting and confidential listening: **0300 131 7000**. Alternatively, you can text **FRONTLINE** to **85258** for support 24/7 via text.

Pastoral Support Line and 'Oasis'

A phone line has been established in order to offer pastoral support to staff members. The purpose of this is to offer emotional support, a listening ear, and to signpost people to additional support/advice as and when necessary. The line will be staffed by the Spiritual Care Team and others external to the Trust. It will be confidential.

The phone line will be available between 8.30am and 4.00pm. A voicemail facility is provided for out-of-hours messages, which will be responded to the next day by a member of the Pastoral Support Team.

The Spiritual Care Team are also providing a much needed 'Oasis' at RBTH within the Spiritual Care Centre. Here staff can take time out and reflect away from the clinical area. We are also looking at providing this facility across other sites. This is available for ALL staff to use and is available 24/7.

Discussion of Unwelcome News during Covid-19 Pandemic: A framework for health and social care professionals

The Real Talk Framework: An Overview

PREPARE YOURSELF

1. Clarify in your own mind the purpose of the conversation you are about to have:
   - What do you need to find out from the other person?
   - What new understanding do you need the other person to reach?

2. Know that you are doing this from a place of compassion
   - Remember the skills you already have
   - Remember that bad news is not your fault
   - Remember that your feelings are important and valid

FIND OUT ABOUT THE PERSON YOU ARE TALKING TO

3. First, find out who you are talking to and (if it's a phone call) where they are. Is it safe for them to talk?
   - Make sure they are not driving; not cooking/supervising bathing children/etc.

4. Tell them the name of the person you are talking/calling about, and ask their relationship to that person (check you are speaking to the right family).

5. Find out what the person you are talking to already knows and/or expects, and how they feel about that.
   - Listen for what they understand; for worries and concerns; for gaps in their understanding. Notice the words they use: check you understand what they mean if they use medical words, they may be repeating something they were told but didn't fully understand.
   - Use silence to encourage them to talk to you.
   - If they stray off the subject, interrupt to bring them back. 'You were telling me about X's heart problems/chest trouble/etc.'

6. Summarise what the person has told you.
   - 'You've told me you know that you have/X has problems with heart trouble/breathlessness/being forgetful…'

7. Because you are asking the person about their situation, if it's a phone call it would work to ask here if they have someone with them (whereas if you ask this at the very beginning, this could be heard very early as bad news) – many self-isolating people may, however, be alone.

BRING THE PERSON TOWARDS AN UNDERSTANDING OF THE SITUATION

8. Describe some of the things that are wrong with the unwell person, in such a way that you are forecasting that a discussion of bad news is going to come
   - 'You told me you already know you have/X has problems with ……. (try to use their words). Over the last few hours/today things have become more difficult because…'
   - Summarise the new developments, checking for understanding.
   - Ask whether they have any questions. Many people will ask 'So are you telling me that things are getting worse?' or similar.

9. Prepare them to hear bad news by expressing your compassion
   - I am so sorry.../ I wish this weren't the case but.../ I'm sorry to have bad news for you…
   - If they interrupt to ask questions, let them do so but don't deflect the conversation from the news to be discussed.
   - 'We can talk about that question later, but first I have to tell you what's happening here at the moment…'

10. Tell them **clearly** what you know and/or expect to happen.
    - Keep the message simple and clear: use non-medical words. Pause to let them take in each part of your message.
    - 'X's lungs are getting worse. It looks unlikely that s/he will survive…' 'I'm talking to you now because we think X is likely to die.' 'We are concerned that he is getting worse and we may not be able to save his life.'
    - Communicate that somebody is so sick that death is a possibility or is very likely or is imminent; even without d-words this can be made unambiguous.
    - 'In normal times, we would use a ventilator for X, but at the moment we can't offer that. They are all in use. I am so sorry.'
    - 'Since someone last updated you, X has become very much less well…' 'I am so sorry to tell you that X died a few minutes ago…'

11. Wait and allow silence after giving the information.

CLOSURE

12. If possible, try to deliver something that is something of comfort if you can say it truthfully
    - 'Although your family couldn't be here, your Mum was talking about you while she was awake and she slipped into a coma before she died.'
    - 'Your brother is breathless but calm, and he understands what is happening. I'll keep you up to date if anything changes.'
    - 'I'm so sorry you can't be with X, but we will arrange a video call for you later today.'

13. Express compassion again
    - I am very sorry… We all send our condolences… I am sorry to leave you with that awful news…

14. Discuss future arrangements
    - Who will call them, what happens next, advice on who they can call for support, encourage them to seek help.
    - This will vary according to conversation
    - When informing of a death, death cert info will need to be included at the end of the call, and how to contact the department that deals with death certificates, return of property etc.

15. Goodbyes
    - Help to orientate the person to their next steps. What are they going to do now? Do they have anyone to talk to? Are there people they need to inform? Who will help them to do this?
    - Remind them of your name, and say goodbye.
    - Stand up and leave the room, or hang up the phone...

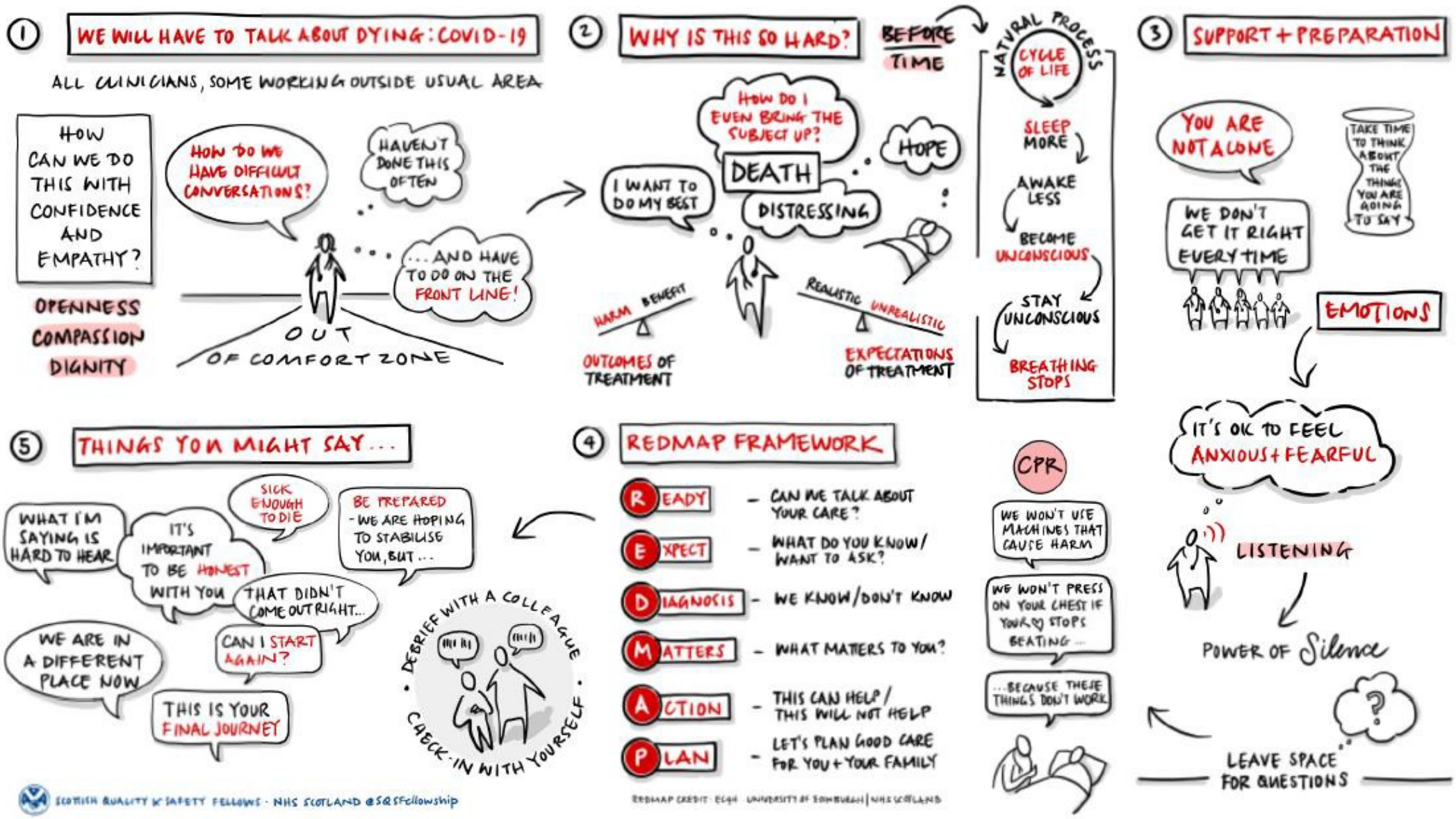
16. After the conversation
    - Write the conversation up straight away. The next person to call will need to build on the conversation you have just finished.
    - If the conversation causes you distress, there should be time for you to take a break afterwards; someone in your organisation designated to listen if you wish to talk; regular supervision sessions for you to debrief and reflect.

Telephone Call Checklist

Framework:	Remember:	Notes:
PREPARE YOURSELF	Clarify in your own mind the purpose of the conversation you are about to have: • What do you need to find out from the other person? • What new understanding do you need the other person to reach? Know that you are doing this from a place of compassion	
FIND OUT ABOUT THE PERSON YOU ARE TALKING TO	Find out who you are talking to and (if it's a phone call) where they are. Is it safe for them to talk? Tell them the name of the person you are talking/ calling about, and ask their relationship to that person (check you are speaking to the right family). Find out what the person you are talking to already knows and/or expects, and how they feel about that. Summarise what the person has told you. Are they alone? Is someone else around to support them? (This will probably suggest bad news is coming)	
BRING THE PERSON TOWARDS AN UNDERSTANDING OF THE SITUATION	Describe some of the things that are wrong with the unwell person, in such a way that you are forecasting that a discussion of bad news is going to come Summarise the new developments, checking for understanding. Ask whether they have any questions. Prepare them to hear bad news by expressing your compassion	

	Tell them **clearly** what you know and/or expect to happen Keep the message simple and clear: use non-medical words. Pause to let them take in each part of your message. Wait and allow silence after giving the information.	
CLOSURE	If possible, try to deliver something that is something of comfort if you can say it truthfully Express compassion again Discuss future arrangements FU phone call? Messages to pass to patient? Death Certificate & belongings Goodbyes Help to orientate the person to their next steps. What are they going to do now? Do they have anyone to talk to? Are there people they need to inform? Who will help them to do this? Remind them of your name, and say goodbye Write the conversation up straight away. The next person to call will need to build on the conversation you have just finished.	
SELF CARE	If the conversation causes you distress, there should be time for you to take a break afterwards; someone in your organisation designated to listen if you wish to talk; regular supervision sessions for you to debrief and reflect.	


PREPARE
clarify purpose
from a place of COMPASSION
Consider the ending and further support
comfortable
undisturbed
BEGIN
Hello... my name is...
outline – update? decision?
speak slowly
attend to tone of voice
FIND OUT
WHO ?
What do they know, expect, feel?
With someone?
PROGRESS
to a new understanding
NORMALLY?
TODAY
EXPLAIN
•What is happening?
•What is expected to happen?
We're so sorry
She is dying
LISTEN
ACKNOWLEDGE
signs of distress
silence
pauses
voice change
FINISH
Are there things we haven't covered?
What's important?
Words of comfort and truth
We will care for her
She is comfortable
WHO ELSE ? needs to know
•What next
•Who can support
•Where to find information
AFTER
DEBRIEF
How do you feel?
It's OK not to be OK:
REFLECT
I am confident that...
We have a shared understanding of what's important
We're focusing on the right things
We know what we need and what we need to do.
DISCUSSING UNWELCOME NEWS ~ COVID19
A FRAMEWORK FOR COMMUNICATION
Real Talk ~ sketchnote @saskie_dorman


1
WE WILL HAVE TO TALK ABOUT DYING: COVID-19
ALL CLINICIANS, SOME WORKING OUTSIDE USUAL AREA
HOW CAN WE DO THIS WITH CONFIDENCE AND EMPATHY?
OPENNESS
COMPASSION
DIGNITY
HOW DO WE HAVE DIFFICULT CONVERSATIONS?
HAVEN'T DONE THIS OFTEN
...AND HAVE TO DO ON THE FRONT LINE!
OUT OF COMFORT ZONE
2
WHY IS THIS SO HARD?
HOW DO I EVEN BRING THE SUBJECT UP?
DEATH
DISTRESSING
HOPE
I WANT TO DO MY BEST
HARM
BENEFIT
OUTCOMES OF TREATMENT
REALISTIC
UNREALISTIC
EXPECTATIONS OF TREATMENT
BEFORE TIME
NATURAL PROCESS
CYCLE OF LIFE
SLEEP MORE
AWAKE LESS
BECOME UNCONSCIOUS
STAY UNCONSCIOUS
BREATHING STOPS
3
SUPPORT + PREPARATION
YOU ARE NOT ALONE
TAKE TIME TO THINK ABOUT THE THINGS YOU ARE GOING TO SAY
WE DON'T GET IT RIGHT EVERY TIME
EMOTIONS
IT'S OK TO FEEL ANXIOUS + FEARFUL
LISTENING
POWER OF Silence
LEAVE SPACE FOR QUESTIONS
4
REDMAP FRAMEWORK
READY - CAN WE TALK ABOUT YOUR CARE?
EXPECT - WHAT DO YOU KNOW/ WANT TO ASK?
DIAGNOSIS - WE KNOW/DON'T KNOW
MATTERS - WHAT MATTERS TO YOU?
ACTION - THIS CAN HELP / THIS WILL NOT HELP
PLAN - LET'S PLAN GOOD CARE FOR YOU + YOUR FAMILY
REDMAP CREDIT · ECAH · UNIVERSITY OF EDINBURGH | NHS SCOTLAND
CPR
WE WON'T USE MACHINES THAT CAUSE HARM
WE WON'T PRESS ON YOUR CHEST IF YOUR ♡ STOPS BEATING ...
...BECAUSE THESE THINGS DON'T WORK
5
THINGS YOU MIGHT SAY...
WHAT I'M SAYING IS HARD TO HEAR
IT'S IMPORTANT TO BE HONEST WITH YOU
SICK ENOUGH TO DIE
BE PREPARED - WE ARE HOPING TO STABILISE YOU, BUT...
THAT DIDN'T COME OUT RIGHT...
CAN I START AGAIN?
WE ARE IN A DIFFERENT PLACE NOW
THIS IS YOUR FINAL JOURNEY
DEBRIEF WITH A COLLEAGUE
CHECK-IN WITH YOURSELF
SCOTTISH QUALITY & SAFETY FELLOWS · NHS SCOTLAND @SQSFellowship

Supporting Families Unable to Be With Their Loved Ones

When supporting families who are unable to be with their loved ones in the last days of life due to Covid-19, these are a few points to consider from David one of our chaplains.

Via phone:

- Families often think that their loved ones will die alone. Reassure them that we are here and we are caring for them and talking to them.

- Assure the family that their loved one is peaceful, if you are able to. That they are in a peaceful environment, they have clean sheets and are being well cared for.

- Assure them that we are doing our very best to manage their symptoms, for example pain or breathlessness.

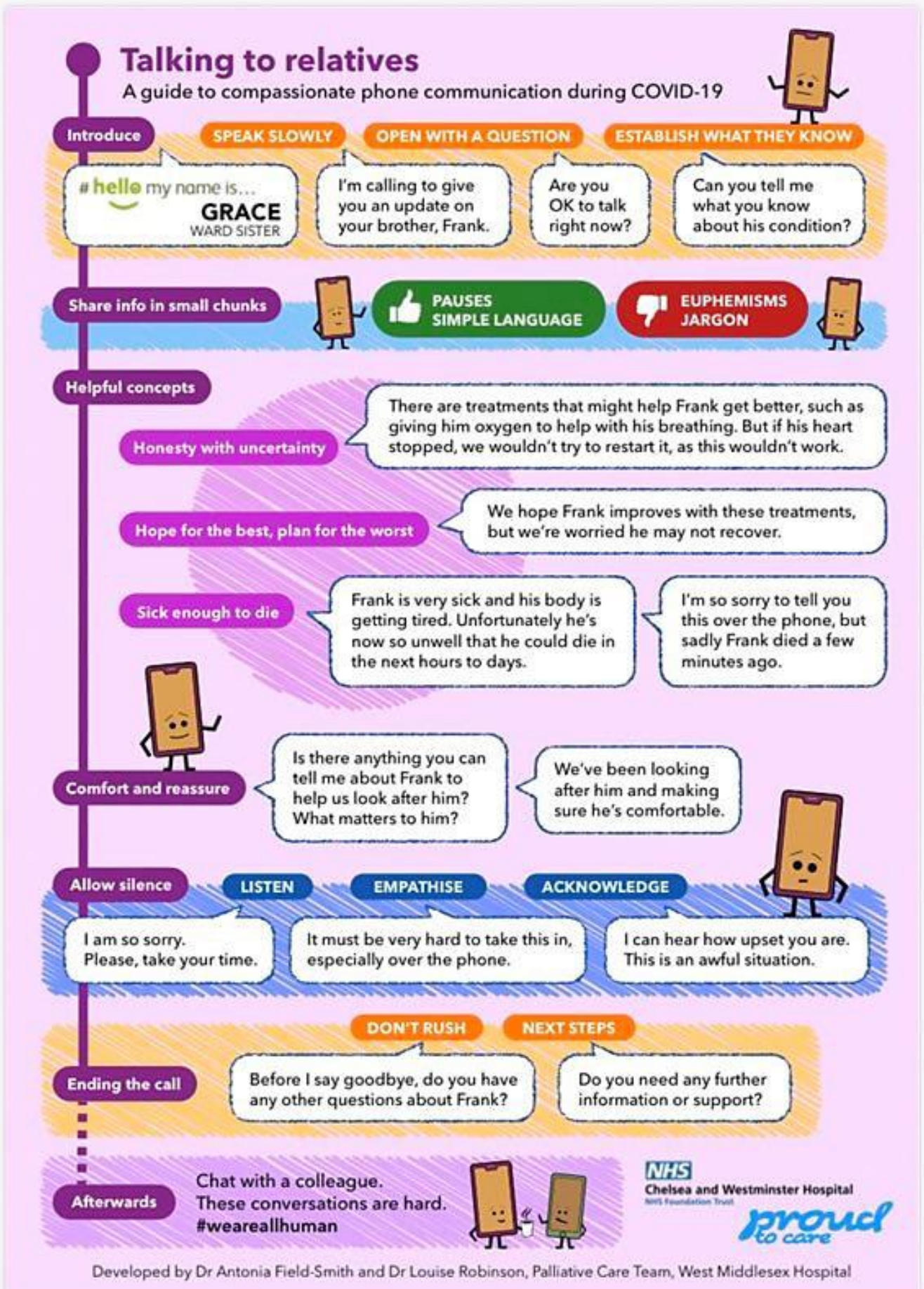
- Ask them if they would like us to say anything to their loved one on their behalf. This can be emotional but it can bring great comfort. Of course if we promise to do this, we must keep that promise no matter what we think about their medical condition.

- Ask the family if they would like their loved one to have a blessing or a prayer from one of the chaplains. If so, page them via the switchboard.

- Acknowledge that this is really painful for them and awful. Reassure them that you will do everything you are able to care for their loved one while you are with them.

- Make sure you tell them your first name at the start of the conversation but also at the end.

Talking to Relatives



British Islamic Medical Association (BIMA) guidance on the performance of ghusl for deceased persons with suspected or confirmed COVID-19

There is significant confusion around the issue of ghusl for deceased COVID patients. While it is understood that ghusl is the normative obligation for any deceased Muslim according to an overwhelming body of scholarly opinion, a range of theological views have come out both advocating for and against ghusl during the current COVID-19 pandemic. The aim of this information leaflet is to highlight the medical considerations that should help inform decision making for those responsible for administering religious burials for deceased Muslims.

Q1. Why is this a concern when Public Health England (PHE) states that washing and handling a deceased COVID-19 body is low risk?

A. With a lot of misinformation and public anxiety prevalent, and a range of practice across different countries[1-6], we consider it is necessary to elaborate on the practical considerations and specifics of ghusl practice to ensure it can safely be carried out during this pandemic. This guidance is drawn up in consultation with relevant specialists.

Q2. If the risk of contracting COVID-19 from a deceased body is low, then what is the problem?

A. While there is currently no evidence to suggest that the risk is significant, please bear in mind that low risk is not the same as no risk and so it is important to take adequate precautions when carrying out a ghusl. [7]

Q3. Where does the risk of contracting COVID-19 from a deceased body come from?

A. There is a small risk of contracting the infection from infected droplets or fomites (e.g. hair or clothes) on the body and possibly from bodily fluids from the mouth, eyes, and back passage.[8] Spread via faecal transmission is something that also may be possible in a ghusl setting.[9]

Q4. What actions would increase the risk of transmission when performing a make a ghusl?

A. Any actions that lead to an aerosol spray or splash such as the use of an istinja/ shower spray or unnecessarily vigorous manipulation of the body.[10] In such cases, the ghusl becomes high risk and we advise not to proceed.

Q5. What facilities are needed to make a ghusl location safe?

A. A room with good ventilation[11] that can be washed down & disinfected thoroughly after each usage.

Q6. What personal protective equipment (PPE) is needed per person for handling a body?

A. PPE required are full sleeve plastic gown, gloves, fluid resistant surgical mask and visor.[12] If body isn't exposed to human contact after ghusl (e.g. in a body bag covered by a shroud) then PPE may not be necessary at burial site.

Q7. What training is needed to wear Personal Protective Equipment?

A. Without proper training in putting on and removing PPE, the performer of ghusl puts themselves at risk of infection.[13] Ideally a PPE trainer should train volunteers in each masjid/ locality/ funeral setting.

Q8. There is a worldwide shortage of PPE. What if we are unable to source enough?

A. This is an ongoing issue, but may be overcome through some forward planning. Local Resilience Forums and local authorities should be able to advise on the availability of PPE in each locality. Depending on availability as the pandemic progresses there needs to be consideration given to where PPE distribution should be prioritised across our communities – for example for use by frontline medical staff dealing with potentially infected patients.[14]

Q9. Who are high risk individuals that should not be involved in ghusl or handling body?

A. Anyone over the age of 70 or with a significant condition[15] as listed on the nhs.uk website.[16] Therefore, local masaajid and funeral directors should begin training volunteers on how to perform ghusl, and how to correctly don and doff PPE.

Q10. If mitigation efforts are not possible, what is the MEDICAL advice?

A. The medical advice is that if despite all possible efforts, you are not able to mitigate the risks – then alternative methods should be sought according to your local scholars. Any questions, please email covid@britishima.org
This guidance is an aide. All communities are advised to contact local specialists for context specific advice.

References for the points made in the guidance document:

1. bit.ly/2Urc012
2. wapo.st/39ot5gg
3. bit.ly/3bzHCHj
4. bit.ly/3bB4Nkz
5. bit.ly/3bwYuQU
6. bit.ly/2QWGkvn
7. bit.ly/2ImIuHu
8. bit.ly/2Ustqu3
9. bit.ly/2Im6ci7
10. bit.ly/2Uvvhyu
11. bit.ly/2wLI78c
12. bit.ly/39uYopR
13. bit.ly/2UsNvRZ
14. bit.ly/2WPGw6p
15. bit.ly/2WUIt1e
16. bit.ly/2ULJCp9

BRITISH ISLAMIC MEDICAL ASSOCIATION

Resources

Resources for looking after ourselves and each other during this very difficult time:

UK: Support with mental wellbeing, finance, housing and unemployment https://www.mentalhealth.org.uk/coronavirus

England: NHS Practitioner Health https://www.practitionerhealth.nhs.uk/covid-19-workforce-wellbeing

Northern Ireland: www.nidirect.gov.uk

Scotland: Section on Mental Wellbeing: https://www.nhsinform.scot/illnesses-and-conditions/infections-and-poisoning/coronavirus-covid-19

Wales
For doctors in training: Professional Support Unit HEIW.ProfessionalSupport@wales.nhs.uk
For all doctors: Health for Health Professionals www.hhpwales.co.uk
RCN – COVID and your mental wellbeing https://www.rcn.org.uk/get-help/member-support-services/counselling-service/covid-19-and-your-mental-wellbeing

These websites provide professionals with direct links to health, wellbeing and other referral sites for doctors in need.

A collaborative guide to COVID-19 care - https://covid-at-home.info/

BMA Wellbeing support services - Open to all doctors whether BMA (British Medical Association) members or not and is staffed by professional telephone counsellors 24 hours a day, 7 days a week. They are all members of the British Association for Counselling and Psychotherapy and are bound by strict codes of confidentiality and ethical practice. You can even choose to remain anonymous when you call.

COVID CRUSE - Grief and Trauma - https://www.cruse.org.uk/coronavirus/trauma

BMJ - Managing mental health challenges faced by healthcare workers during covid-19 pandemic BMJ 2020;368:m1211 https://www.bmj.com/content/368/bmj.m1211

DocHealth - A self-referral service available to all doctors, UK wide, and aims to provide confidential, specialist-led support for those suffering with stress-related depression or anxiety. The programme will initially run as a 24-month pilot, and aims to complement existing support services such as BMA Counselling and the Doctor Advisor Service. It is a joint venture from the RMBF and BMA. DocHealth is exclusively self-referral, with no report writing unless specifically requested by the doctor using the service. Fees are based on a sliding scale relating to the grade and circumstances of the doctor.

Doctors Support Network - A self-help group for doctors with mental health concerns, including stress, burnout, anxiety, depression, bipolar affective disorder, psychoses and eating disorders. All doctors in the group have been troubled at some stage in their lives. There are regular meetings around the UK, a newsletter and an email forum.

GMC (General Medical Council) online guide 'Your health matters' - Provides the first step in this support, helping to provide timely information for doctors who may for health reasons be

involved in the GMC's fitness to practise procedures. The content was written with the help of Practitioner Health Programme, the Doctors' Support Network and the British Medical Association.

National example of GP Surgery Bereavement leaflet - https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2020/03/NHS-Bereavement-Leaflet.pdf

NHS England and NHS England Education - Support pack for conversations about Unwelcome News and COVID-19 https://portal.e-lfh.org.uk/Component/Details/605650

Practitioner Performance Advice (formerly NCAS) - Allows you to self-refer, if you are returning to work after a period of absence, or you have health problems which may be impacting on your performance, and they will provide expert advice about the steps you can take and where you can go for help.

Royal Medical Benevolent Fund - A UK charity for doctors, medical students and their families. They provide financial support, money advice and information when it is most needed due to age, ill health, disability or bereavement.

Sick Doctors Trust - A proactive service for actively addicted doctors that is structured to provide an early intervention programme. The trust facilitates treatment in appropriate centres, arranges funding for inpatient treatment and provides advocacy and representation when required. A charitable trust controlled by a board of trustees and staffed by doctors in recovery.

Samaritans - supporting anyone through branches across the UK and Republic of Ireland www.samaritans.org/

Support for doctors - Academy of Medical Royal Colleges - A listing of websites that can offer support https://www.aomrc.org.uk/

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Galek K, Vanderwerker LC, Flannelly KJ, et al: Topography of referrals to chaplains in the Metropolitan Chaplaincy Study. *J Pastoral Care Counsel*. 2009, 63 (6): 1-13

Handzo GF, Flannelly KJ, Kudler T, et al: What do chaplains really do? II. Interventions in the New York Chaplaincy Study. *J Health Care Chaplain*. 2008, 14: 39-56. 10.1080/08854720802053853

NHS Health Education England (2020) *Discussion of Unwelcome News during Covid-19 Pandemic: a framework for health and social care professionals* [ONLINE] Available at https://portal.e-lfh.org.uk/LearningContent/LaunchFileForGuestAccess/611123 (Accessed 07th April 2020)

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Vanderwerker LC, Flannelly KJ, Galek K, et al: What do chaplains really do? III. Referrals in the New York Chaplaincy Study. *J Health Care Chaplain*. 2008, 14: 57-73. 10.1080/08854720802053861

Weissman DE, Meier DE: Center to advance palliative care inpatient unit operational metrics: consensus recommendations. *J Palliat Med*. 2009, 12: 21-25. 10.1089/jpm.2008.0210

Appendix 1 - Virtual Visits Interim Guidance

For the initial period of time there are only limited devices you can use In order to enable families to conduct a virtual visit. You will need:

1) **An iPad provided via the Spiritual Care Team or the Palliative care Team**
2) **A staff member available who has external access to their ELHT email account.**
3) **Each iPad is loaded with 'Zoom' software for ease of use.**
4) **Some guidance on how to use the iPad will be distributed with each device.**
5) **Whilst it is recommended that a Trust allocated iPad is used for virtual visits, using WhatsApp or Facetime or Skype is also fine on any personal device in this situation.**

Below is a list of FAQs and on using IPad for Virtual Visiting

What is a virtual visit?

This is when staff use technology to enable relatives to virtually visit critically ill patients. Relatives may not be able to see the patient due to Covid restrictions and so you may be requested or think it would be beneficial to offer a virtual visit.

What do I do if a relative requests a virtual visit?

If the patient is critically ill and close relatives cannot visit the patient, consider if this is suitable. For example, you could offer an audio visit where the loved one speaks to the patient, rather than a video. Feel free to offer a virtual visit to anyone who is very unwell as they may not realise it is an option.

How many virtual visits can one patient have a day?

In order to be fair on all patients and staff we suggest a maximum of 2 virtual visits in 24 hours per patient with discretion to extend the number allowed.

Can relatives virtually visit at any time?

Yes, but this will vary dependent on the ward concerned. As long as there is a staff member and a device available, a close relative can virtually visit at the most appropriate time, staff will advise them on this.

How long should the virtual visit be for?

If the patient is unconscious, a sensible limit would be 5 minutes. If the patient is conscious, a sensible limit would be 15 minutes. Please use discretion around these numbers.

What should I do during the virtual visit?

You may need to be present for the whole visit as the patient may be very unwell. Confirm the identity of those attending and ensure that ward staff and other patients are aware that a virtual visit is occurring. Be available to answer any questions from the family and maintain the dignity of the patient.

What if the patient is unconscious?

You can support the visit as you would do for any family member that wanted to physically visit an unconscious patient. Explain that the visit can be for 10 minutes but you will have to remain in the room for the whole visit.

Can the device be left with the patient temporarily?

It is expected that these virtual visits will be during very difficult and sensitive times. In order to ensure the family and relatives have the most positive experience please try and be available for the visit or at least be close by in case there are any issues.

What happens if it gets cut off?

Try and reconnect the patient but if that still fails please ring the relatives directly.

What happens if the patient dies during the virtual visit?

Immediately stop the video call and call the relatives by telephone as soon as possible.

What happens if inappropriate people are invited onto the virtual visit?

Stop the video call and call the primary relatives on the telephone to clarify the situation. Virtual visits are only available for close relatives that cannot visit in person due to infection control risks.

What if the email address or telephone number is wrong?

If you realise that you have connected to an incorrect email address or telephone number immediately stop the video call, check and then connect to the correct email address/number as soon as you can. When the virtual visit is over, please complete an IR1.

What do I do if the person on the screen gets upset?

As much as possible your role in being present is to facilitate the visit, not to be part of it. This is a distressing situation and people are expected to get upset. Please try to allow people to be upset with each other without feeling the need to intervene.

Can I use my own device if nothing else is available?

We are providing devices for all areas and thus are not expecting anyone to use their personal device. Staff will not be sanctioned for doing so if they choose to. If a personal devise must be used urgently please ensure you protect your personal number from being shared with people's relatives. You may use Zoom/WhatsApp/Facetime but please be aware this will be at your own risk for data protection.

Will the visit be recorded?

You cannot record the visit at the trust end. It is unlikely that visitors will record the visit but they are within their rights to record the visit with your consent and with the understanding that the images will not be made public. If the patient is unconscious and cannot give consent then recording permission is at the discretion of staff.

What do I do after the visit?

Clean the device with a slightly soapy damp cloth. Consider calling the relatives if you feel that is appropriate. Record that the visit occurred in the patient's medical record. If any mobile number/email has been stored on the device then that will need to be deleted after the set of visits is complete. Please ask relatives to confirm the phone number every time they contact for a visit.

If I still need extra help?

Please contact the Chaplaincy & Spiritual Care Department and ask to speak to Andrew or David who will do their best to help.