Dying, Death and Bereavement: A re-audit of HSC Trusts' policies, procedures and practices when death occurs

Staff Survey

April – July 2015

Supplementary Report produced: 15 March 2016

Survey forms were completed by HSC staff members in a range of disciplines across all 5 HSC Trusts. Forms were completed on either hard (paper) copy (1,350 forms) or online via the Survey Monkey platform (565 forms). One form was excluded from the data analysis as the respondent did not state which Trust he/she was currently working in and as a result further analysis and extrapolation of the data contained on the form was not possible.

Which Trust are you currently working in?

Trust	Number of respondents
Northern Health & Social Care Trust (NHSCT)	**419 (21.9%)**
Western Health & Social Care Trust (WHSCT)	**169 (8.8%)**
Belfast Health & Social Care Trust (BHSCT)	**765 (40%)**
Southern Health & Social Care Trust (SHSCT)	**249 (13%)**
South Eastern Health & Social Care Trust (SEHSCT)	**312 (16.3%)**
Total	**1,914 (100%)**

Which area of the Trust are you working in?

Area of the Trust	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Acute Hospital	259 (61.8%)	127 (75.2%)	643 (84%)	163 (65.5%)	264 (84.6%)	**1,456 (76.1%)**
Non-Acute Hospital	39 (9.3%)	13 (7.7%)	52 (6.8%)	20 (8%)	10 (3.2%)	**134 (7%)**
Community	112 (26.7%)	21 (12.4%)	51 (6.7%)	54 (21.7%)	27 (8.7%)	**265 (13.8%)**
Other*	7 (1.7%)	8 (4.7%)	19 (2.5%)	12 (4.8%)	11 (3.5%)	**57 (3%)**
Not recorded	2 (0.5%)	-	-	-	-	**2 (0.1%)**
Total	**419 (100%)**	**169 (100%)**	**765 (100%)**	**249 (100%)**	**312 (100%)**	**1,914 (100%)**

Note: Other* included for example - Women and Child Health, Mental Health, Cancer Centre, Acute and Community, Maternity, Training, Specialist Services, Governance, Maternity delivery suite, Nursing Student, Primary and Social Care, Rehabilitation, Administration, Neurology

What is your role?

Work Role	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Doctor	40 (9.5%)	31 (18.3%)	57 (7.5%)	27 (10.8%)	27 (8.7%)	**182 (9.5%)**
Nurse/Midwife	266 (63.5%)	106 (62.7%)	486 (63.5%)	153 (61.4%)	196 (62.8%)	**1,207 (63.1%)**
Social Worker	18 (4.3%)	5 (3%)	24 (3.1%)	8 (3.2%)	6 (1.9%)	**61 (3.2%)**
Chaplain	9 (2.1%)	6 (3.6%)	5 (0.7%)	5 (2%)	2 (0.6%)	**27 (1.4%)**
Health Care Assistant	27 (6.4%)	9 (5.3%)	99 (12.9%)	16 (6.4%)	38 (12.2%)	**189 (9.9%)**
Allied Health Professional	12 (2.9%)	6 (3.6%)	32 (4.2%)	8 (3.2%)	14 (4.5%)	**72 (3.8%)**
Social Care Staff	2 (0.5%)	2 (1.2%)	2 (0.3%)	1 (0.4%)	2 (0.6%)	**9 (0.5%)**
Domiciliary/Homecare staff	10 (2.4%)	-	15 (2%)	2 (1%)	1 (0.3%)	**28 (1.5%)**
Mortuary Technician	4 (1%)	1 (0.6%)	6 (0.8%)	2 (1%)	2 (0.6%)	**15 (0.8%)**
Porter	13 (3.1%)	1 (0.6%)	-	-	-	**14 (0.7%)**
Administrative staff	4 (1%)	-	11 (1.4%)	12 (4.8%)	7 (2.2%)	**34 (1.8%)**
Other*	14 (3.3%)	2 (1.2%)	28 (3.7%)	14 (5.6%)	17 (5.4%)	**75 (3.9%)**
Not recorded	-	-	-	1 (0.4%)	-	**1 (0.1%)**
Total	**419 (100%)**	**169 (100%)**	**765 (100%)**	**249 (100%)**	**312 (100%)**	**1,914 (100%)**

Note: Other* (N=75) includes for example:
Care Management; Clinical Nurse Specialist; Support services supervisor; Domestic; Student Nurse; Day Centre Manager; District Sister; Pharmacist; Student Nurse; Care Manager; Ward liaison officer; Resuscitation Officer; Governance; Nursing Auxiliary; Learning & Development Co-ordinator; Senior Practitioner for Social Work; Management; Manager of school nurses; SANNP; Re-ablement team; Counsellor; Radiographer; Maternity Support Worker; CPN; R and D nurse; Nurse education consultant; Clinical psychologist; Senior manager; Macmillan Palliative Care CNS; District Sister; Protect Life Coordinator working to the Protect Life Strategy; Specialist nurse -organ donation; Health Promotion Worker (Children and Family); User Involvement Development Officer; Sister; Portering supervisor; Benefit advisor; Dentist; Assistant Director responsible for Corporate Support Services e.g. portering, cleaning, catering, laundry; and Clinical Health Psychologist

Other work roles have been grouped as follows: Nursing (42), Manager (4), Social Work or Social Care (4), Professional/Technical e.g. health care professions, pharmacy, radiography (10), Health Promotion/Improvement (2), Training (2), Other (8), Role not recorded (3)

Please detail which specialty:

Specialty	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Maternity	52 (12.4%)	7 (4.1%)	31 (4.1%)	26 (10.4%)	20 (6.4%)	**136 (7.1%)**
Adults	242 (57.8%)	109 (64.5%)	594 (77.6%)	147 (59%)	244 (78.2%)	**1,336 (69.8%)**
Children's	23 (5.5%)	15 (8.9%)	53 (6.9%)	28 (11.2%)	4 (1.3%)	**123 (6.4%)**
Mental Health	34 (8.1%)	6 (3.6%)	26 (3.4%)	12 (4.8%)	14 (4.5%)	**92 (4.8%)**
Learning Disability	1 (0.2%)	-	7 (0.9%)	3 (1.2%)	2 (0.6%)	**13 (0.7%)**
Other*	64 (15.3%)	32 (18.9%)	53 (6.9%)	27 (10.8%)	28 (9%)	**204 (10.7%)**
Not recorded	3 (0.7%)	-	1 (0.1%)	6 (2.4%)	-	**10 (0.5%)**
Total	**419 (100%)**	**169 (100%)**	**765 (100%)**	**249 (100%)**	**312 (100%)**	**1,914 (100%)**

Note: Other* (N=204) includes for example:
Emergency Medicine; Palliative Care; Support services; All areas; Physical disability; Adults and Children; All areas excluding children's and maternity; All areas excluding only maternity; Adults, mental health, palliative care; Neonates; All specialties; Elder care; Anaesthetics; Theatres; Orthopaedics Rehab/Multiple Sclerosis Respite; Haematology; Stroke; General Practice; Research and Development; Out of Hours; general surgery; Radiology/Cardiology; Safe and effective care; CAMHS (Child and Adolescent Mental Health; EPAU/GAU; Older People; Teenagers and Young Adults; Respiratory; Cancer; Occupational Medicine; Cellular Pathology; and Neonatology

Other specialties have been grouped as follows: More than one specialty/Across multiple or all specialties (70), Cancer Services/Palliative Care (51), Emergency Medicine (12), Medicine (13), Support Services/Non clinical (11), Elder Care/Older People's Services (7), Other Specialty (26), and Specialty not recorded (14)

Q1.0 Are you aware of the HSC Service Strategy for Bereavement Care (2009)?

Answer	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Yes	237 (56.5%)	87 (51.5%)	339 (44.3%)	145 (58.2%)	150 (48.1%)	**958 (50%)**
No	179 (42.7%)	78 (46.2%)	421 (55%)	104 (41.8%)	159 (51%)	**941 (49.2%)**
Not recorded	3 (0.7%)	4 (2.4%)	5 (0.7%)	-	3 (1%)	**15 (0.8%)**
Total	**419 (100%)**	**169 (100%)**	**765 (100%)**	**249 (100%)**	**312 (100%)**	**1,914 (100%)**

Q2.0 If you commenced your current post since 2009 did you receive information on dealing with death, grief and bereavement at:

Answered 'Yes'	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Corporate Induction	58/182 (31.9%)	9/67 (13.4%)	110/416 (26.4%)	29/101 (28.7%)	50/150 (33.3%)	**256/916 (28%)**
Professional induction	38/163 (23.3%)	13/74 (17.6%)	85/409 (20.8%)	26/98 (26.5%)	28/144 (19.4%)	**190/888 (21.4%)**
Department / Service / Team Induction	58/180 (32.2%)	25/78 (32%)	114/418 (27.3%)	38/109 (34.9%)	40/149 (26.8%)	**275/934 (29.4%)**

Q3.0 Do you care for dying patients?

Answer	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Yes	330 (78.8%)	142 (84%)	680 (88.9%)	186 (74.7%)	265 (84.9%)	**1,603 (83.8%)**
No	83 (19.8%)	27 (16%)	80 (10.5%)	60 (24.1%)	44 (14.1%)	**294 (15.4%)**
Not recorded	6 (1.4%)	-	5 (0.7%)	3 (1.2%)	3 (1%)	**17 (0.9%)**
Total	**419 (100%)**	**169 (100%)**	**765 (100%)**	**249 (100%)**	**312 (100%)**	**1,914 (100%)**

Q3.1 Do you provide care for the deceased at the time of death or afterwards?

Answer	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Yes	314 (74.9%)	130 (76.9%)	633 (82.7%)	179 (71.9%)	241 (77.2%)	**1,497 (78.2%)**
No	100 (23.9%)	35 (20.7%)	126 (16.5%)	70 (28.1%)	69 (22.1%)	**400 (20.9%)**
Not recorded	5 (1.2%)	4 (2.4%)	6 (0.8%)	-	2 (0.6%)	**17 (0.9%)**
Total	**419 (100%)**	**169 (100%)**	**765 (100%)**	**249 (100%)**	**312 (100%)**	**1,914 (100%)**

Q3.2 Do you provide care, information or support to bereaved relatives?

Answer	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Yes	329 (78.5%)	140 (82.8%)	626 (81.8%)	205 (82.3%)	242 (77.6%)	**1,542 (80.6%)**
No	82 (19.6%)	28 (16.6%)	134 (17.5%)	43 (17.3%)	65 (20.8%)	**352 (18.4%)**
Not recorded	8 (1.9%)	1 (0.6%)	5 (0.7%)	1 (0.4%)	5 (1.6%)	**20 (1%)**
Total	**419 (100%)**	**169 (100%)**	**765 (100%)**	**249 (100%)**	**312 (100%)**	**1,914 (100%)**

Q4.0 What Dying, Death and Bereavement related Trust policies, procedures or guidance do you follow?

Policies, procedures or guidance followed	Trust					
	NHSCT (n=419)	WHSCT (n=169)	BHSCT (n=765)	SHSCT (n=249)	SEHSCT (n=312)	Total (n=1,914)
Last offices	182 (43.4%)	83 (49.1%)	445 (58.2%)	90 (36.1%)	169 (54.2%)	**969 (50.6%)**
Identification and transfer of bodies	189 (45.1%)	76 (45%)	404 (52.8%)	92 (37%)	162 (51.9%)	**923 (48.2%)**
Storage, viewing and release of bodies	70 (16.7%)	18 (10.7%)	106 (13.9%)	23 (9.2%)	45 (14.4%)	**262 (13.7%)**
Verification of death	128 (30.5%)	45 (26.6%)	200 (26.1%)	67 (26.9%)	102 (32.7%)	**542 (28.3%)**
Issuing of Medical Certificate of Cause of death	126 (30.1%)	39 (23.1%)	183 (23.9%)	55 (22.1%)	98 (31.4%)	**501 (26.2%)**
Management of sudden / unexpected death	137 (32.7%)	54 (32%)	257 (33.6%)	73 (29.3%)	106 (34%)	**627 (32.8%)**
Reporting deaths to the coroner	119 (28.4%)	35 (20.7%)	169 (22.1%)	53 (21.3%)	75 (24%)	**451 (23.6%)**
Preservation of evidence in forensic cases	65 (15.5%)	22 (13%)	102 (13.3%)	24 (9.6%)	37 (11.9%)	**250 (13.1%)**
Seeking and obtaining consent for hospital post mortem examination	73 (17.4%)	26 (15.4%)	103 (13.5%)	35 (14.1%)	60 (19.2%)	**297 (15.5%)**
Organ donation	79 (18.9%)	21 (12.4%)	139 (18.2%)	27 (10.8%)	46 (14.7%)	**312 (16.3%)**
Chaplaincy / Spiritual care	145 (34.6%)	70 (41.4%)	292 (38.2%)	76 (30.5%)	119 (38.1%)	**702 (36.7%)**
Do not attempt cardio pulmonary resuscitation	197 (47%)	74 (43.8%)	382 (49.9%)	110 (44.2%)	160 (51.3%)	**923 (48.2%)**
Advanced care planning for adults	101 (24.1%)	42 (24.9%)	191 (25%)	59 (23.7%)	84 (26.9%)	**477 (24.9%)**
Advanced care planning for children	22 (5.3%)	13 (7.7%)	36 (4.7%)	8 (3.2%)	18 (5.8%)	**97 (5.1%)**
Breaking bad news	182 (43.4%)	86 (50.9%)	377 (49.3%)	118 (47.4%)	171 (54.8%)	**934 (48.8%)**
Bereavement care	171 (40.8%)	60 (35.5%)	333 (43.5%)	109 (43.8%)	128 (41%)	**801 (41.9%)**
Other*	13 (3.1%)	9 (5.3%)	14 (1.8%)	5 (2%)	9 (2.9%)	**50 (2.6%)**

See **Appendix A** for details of work role of respondents following Dying, Death and Bereavement related Trust policies, procedures or guidance as detailed in the above table

Note: Other*

NHSCT
5/13 staff members commented:

- Living well dying well strategy grief & bereavement staff induction
- Collection of equipment
- Miscarriages
- Assessing for and implementing packages of care
- Palliative Care

WHSCT
8/9 staff members commented:

- Management of staff who use these policies
- Relatives made aware of bereavement counselling
- None of above
- Care of a mother and father whose baby has died before or just after birth
- As a Social Worker with adults over 65, my work entails provision of support to individuals, carers and families in addressing the trajectory of chronic and terminal illnesses and its impact at end of life and death of a loved one
- Facilitating support groups
- I would support staff to engage with services users, carers and the public to have their say in the planning, development and delivery of services including bereavement care/services. This support would include meeting with service users, carers and the public during meetings, focus groups, events etc.
- RJMS RNU policy guideline

BHSCT
8/14 staff members commented:

- Palliative care
- Palliative care at home through care management process
- Cruse bereavement training
- N/A
- Management of deceased patient records
- Syringe driver, controlled drugs in the community
- Maternal death
- I provide emotional support to patients and their families

SHSCT
5/5 staff members commented:

- Provide information and support to patients and their relatives
- Caring for dying children in their own home
- None of the above
- We do not do any of the above but in circumstances we may have to break bad news to family when a death occurs and this is hard to do with little training
- N/A

SEHSCT
8/9 staff members commented:

- Care management of bodies
- Palliative end of life care
- I do not use these policies
- Support for relative who have had loved one attend our day care service
- Looking after parents who have suffered a pregnancy loss at all stages of pregnancy
- Passing messages to District Nursing teams or other professionals (OT, Respiratory, GP reception, Pall Care teams, other professionals involved in the patient's care; also listening to and reassuring relatives who want to "offload" a bit but not to the Nursing Teams. I find people are afraid to say anything negative (even when justified) in case the patient would be impacted by this
- Basic communication skills to HCAs
- My role is not clinical

Q4.1 Do you know how to access Dying, Death and Bereavement policies, procedures or guidance?

Answer	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Yes	355 (84.7%)	114 (67.5%)	576 (75.3%)	213 (85.5%)	270 (86.5%)	**1,528 (79.8%)**
No	57 (13.6%)	51 (30.2%)	180 (23.5%)	33 (13.3%)	37 (11.9%)	**358 (18.7%)**
Not recorded	7 (1.7%)	4 (2.4%)	9 (1.2%)	3 (1.2%)	5 (1.6%)	**28 (1.5%)**
Total	**419 (100%)**	**169 (100%)**	**765 (100%)**	**249 (100%)**	**312 (100%)**	**1,914 (100%)**

If 'No' – Work Role by Trust and Overall (n=358)	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Administrative staff	2 (3.5%)	--	4 (2.2%)	6 (18.2%)	1 (2.7%)	**13 (3.6%)**
Allied Health Professions	4 (7%)	3 (5.9%)	11 (6.1%)	--	2 (5.4%)	**20 (5.6%)**
Chaplain	5 (8.8%)	3 (5.9%)	2 (1.1%)	--	--	**10 (2.8%)**
Doctor	6 (10.5%)	18 (35.3%)	26 (14.4%)	6 (18.2%)	8 (21.6%)	**64 (17.9%)**
Dom/Homecare staff	3 (5.3%)	--	12 (6.7%)	--	1 (2.7%)	**16 (4.5%)**
HCA	7 (12.3%)	5 (9.8%)	25 (13.9%)	7 (21.2%)	9 (24.3%)	**53 (14.8%)**
Mortuary Technician	--	1 (2%)	2 (1.1%)	--	--	**3 (0.8%)**
Nurse/Midwife	14 (24.6%)	17 (33.3%)	81 (45%)	13 (39.4%)	9 (24.3%)	**134 (37.4%)**
Porter	9 (15.8%)	1 (2%)	--	--	--	**10 (2.8%)**
Social care staff	1 (1.8%)	2 (3.9%)	2 (1.1%)	--	1 (2.7%)	**6 (1.7%)**
Social Worker	2 (3.5%)	1 (2%)	8 (4.4%)	--	2 (5.4%)	**13 (3.6%)**
Other	4 (7%)	--	7 (3.9%)	1 (3%)	4 (10.8%)	**16 (4.5%)**
Total	**57 (100%)**	**51 (100%)**	**180 (100%)**	**33 (100%)**	**37 (100%)**	**358 (100%)**

If 'No' – Work Area by Trust and Overall (n=358)	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Acute Hospital	35 (61.4%)	38 (74.5%)	143 (79.4%)	20 (60.6%)	26 (70.3%)	**262 (73.2%)**
Non Acute Hospital	4 (7%)	6 (11.8%)	11 (6.1%)	6 (18.2%)	2 (5.4%)	**29 (8.1%)**
Community	17 (29.8%)	6 (11.8%)	19 (10.6%)	5 (15.2%)	6 (16.2%)	**53 (14.8%)**
Other	1 (1.8%)	1 (2%)	7 (3.9%)	2 (6.1%)	3 (8.1%)	**14 (3.9%)**
Total	**57 (100%)**	**51 (100%)**	**180 (100%)**	**33 (100%)**	**37 (100%)**	**358 (100%)**

Q5.0 If you provide care to patients at the time of death are you aware of when and how to access chaplaincy services? (n= 1,429)*

**1,603 respondents had stated that they provide care to patients at time of death however 174 of these respondents went on to indicate that this question was 'not applicable' to them*

Answer	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Yes	239 (86.3%)	118 (90.8%)	575 (91.6%)	146 (93%)	212 (89.4%)	**1,290 (90.3%)**
No	32 (11.6%)	10 (7.7%)	51 (8.1%)	11 (7%)	24 (10.1%)	**128 (9%)**
Not recorded	6 (2.2%)	2 (1.5%)	2 (0.3%)	-	1 (0.4%)	**11 (0.8%)**
Total	**277 (100%)**	**130 (100%)**	**628 (100%)**	**157 (100%)**	**237 (100%)**	**1,429 (100%)**

If 'No' – Work Role by Trust and Overall (n=128)	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Allied Health Professions	2 (6.3%)	--	2 (3.9%)	--	2 (8.3%)	**6 (4.7%)**
Doctor	8 (25%)	9 (90%)	14 (27.5%)	9 (81.8%)	8 (33.3%)	**48 (37.5%)**
Dom/Homecare staff	1 (3.1%)	--	3 (5.9%)	--	--	**4 (3.1%)**
HCA	5 (15.6%)	--	14 (27.5%)	--	8 (33.3%)	**27 (21.1%)**
Mortuary Technician	--	--	1 (2%)	--	--	**1 (0.8%)**
Nurse/Midwife	10 (31.3%)	1 (10%)	14 (27.5%)	1 (9.1%)	2 (8.3%)	**28 (21.9%)**
Social care staff	--	--	--	--	1 (4.2%)	**1 (0.8%)**
Social Worker	3 (9.4%)	--	1 (2%)	1 (9.1%)	--	**5 (3.9%)**
Other	3 (9.4%)	--	2 (3.9%)	--	3 (12.5%)	**8 (6.3%)**
Total	**32 (100%)**	**10 (100%)**	**51 (100%)**	**11 (100%)**	**24 (100%)**	**128 (100%)**

If 'No' – Work Area by Trust and Overall (n=128)	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Acute Hospital	12 (37.5%)	9 (90%)	41 (80.4%)	8 (72.7%)	18 (75%)	**88 (68.8%)**
Non Acute Hospital	2 (6.3%)	1 (10%)	3 (5.9%)	1 (9.1%)	3 (12.5%)	**10 (7.8%)**
Community	18 (56.3%)	--	5 (9.8%)	1 (9.1%)	2 (8.3%)	**26 (20.3%)**
Other	--	--	2 (3.9%)	1 (9.1%)	1 (4.2%)	**4 (3.1%)**
Total	**32 (100%)**	**10 (100%)**	**51 (100%)**	**11 (100%)**	**24 (100%)**	**128 (100%)**

Q6.0 Is it your responsibility to inform other professionals / agencies of a death?

Answer	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Yes	280 (66.8%)	110 (65.1%)	462 (60.4%)	151 (60.6%)	201 (64.4%)	**1,204 (62.9%)**
No	133 (31.7%)	57 (33.7%)	292 (38.2%)	95 (38.2%)	109 (34.9%)	**686 (35.8%)**
Not recorded	6 (1.4%)	2 (1.2%)	11 (1.4%)	3 (1.2%)	2 (0.6%)	**24 (1.3%)**
Total	**419 (100%)**	**169 (100%)**	**765 (100%)**	**249 (100%)**	**312 (100%)**	**1,914 (100%)**

Q6.0 If it is your responsibility to inform other professionals / agencies of a death, what methods do you use to do this? (n=1,204)

Some members of staff use more than one method	Trust					
	NHSCT (n=280)	WHSCT (n=110)	BHSCT (n=462)	SHSCT (n=151)	SEHSCT (n=201)	Total (n=1,204)
Checklist in place to ensure relevant parties are informed of the death	87 (31.1%)	27 (24.5%)	132 (28.6%)	70 (46.4%)	80 (39.8%)	**396 (32.9%)**
Telephone call	97 (34.6%)	36 (32.7%)	346 (74.9%)	129 (85.4%)	170 (84.6%)	**778 (64.6%)**
Letter	58 (20.7%)	17 (15.5%)	143 (31%)	33 (21.9%)	85 (42.3%)	**336 (27.9%)**
Email	38 (13.6%)	4 (3.6%)	46 (10%)	34 (22.5%)	17 (8.5%)	**139 (11.5%)**
Other*	8 (2.9%)	7 (6.4%)	17 (3.7%)	5 (3.3%)	5 (2.5%)	**42 (3.5%)**

Note: Other* included:

- Face to face/in person/verbally/discussion (19 respondents)
- Via computer system (SOSCARE or CIS Paris) (3 respondents)
- Mobile/fax/bleep (4 respondents)
- In writing (e.g. record in notes, GP notification form, pre-printed cards, send copy of death certificate) (5 respondents)
- Other (e.g. health care profession specified or method of communication not stated) (11 respondents)

Q7.0 Do you prepare deceased patients for removal from place of death?

Answer	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Yes	216 (51.6%)	87 (51.5%)	514 (67.2%)	112 (45%)	199 (63.8%)	**1,128 (58.9%)**
No	191 (45.6%)	80 (47.3%)	234 (30.6%)	133 (53.4%)	108 (34.6%)	**746 (39%)**
Not recorded	12 (2.9%)	2 (1.2%)	17 (2.2%)	4 (1.6%)	5 (1.6%)	**40 (2.1%)**
Total	**419 (100%)**	**169 (100%)**	**765 (100%)**	**249 (100%)**	**312 (100%)**	**1,914 (100%)**

Q7.1 If Yes, what documentation accompanies the body to the mortuary or to the funeral directors? (n=1,128)

Some members of staff send more than one document	Trust					
	NHSCT (n=216)	WHSCT (n=87)	BHSCT (n=514)	SHSCT (n=112)	SEHSCT (n=199)	Total (n=1,128)
Mortuary slip	84 (38.9%)	58 (66.7%)	195 (37.9%)	64 (57.1%)	114 (57.3%)	**515 (45.7%)**
Body transfer form	191 (88.4%)	60 (69%)	439 (85.4%)	99 (88.4%)	183 (92%)	**972 (86.2%)**
Other*	8 (3.7%)	2 (2.3%)	13 (2.5%)	4 (3.6%)	9 (4.5%)	**36 (3.2%)**

Note: Other* forms of documentation have been categorised as follows:

- Armbands/identification labels (9 respondents)
- Cremation form (6 respondents)
- Death certificate/notification of death book (12 respondents)
- Post mortem consent form (3 patients)
- Tissue/organ donation information (2 respondents)
- Others (including GP sees patient before body removed from house, children sometimes leave the ward and go directly home, medical/nursing notes, babies - placenta and infection control form) (5 respondents)

1 respondent provided 2 'Other' responses

Q7.1 If 'Did not use Body Transfer Form'– Breakdown of Role and Area of Work by Overall Respondents (n=156)

Answer	Acute Hospital	Non Acute Hospital	Community	Other	Total
Allied Health Professions	2 (1.7%)	--	--	--	**2 (1.3%)**
Dom/Homecare staff	--	--	1 (7.1%)	--	**1 (0.6%)**
HCA	32 (27.6%)	9 (40.9%)	2 (14.3%)	--	**43 (27.6%)**
Nurse/Midwife	78 (67.2%)	13 (59.1%)	11 (78.6%)	3 (75%)	**105 (67.3%)**
Other	4 (3.4%)	--	--	1 (25%)	**5 (3.2%)**
Total	**116 (100%)**	**22 (100%)**	**14 (100%)**	**4 (100%)**	**156 (100%)**

Note: Some respondents clearly answered question 7.1 in error as they would not have a role in preparing deceased patients for removal from place of death

Q8.0 When death occurs do you provide written information to bereaved relatives? (n=1,535)*

** Of 1,914 total respondents 379 of these indicated that this question was 'not applicable' to them*

Answer	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Yes	189 (57.4%)	67 (47.5%)	383 (60%)	97 (51.6%)	173 (72.4%)	**909 (59.2%)**
No	134 (40.7%)	68 (48.2%)	227 (35.6%)	86 (45.7%)	61 (25.5%)	**576 (37.5%)**
Not recorded	6 (1.8%)	6 (4.3%)	28 (4.4%)	5 (2.7%)	5 (2.1%)	**50 (3.3%)**
Total	**329 (100%)**	**141 (100%)**	**638 (100%)**	**188 (100%)**	**239 (100%)**	**1,535 (100%)**

Q8.1 If Yes, please indicate which resources/information you use? (n=909)

Some members of staff use more than one resource	Trust					
	NHSCT (n=189)	**WHSCT (n=67)**	**BHSCT (n=383)**	**SHSCT (n=97)**	**SEHSCT (n=173)**	**Total (n=909)**
Trust Bereavement Booklet	146 (77.2%)	47 (70.1%)	323 (84.3%)	59 (60.8%)	155 (89.6%)	**730 (80.3%)**
Information Booklet for parents on death of a child	55 (29.1%)	9 (13.4%)	84 (21.9%)	31 (32%)	21 (12.1%)	**200 (22%)**
Information Booklet for parents who suffer a still birth or neonatal death	54 (28.6%)	9 (13.4%)	31 (8.1%)	30 (30.9%)	17 (9.8%)	**141 (15.5%)**
Information Booklet for parents who suffer a miscarriage	41 (21.7%)	9 (13.4%)	11 (2.9%)	19 (19.6%)	15 (8.7%)	**95 (10.5%)**
Information for families bereaved through suicide	15 (7.9%)	6 (9%)	28 (7.3%)	12 (12.4%)	5 (2.9%)	**66 (7.3%)**
'When someone close to you dies, a guide for talking with and supporting children'	34 (18%)	14 (20.9%)	71 (18.5%)	19 (19.6%)	13 (7.5%)	**151 (16.6%)**
Dealing with Sudden Death: Common grief reactions	22 (11.6%)	2 (3%)	92 (24%)	12 (12.4%)	8 (4.6%)	**136 (15%)**
Hospital post-mortem examination of a child or adult – information for parents/relatives	50 (26.5%)	6 (9%)	66 (17.2%)	8 (8.2%)	31 (17.9%)	**161 (17.7%)**
Hospital post-mortem examination of a baby – information for parents	61 (32.3%)	11 (16.4%)	33 (8.6%)	27 (27.8%)	16 (9.2%)	**148 (16.3%)**
Information relating to the Coroner's Service	62 (32.8%)	8 (11.9%)	68 (17.8%)	17 (17.5%)	33 (19.1%)	**188 (20.7%)**
Other resources*	3 (1.6%)	10 (14.9%)	12 (3.1%)	6 (6.2%)	11 (6.4%)	**42 (4.6%)**

Note: Other resources* included:

- Death certificate/death registration form/information on how to register a death (8 respondents)
- Macmillan information (2 respondents)
- Tissue donation information (3 respondents)
- End of life guide (3 respondents)

- Information on other voluntary organisations e.g. Cruse, CLIC Sargent, other cancer charities and their services (6 respondents)
- Other information e.g. NI Direct Bereavement Service, assist with contacting funeral services (2 respondents)
- SANDS information, leaflets and memory box (3 respondents)
- Winston's wish materials (2 respondents)
- Chaplaincy booklet or other information from chaplain e.g. personalised note card (3 respondents)
- Counselling (2 respondents)
- Other included leaflets, palliative care team, discharge form for parents travelling with deceased baby, patient records may be required for medico legal purposes/requests by family to access records or if needed for SAI/complaint, ICU steps material, tend to write letter following death of patient treated for several years, information on dealing with specialised equipment on loan and how to return, various books, hospital PM information and use tools from recently completed bereavement course (9 respondents)

Respondents who answered 'Other' provided more than one response in a few instances

If 'Did not use Bereavement Booklet' – Breakdown of Work Role and Area by Overall Respondents (n=179)	**Acute Hospital**	**Non Acute Hospital**	**Community**	**Other**	**Total**
Administrative staff	--	1 (7.7%)	--	--	**1 (0.6%)**
Allied Health Professions	1 (0.7%)	1 (7.7%)	--	--	**2 (1.1%)**
Chaplain	2 (1.3%)	--	--	--	**2 (1.1%)**
Doctor	26 (17.3%)	1 (7.7%)			**27 (15.1%)**
HCA	2 (1.3%)	1 (7.7%)	--	--	**3 (1.7%)**
Mortuary Technician	1 (0.7%)	--	--	--	**1 (0.6%)**
Nurse/Midwife	114 (76%)	6 (46.2%)	13 (86.7%)	1 (100%)	**134 (74.9%)**
Social Worker	3 (2%)	3 (23.1%)	1 (6.7%)	--	**7 (3.9%)**
Other	1 (0.7%)	--	1 (6.7%)	--	**2 (1.1%)**
Total	**150 (100%)**	**13 (100%)**	**15 (100%)**	**1 (100%)**	**179 (100%)**

Q8.2 If you do not provide written information to bereaved relatives, what prevents you from providing such information? (n= 576)

NHSCT
47/134 staff members commented:

- Face to face discussions
- Information may not be relevant
- Do not have any leaflets at present
- Not appropriate perhaps
- They don't appear to need it
- As a junior doctor I do not feel it is my role
- Not present in home at appropriate time
- We could do with more training regarding death and speaking to relatives following or leading up to death
- Readily available on notice boards
- Normally not appropriate at the time as we are rarely present
- Have never been asked to provide written information to bereaved relatives. I meet with family members if requested. I think the nursing staff may offer written information
- Nursing staff have normally already provided
- None available
- None available
- Not aware of such information
- They are usually present in the home at time of death
- No training. Not in my job role
- Not specifically my role, but can access the information from manager if required
- Would verbally speak to bereaved relatives
- Not aware that this exists and presumption that the nurses probably give out a leaflet if there are any
- Nursing staff kindly deal with this
- Information is provided by other members of the team
- We usually ensure relatives get the death certificate and information on how to register the death. Nothing else available
- Didn't know where to get it. Didn't even know there was one on the ward
- I think verbal communication is more effective than handing someone a book or leaflet
- Not available at ward level
- I think it is very cold to hand out this information at times
- Don't know what is available. Information that I have is "out of date" - Year 2000
- Not my role
- Unaware of such information
- We don't have any
- Do not have any documentation to provide them with
- I adhere to verbal communication
- No training or information provided for staff re palliative care. Self learning only

- Not my job
- Usually talking to them is enough and asking if you can do anything else for them and if they are happy enough
- If relative shave already been bereaved they know the protocol
- Unaware it exists
- No reason to give, unfortunately this is an area our team need to improve
- Information is provided by other members of staff
- As a trainee, we move Trust every 6 months. It is not practical be familiar with every trusts individual polices and documents, as well as to know where these brochures are kept on 15 different wards to access them
- Provided by nursing staff where required
- Not appropriate to my role as a chaplain
- Not applicable to my role
- It's rarely required as other professionals have usually been involved. occasionally would give information via telephone
- Not applicable to the job role
- Have not found anything appropriate

WHSCT
25/68 staff members commented:

- I mainly have to break the bad news of death in an acute setting
- Time constraints. Knowledge of what to deliver
- Relatives leave ward too soon after death
- Not applicable to my job role
- Not within my remit
- None available
- Unaware of the existence of such paperwork
- Dealt with on case by case basis, rare event
- Not necessary
- No readily available
- It feels inappropriate as the grief is very raw at this stage
- It was never a job requirement to carry out this task. Family are usually present when their loved ones pass away on my ward
- Availability and knowledge
- Usually no leaflets available on ward
- N/A
- Many relatives do not ask for information booklet at time of death
- Most of patients in community are palliative care and above list not that appropriate.
- I was not aware
- Accessibility The trust website is difficult to navigate. Even our own access is difficult and unnecessarily complicated
- No leaflets available in department
- Not often present at this point. Usually other members of the team or the ward will provide this information. This has prompted me to ensure that I encourage ward staff

to provide relevant written information to family after someone dies and incorporate this into my suggested management plan for patients who are dying
- Usually provided by ward nursing staff
- Nursing staff would provide this care
- Never knew written information is needed for bereaved relatives. What is the need for it, who should give it and how can it be done?
- The information is already provided by the nursing staff in the ward. There is usually no requirement to reissue this

BHSCT
82/227 staff members commented:

- Don't have information available
- No Trust bereavement booklets available for distribution
- Not available
- Access to written information
- No knowledge of same
- Not my role
- Trust policies. Role of the GP
- Wasn’t aware I needed to attend counselling with parent at a later date
- Time, unsure as to what resources are available
- Not my role
- Information not always available at ward level
- Not relevant to my post
- Family are contacted by phone at time of deterioration
- Provided by other staff
- I was not aware of any
- No information to provide. Advice delivered verbally
- Info not always available
- Unsure where to access this
- Unaware of what we should provide. No training on this subject
- Don’t know where to access this information
- Face to face communication is normally preferred
- Family members would usually be with dying clients
- No training
- No training
- Not my role
- Usually the nurse in charge will do this
- Nurse in charge does this
- Nurses in charge
- Not available
- Relatives usually contacted via telephone
- Consultant deals with this
- None available at ward level
- Information deemed inappropriate sometimes
- None available

- Nothing available on the ward
- Would not be appropriate
- Not my job
- Medical staff provide written
- The nurse in charge will mainly provide this
- Patients' families rarely remain on ward for any length of time
- Not aware of any information
- Unaware of information and where it is kept
- Lack of info/ leaflets/ training
- No relevant information available on ward
- Not always available
- Unsure about available resources
- Not sure what information to provide
- I was unaware that I could provide such information to bereaved relatives
- Not my role
- Too many leaflets to choose from. Have not read all these leaflets and therefore do not know which is the best to hand over
- Very rarely see these families
- No leaflets in working area
- Nurse in charge deals with this
- I have no training in this area
- Not requested
- Availability
- Hasn't been appropriate at the time
- Not available
- Difficult to access resources/information
- Not available
- Not my role
- Not available on ward
- Unsure of where it is - Recently started working on ward
- As clinical research nurse it's not my role
- I may not be present at the time of death
- None available at ward level.
- Information is provided by nursing staff.
- No written information available
- Not required by a nurse
- Sometimes no relevant advice booklets
- Would provide information regarding Cruse counselling
- N/A
- Not my current responsibility: bank nurse only with no responsibility for ward/ service management
- None on the ward
- Nursing staff provide this information on our ward
- Don't have any

- Relatives are given all information verbally and staff spend long periods of time talking them through the process. Some relatives need more support than others
- Do not have opportunity of contact
- It is usually seen as the nurses role to do this
- The nursing staff usually provide this
- Others do so
- It is the responsibility of others

SHSCT
34/86 staff members commented:

- Not my role
- Relatives are usually with patient
- I have not been involved in dealing with bereaved relatives
- Only if needed
- Lack of resources available on ward
- Was not aware of any written information that was available
- Not my role
- Nurse in charge would do this
- Not appropriate to give written early this soon after death I don't feel
- Leaflets not available at ward level. It is not emphasised enough to provide these booklets. Lack of awareness that they exist
- Not aware of information
- This is already provided by other professionals & I am not present at exact time of death of patient but we follow up with bereavement visits and give verbal information and advice
- I am not ward/department based
- In my role as a Senior manager, am rarely the first person in direct contact with relatives following a bereavement
- I work in the evenings and day staff visit the next day to see relatives and provide written information
- N/A
- Relatives refuse or do not stay on ward long enough
- Not available
- Unsure where they are or if there are any
- Prefer to use verbal communication rather than leaflets at this time
- I feel verbal communication is better than leaflet. Kind word is better
- Was unaware of written documentation
- Never realised it was suggested
- Nursing staff provide this information as part of MDT approach
- Availability in theatres department
- No barriers, would not see as routine practice
- The nursing staff provide this
- Performed by others
- Not available on ward
- Not available in OOH

- I usually talk with relatives and answer any queries they have
- It is not my role to do so
- Not aware of same
- I assume that nursing staff will do this. I rarely speak to relatives after death - usually before

SEHSCT
25/61 staff members commented:

- Lack of information/training
- Not my role
- Normally it is the Doctor who delivers this information
- Didn't know it existed
- Nursing staff normally attend
- Not aware of these
- Not sure what information to hand out as I have never had any training in this area
- Wasn't aware it was available
- It's is not my place as a HCA to provide this information
- No written information so advice is delivered verbally
- Generally provided by nursing staff
- Death certificate issues
- Not my role
- Nurses provide same
- Nursing staff provide same
- Was not aware of written information
- Not my role
- Ward staff provide this
- Feel it is not my role
- Nursing staff provide written material
- Don't have leaflets available
- Front cover of booklet info and guidance after death of relative/friend very cold and impersonal. we give verbal advice and inform them there is written booklet if they wish to see it
- Availability in Primary Care
- This is carried out by nursing staff
- Unaware of where to obtain leaflets

Q9.0 If you seek consent for hospital/consented post mortem, have you completed training on this in the last 3 years? (n=182)*

**182 respondents were doctors however 48 of these respondents indicated that this question was 'not applicable' to them*

Applicable to Doctors only	Trust					
	NHSCT	**WHSCT**	**BHSCT**	**SHSCT**	**SEHSCT**	**Total**
Yes	18 (54.5%)	10 (43.5%)	8 (21.6%)	15 (71.4%)	5 (25%)	**56 (41.8%)**
No	14 (42.4%)	12 (52.2%)	27 (73%)	6 (28.6%)	15 (75%)	**74 (55.2%)**
Not recorded	1 (3%)	1 (4.4%)	2 (5.4%)	-	-	**4 (3%)**
Total	**33 (100%)**	**23 (100%)**	**37 (100%)**	**21 (100%)**	**20 (100%)**	**134 (100%)**

Q9.1 If No, do you know what training is available? (n=72)*

**74 respondents answered 'No' however 2 of these respondents indicated that this question was 'not applicable' to them*

Doctors only	Trust					
	NHSCT	**WHSCT**	**BHSCT**	**SHSCT**	**SEHSCT**	**Total**
Yes	2 (15.4%)	1 (8.3%)	3 (11.5%)	-	1 (6.7%)	**7 (9.7%)**
No	11 (84.6%)	11 (91.7%)	23 (88.5%)	6 (100%)	14 (93.3%)	**65 (90.3%)**
Total	**13 (100%)**	**12 (100%)**	**26 (100%)**	**6 (100%)**	**15 (100%)**	**72 (100%)**

Q9.2 Do you know how to access post mortem training? (n=74)

Applicable to Doctors only	Trust					
	NHSCT	**WHSCT**	**BHSCT**	**SHSCT**	**SEHSCT**	**Total**
Yes	-	-	2 (7.4%)	-	1 (6.7%)	**3 (4.1%)**
No	14 (100%)	12 (100%)	24 (88.8%)	6 (100%)	14 (93.3%)	**70 (94.6%)**
Not recorded	-	-	1 (3.7%)	-	-	**1 (1.4%)**
Total	**14 (100%)**	**12 (100%)**	**27 (100%)**	**6 (100%)**	**15 (100%)**	**74 (100%)**

Q10.0 Have you ever received feedback from bereaved relatives, either positive or negative, on the care you have provided for their dying relatives? (n=1,597)*

** Of 1,914 total respondents 317 of these indicated that this question was 'not applicable' to them*

Answer	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Yes	270 (77.8%)	116 (77.3%)	476 (72.7%)	149 (75.6%)	197 (79.4%)	**1,208 (75.6%)**
No	71 (20.5%)	33 (22%)	161 (24.6%)	39 (19.8%)	48 (19.4%)	**352 (22%)**
Not recorded	6 (1.7%)	1 (0.7%)	18 (2.8%)	9 (4.6%)	3 (1.2%)	**37 (2.3%)**
Total	**347 (100%)**	**150 (100%)**	**655 (100%)**	**197 (100%)**	**248 (100%)**	**1,597 (100%)**

Breakdown of staff who <u>have received feedback</u> from bereaved relatives, either positive or negative, on the care they have provided for their dying relatives

Analysis by Work Role, Trust and Overall (n=1,208)	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Administrative staff	1 (0.4%)	--	1 (0.2%)	--	2 (1%)	**4 (0.3%)**
Allied Health Professions	4 (1.5%)	2 (1.7%)	10 (2.1%)	3 (2%)	6 (3%)	**25 (2.1%)**
Chaplain	6 (2.2%)	4 (3.4%)	5 (1.1%)	4 (2.7%)	2 (1%)	**21 (1.7%)**
Doctor	33 (12.2%)	19 (16.4%)	42 (8.8%)	18 (12.1%)	22 (11.2%)	**134 (11.1%)**
Dom/Homecare staff	9 (3.3%)	--	5 (1.1%)	2 (1.3%)	1 (0.5%)	**17 (1.4%)**
HCA	17 (6.3%)	7 (6%)	62 (13%)	7 (4.7%)	15 (7.6%)	**108 (8.9%)**
Mortuary Technician	3 (1.1%)	1 (0.9%)	1 (0.2%)	1 (0.7%)	--	**6 (0.5%)**
Nurse/Midwife	184 (68.1%)	80 (69%)	324 (68.1%)	104 (69.8%)	141 (71.6%)	**833 (69%)**
Social care staff	1 (0.4%)	--	2 (0.4%)	--	1 (0.5%)	**4 (0.3%)**
Social Worker	5 (1.9%)	2 (1.7%)	12 (2.5%)	3 (2%)	2 (1%)	**24 (2%)**
Other	7 (2.6%)	1 (0.9%)	12 (2.5%)	6 (4%)	5 (2.5%)	**31 (2.6%)**
Not recorded	--	--	--	1 (0.7%)	--	**1 (0.1%)**
Total	**270 (100%)**	**116 (100%)**	**476 (100%)**	**149 (100%)**	**197 (100%)**	**1,208 (100%)**

Breakdown of staff who have received feedback from bereaved relatives, either positive or negative, on the care they have provided for their dying relatives

Analysis by Work Area, Trust and Overall (n=1,208)	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Acute Hospital	163 (60.4%)	88 (75.9%)	406 (85.3%)	100 (67.1%)	168 (85.3%)	**925 (76.6%)**
Non Acute Hospital	28 (10.4%)	11 (9.5%)	27 (5.7%)	13 (8.7%)	6 (3%)	**85 (7%)**
Community	74 (27.4%)	12 (10.3%)	32 (6.7%)	29 (19.5%)	20 (10.2%)	**167 (13.8%)**
Other	4 (1.5%)	5 (4.3%)	11 (2.3%)	7 (4.7%)	3 (1.5%)	**30 (2.5%)**
Not recorded	1 (0.4%)	--	--	--	--	**1 (0.1%)**
Total	**270 (100%)**	**116 (100%)**	**476 (100%)**	**149 (100%)**	**197 (100%)**	**1,208 (100%)**

Q10.1 Have you ever received feedback from your line manager regarding the care you have provided to dying patients and/or their bereaved relatives?

Some members of staff received feedback from more than one source	Trust					
	NHSCT (n=419)	WHSCT (n=169)	BHSCT (n=765)	SHSCT (n=249)	SEHSCT (n=312)	Total (n=1,914)
Yes, at staff/team meeting	135 (32.2%)	59 (34.9%)	279 (36.5%)	82 (32.9%)	106 (34%)	**661 (34.5%)**
Yes, given a copy of the written feedback	59 (14.1%)	22 (13%)	73 (9.5%)	22 (8.8%)	29 (9.3%)	**205 (10.7%)**
Yes, at one to one meeting with manager	39 (9.3%)	13 (7.7%)	78 (10.2%)	21 (8.4%)	35 (11.2%)	**186 (9.7%)**
Yes, via email	23 (5.5%)	5 (3%)	42 (5.5%)	16 (6.4%)	13 (4.2%)	**99 (5.2%)**
Yes, put on display in workplace	53 (12.6%)	17 (10.1%)	84 (11%)	24 (9.6%)	49 (15.7%)	**227 (11.9%)**
No, never received any feedback	178 (42.5%)	77 (45.6%)	332 (43.4%)	109 (43.8%)	136 (43.6%)	**832 (43.5%)**

Breakdown of staff who <u>have not received feedback</u> from their line manager regarding the care they have provided to dying patients and/or their bereaved relatives

Analysis by Work Role, Trust and Overall (n=832)	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Administrative staff	1 (0.6%)	-	5 (1.5%)	3 (2.7%)	3 (2.2%)	**12 (1.4%)**
Allied Health Professions	8 (4.5%)	3 (3.9%)	22 (6.6%)	6 (5.5%)	10 (7.4%)	**49 (5.9%)**
Chaplain	4 (2.2%)	4 (5.2%)	1 (0.3%)	1 (0.9%)	1 (0.7%)	**11 (1.3%)**
Doctor	31 (17.4%)	19 (24.7%)	37 (11.1%)	16 (14.7%)	17 (12.5%)	**120 (14.4%)**
Dom/Homecare staff	-	-	9 (2.7%)	-	-	**9 (1.1%)**
HCA	10 (5.6%)	2 (2.6%)	28 (8.4%)	5 (4.6%)	16 (11.8%)	**61 (7.3%)**
Mortuary Technician	-	1 (1.3%)	5 (1.5%)	1 (0.9%)	-	**7 (0.8%)**
Nurse/Midwife	101 (56.7%)	44 (57.1%)	203 (61.1%)	66 (60.6%)	81 (59.6%)	**495 (59.5%)**
Porter	4 (2.2%)	-	-	-	-	**4 (0.5%)**
Social care staff	1 (0.6%)	1 (1.3%)	1 (0.3%)	-	1 (0.7%)	**4 (0.5%)**
Social Worker	11 (6.2%)	2 (2.6%)	9 (2.7%)	4 (3.7%)	1 (0.7%)	**27 (3.2%)**
Other	7 (3.9%)	1 (1.3%)	12 (3.6%)	6 (5.5%)	6 (4.4%)	**32 (3.8%)**
Not recorded	-	-	-	1 (0.9%)	-	**1 (0.1%)**
Total	**178 (100%)**	**77 (100%)**	**332 (100%)**	**109 (100%)**	**136 (100%)**	**832 (100%)**

Breakdown of staff who <u>have not received feedback</u> from their line manager regarding the care they have provided to dying patients and/or their bereaved relatives

Analysis by Work Area, Trust and Overall (n=832)	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Acute Hospital	126 (70.8%)	57 (74.0%)	286 (86.1%)	75 (68.8%)	113 (83.1%)	**657 (79.0%)**
Non Acute Hospital	13 (7.3%)	5 (6.5%)	17 (5.1%)	6 (5.5%)	7 (5.1%)	**48 (5.8%)**
Community	36 (20.2%)	13 (16.9%)	21 (6.3%)	25 (22.9%)	12 (8.8%)	**107 (12.9%)**
Other	2 (1.1%)	2 (2.6%)	8 (2.4%)	3 (2.8%)	4 (2.9%)	**19 (2.3%)**
Not recorded	1 (0.6%)	-	-	-	-	**1 (0.1%)**
Total	**178 (100%)**	**77 (100%)**	**332 (100%)**	**109 (100%)**	**136 (100%)**	**832 (100%)**

Q11.0 Have you ever been involved in a complaint relating to the care of the dying, deceased or bereaved?

Answer	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Yes	32 (7.6%)	24 (14.2%)	75 (9.8%)	27 (10.8%)	40 (12.8%)	**198 (10.3%)**
No	381 (90.9%)	144 (85.2%)	672 (87.8%)	218 (87.6%)	266 (85.3%)	**1,681 (87.8%)**
Not recorded	6 (1.4%)	1 (0.6%)	18 (2.4%)	4 (1.6%)	6 (1.9%)	**35 (1.8%)**
Total	**419 (100%)**	**169 (100%)**	**765 (100%)**	**249 (100%)**	**312 (100%)**	**1,914 (100%)**

Q11.1 Have you ever been involved in an incident relating to the care of the dying, deceased or bereaved?

Answer	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Yes	42 (10%)	22 (13%)	78 (10.2%)	27 (10.8%)	37 (11.9%)	**206 (10.8%)**
No	370 (88.3%)	144 (85.2%)	673 (88%)	217 (87.2%)	271 (86.9%)	**1,675 (87.5%)**
Not recorded	7 (1.7%)	3 (1.8%)	14 (1.8%)	5 (2%)	4 (1.3%)	**33 (1.7%)**
Total	**419 (100%)**	**169 (100%)**	**765 (100%)**	**249 (100%)**	**312 (100%)**	**1,914 (100%)**

Breakdown of staff who have been involved in an incident relating to the care of the dying, deceased or bereaved

Analysis by Work Role, Trust and Overall (n=206)	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Administrative staff	-	-	2 (2.6%)	-	1 (2.7%)	**3 (1.5)**
Allied Health Professions	1 (2.4%)	-	4 (5.1%)	1 (3.7%)	-	**6 (2.9%)**
Chaplain	-	-	-	-	2 (5.4%)	**2 (1%)**
Doctor	7 (16.7%)	11 (50%)	9 (11.5%)	5 (18.5%)	6 (16.2%)	**38 (18.4%)**
HCA	-	1 (4.5%)	5 (6.4%)	-	1 (2.7%)	**7 (3.4%)**
Mortuary Technician	-	-	1 (1.3%)	-	-	**1 (0.5%)**
Nurse/Midwife	32 (76.2%)	9 (40.9%)	53 (67.9%)	17 (63%)	26 (70.2%)	**137 (66.5%)**
Social care staff	-	-	-	1 (3.7%)	-	**1 (0.5%)**
Social Worker	1 (2.4%)	1 (4.5%)	1 (1.3%)	1 (3.7%)	-	**4 (1.9%)**
Other	1 (2.4%)	-	3 (3.8%)	2 (7.4%)	1 (2.7%)	**7 (3.4%)**
Total	**42 (100%)**	**22 (100%)**	**78 (100%)**	**27 (100%)**	**37 (100%)**	**206 (100%)**

Breakdown of staff that that been involved in an incident relating to the care of the dying, deceased or bereaved

Analysis by Work Area, Trust and Overall (n=206)	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Adults	21 (50%)	9 (40.9%)	60 (76.9%)	17 (63%)	26 (70.3%)	**133 (64.6%)**
Children's	1 (2.4%)	3 (13.6%)	3 (3.8%)	4 (14.8%)	-	**11 (5.3%)**
Maternity	15 (35.7%)	3 (13.6%)	3 (3.8%)	3 (11.1%)	5 (13.5%)	**29 (14.1%)**
Mental Health	2 (4.8%)	3 (13.6%)	7 (9%)	1 (3.7%)	-	**13 (6.3%)**
Other	3 (7.1%)	4 (18.2%)	5 (6.4%)	2 (7.4%)	6 (16.2%)	**20 (9.7%)**
Total	**42 (100%)**	**22 (100%)**	**78 (100%)**	**27 (100%)**	**37 (100%)**	**206 (100%)**

Q11.2 If you ever been involved in an incident or complaint relating to the care of the dying, deceased or bereaved, has there been learning identified from this? (n=303)

Some respondents may have been involved in an incident only, complaint only or both	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Yes	40 (67.8%)	25 (78.1%)	81 (69.8%)	28 (71.8%)	43 (75.4%)	**217 (71.6%)**
No	10 (16.9%)	6 (18.8%)	15 (12.9%)	4 (10.3%)	5 (8.8%)	**40 (13.2%)**
Not applicable	7 (11.9%)	1 (3.1%)	17 (14.7%)	7 (17.9%)	9 (15.8%)	**41 (13.5%)**
Not recorded	2 (3.4%)	-	3 (2.6%)	-	-	**5 (1.7%)**
Total	**59 (100%)**	**32 (100%)**	**116 (100%)**	**39 (100%)**	**57 (100%)**	**303 (100%)**

Q12.0 Are you aware of any systems within the Trust to support you in your role caring for dying or deceased patients and/or bereaved relatives? (n=1,798)

Respondents answered 'Yes' at one or more parts of questions 3.0 – 3.2	Trust					
	NHSCT	**WHSCT**	**BHSCT**	**SHSCT**	**SEHSCT**	**Total**
Yes	243 (62.1%)	77 (49.7%)	355 (49.4%)	155 (65.1%)	158 (53.4%)	**988 (54.9%)**
No	125 (32%)	74 (47.7%)	335 (46.7%)	74 (31.1%)	135 (45.6%)	**743 (41.3%)**
Not recorded	23 (5.9%)	4 (2.6%)	28 (3.9%)	9 (3.8%)	3 (1%)	**67 (3.7%)**
Total	**391 (100%)**	**155 (100%)**	**718 (100%)**	**238 (100%)**	**296 (100%)**	**1,798 (100%)**

Breakdown of staff who are aware of systems within the Trust to support them in their role caring for dying or deceased patients and/or bereaved relatives

Analysis by Work Area, Trust and Overall (n=988)	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Administrative staff	1 (0.4%)	1 (1.3%)	5 (1.4%)	2 (1.3%)	2 (1.3%)	**11 (1.1%)**
Allied Health Professions	2 (0.8%)	-	9 (2.5%)	5 (3.2%)	4 (2.5%)	**20 (2%)**
Chaplain	5 (2.1%)	1 (1.3%)	4 (1.1%)	3 (1.9%)	-	**13 (1.3%)**
Doctor	21 (8.6%)	9 (11.7%)	15 (4.2%)	17 (11%)	10 (6.3%)	**72 (7.3%)**
Dom/Homecare staff	3 (1.2%)	-	5 (1.4%)	2 (1.3%)	-	**10 (1%)**
HCA	11 (4.5%)	4 (5.2%)	44 (12.4%)	5 (3.2%)	13 (8.2%)	**77 (7.8%)**
Mortuary Technician	1 (0.4%)	-	2 (0.6%)	2 (1.3%)	1 (0.6%)	**6 (0.6%)**
Nurse/Midwife	181 (74.5%)	56 (72.7%)	244 (68.7%)	105 (67.7%)	117 (74.1%)	**703 (71.2%)**
Porter	1 (0.4%)	-	-	-	-	**1 (0.1%)**
Social care staff	1 (0.4%)	-	-	1 (0.6%)	1 (0.6%)	**3 (0.3%)**
Social Worker	9 (3.7%)	4 (5.2%)	14 (3.9%)	4 (2.6%)	4 (2.5%)	**35 (3.5%)**
Other	7 (2.9%)	2 (2.6%)	13 (3.7%)	9 (5.8%)	6 (3.8%)	**37 (3.7%)**
Total	**243 (100%)**	**77 (100%)**	**355 (100%)**	**155 (100%)**	**158 (100%)**	**988 (100%)**

Breakdown of staff who are aware of systems within the Trust to support them in their role caring for dying or deceased patients and/or bereaved relatives

Analysis by Specialty, Trust and Overall (n=988)	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Adults	141 (58%)	48 (62.3%)	251 (70.7%)	90 (58%)	124 (78.5%)	**654 (66.2%)**
Children's	16 (6.6%)	7 (9.1%)	28 (7.9%)	24 (15.5%)	3 (1.9%)	**78 (7.9%)**
Learning Disability	1 (0.4%)	-	4 (1.1%)	2 (1.3%)	-	**7 (0.7%)**
Maternity	35 (14.4%)	5 (6.5%)	21 (5.9%)	17 (11%)	13 (8.2%)	**91 (9.2%)**
Mental Health	22 (9.1%)	3 (3.9%)	18 (5.1%)	6 (3.9%)	6 (3.8%)	**55 (5.6%)**
Other	26 (10.7%)	14 (18.2%)	32 (9%)	13 (8.4%)	12 (7.6%)	**97 (9.8%)**
Not recorded	2 (0.8%)	-	1 (0.3%)	3 (1.9%)	-	**6 (0.6%)**
Total	**243 (100%)**	**77 (100%)**	**355 (100%)**	**155 (100%)**	**158 (100%)**	**988 (100%)**

Q12.0 If Yes, please indicate those you are aware of, whether you know how to avail of them and whether you have used them (n=988)

Some respondents indicated that they were aware of more than one system. Each section of this question had 3 parts however not all respondents answered every part		Trust					
		NHSCT (n=243)	**WHSCT (n=77)**	**BHSCT (n=355)**	**SHSCT (n=155)**	**SEHSCT (n=158)**	**Total (n=988)**
Bereavement co-ordinator	Aware of	138 (56.8%)	39 (50.6%)	167 (47.0%)	102 (65.8%)	85 (53.8%)	**531 (53.7%)**
	Know how to avail of	64 (26.3%)	23 (29.9%)	66 (18.6%)	52 (33.6%)	47 (29.8%)	**252 (25.5%)**
	Have used	14 (5.8%)	10 (13%)	21 (5.9%)	20 (12.9%)	23 (14.6%)	**88 (8.9%)**
Carecall / Staff care	Aware of	143 (58.9%)	32 (41.6%)	136 (38.3%)	88 (56.8%)	62 (39.2%)	**461 (46.7%)**
	Know how to avail of	83 (34.2%)	19 (24.7%)	67 (18.9%)	50 (32.3%)	32 (20.2%)	**251 (25.4%)**
	Have used	18 (7.4%)	6 (7.8%)	15 (4.2%)	17 (11%)	10 (6.3%)	**66 (6.7%)**
Occupational health	Aware of	139 (57.2%)	39 (50.6%)	199 (56.1%)	92 (59.4%)	83 (52.5%)	**552 (55.9%)**
	Know how to avail of	84 (34.6%)	27 (35.1%)	106 (29.9%)	59 (38.1%)	47 (29.8%)	**323 (32.7%)**
	Have used	13 (5.4%)	3 (3.9%)	21 (5.9%)	14 (9%)	12 (7.6%)	**63 (6.4%)**
Debriefing	Aware of	84 (34.6%)	24 (31.2%)	126 (35.5%)	64 (41.3%)	52 (32.9%)	**350 (35.4%)**
	Know how to avail of	40 (16.5%)	14 (18.2%)	58 (16.3%)	31 (20%)	27 (17.1%)	**170 (17.2%)**
	Have used	31 (12.8%)	11 (14.3%)	35 (9.9%)	20 (12.9%)	23 (14.6%)	**120 (12.2%)**
Supervision	Aware of	91 (37.4%)	33 (42.9%)	163 (45.9%)	81 (52.3%)	81 (51.3%)	**449 (45.4%)**
	Know how to avail of	64 (26.3%)	19 (24.7%)	80 (22.5%)	45 (29%)	35 (22.2%)	**243 (24.6%)**
	Have used	31 (12.8%)	16 (20.8%)	56 (15.8%)	40 (25.8%)	30 (19%)	**173 (17.5%)**
Peer support	Aware of	135 (55.6%)	36 (46.8%)	179 (50.4%)	91 (58.7%)	88 (55.7%)	**529 (53.5%)**
	Know how to avail of	80 (32.9%)	21 (27.3%)	89 (25.1%)	52 (33.6%)	42 (26.6%)	**284 (28.7%)**
	Have used	55 (22.6%)	24 (31.2%)	93 (26.2%)	57 (36.8%)	46 (29.1%)	**275 (27.8%)**
Other	Aware of	4 (1.6%)	2 (2.6%)	9 (2.5%)	7 (4.5%)	4 (2.5%)	**26 (2.6%)**
	Know how to avail of	1 (0.4%)	3 (3.9%)	3 (0.8%)	1 (0.6%)	3 (1.9%)	**11 (1.1%)**
	Have used	-	-	8 (2.2%)	3 (1.9%)	3 (1.9%)	**14 (1.4%)**

BHSCT

13 staff members who were aware of and/or knew how to avail of and/or had used other systems to support them in their role caring for dying or deceased patients and/or bereaved relatives stated:

- Palliative Care Team (4 respondents)
- Reflective Practice (2 respondents)
- Counselling supervision/reflection
- Counselling Supervision
- Chaplaincy (2 respondents)
- Clinical Psychologist for maternity services
- Action learning
- Neonatal access to maternity psychologist, not funded post for neonates in-service bereavement study conference

**Some BHSCT staff provided comments regarding 'Other' support systems but had not stated whether this was in the context of being aware of, knowing how to avail of or having used*

SHSCT

5 staff members who were aware of and/or knew how to avail of and/or had used other systems to support them in their role caring for dying or deceased patients and/or bereaved relatives stated:

- Within my own team we do discuss and support each other with difficult cases
- Community palliative nurse specialist
- Chaplaincy services/team (2 respondents)
- Patient support, PPI training, Bereavement speed networking events

SEHSCT

3 staff members who were aware of and/or knew how to avail of and/or had used other systems to support them in their role caring for dying or deceased patients and/or bereaved relatives stated:

- Palliative Care team
- Palliative Care Team Advice
- Team reflection

Q13.0 Have you attended any training/awareness raising sessions which covered the following areas?

Some members of staff who answered ' Yes' attended more than one training / awareness raising session	Trust					
	NHSCT (n=419)	**WHSCT (n=169)**	**BHSCT (n=765)**	**SHSCT (n=249)**	**SEHSCT (n=312)**	**Total (n=1,914)**
Last offices	30 (7.2%)	20 (11.8%)	90 (11.8%)	8 (3.2%)	28 (9%)	**176 (9.2%)**
Identification and transfer of bodies	28 (6.7%)	15 (8.9%)	55 (7.2%)	16 (6.4%)	18 (5.8%)	**132 (6.9%)**
Storage, viewing and release of bodies	18 (4.3%)	5 (3%)	14 (1.8%)	4 (1.6%)	6 (1.9%)	**47 (2.5%)**
Verification of death	37 (8.8%)	15 (8.9%)	29 (3.8%)	14 (5.6%)	12 (3.8%)	**107 (5.6%)**
Issuing of Medical Certificate of Cause of death	31 (7.4%)	11 (6.5%)	33 (4.3%)	15 (6%)	15 (4.8%)	**105 (5.5%)**
Management of sudden / unexpected death	25 (6%)	4 (2.4%)	27 (3.5%)	12 (4.8%)	7 (2.2%)	**75 (3.9%)**
Reporting deaths to the Coroner	49 (11.7%)	14 (8.3%)	32 (4.2%)	18 (7.2%)	10 (3.2%)	**123 (6.4%)**
Preservation of evidence in forensic cases	13 (3.1%)	3 (1.8%)	10 (1.3%)	4 (1.6%)	3 (1%)	**33 (1.7%)**
Seeking and obtaining consent for hospital post mortem examination	34 (8.1%)	11 (6.5%)	15 (2%)	19 (7.6%)	10 (3.2%)	**89 (4.6%)**
Organ donation	56 (13.4%)	14 (8.3%)	103 (13.5%)	24 (9.6%)	17 (5.4%)	**214 (11.2%)**
Chaplaincy / Spiritual care	32 (7.6%)	22 (13%)	73 (9.5%)	16 (6.4%)	30 (9.6%)	**173 (9%)**
Do not attempt cardio pulmonary resuscitation	40 (9.5%)	19 (11.2%)	77 (10%)	26 (10.4%)	21 (6.7%)	**183 (9.6%)**
Advanced care planning for adults	31 (7.4%)	12 (7.1%)	48 (6.3%)	23 (9.2%)	23 (7.4%)	**137 (7.2%)**
Advanced care planning for children	11 (2.6%)	3 (1.8%)	6 (0.8%)	2 (0.8%)	3 (1%)	**25 (1.3%)**
Breaking bad news	82 (19.6%)	38 (22.5%)	125 (16.3%)	51 (20.5%)	70 (22.4%)	**366 (19.1%)**
Bereavement Care	90 (21.5%)	20 (11.8%)	100 (13.1%)	58 (23.3%)	41 (13.1%)	**309 (16.1%)**
Other*	10 (2.4%)	6 (3.6%)	18 (2.4%)	6 (2.4%)	2 (0.6%)	**42 (2.2%)**
No training/awareness sessions attended	207 (49.4%)	82 (48.5%)	435 (56.9%)	126 (50.6%)	191 (61.2%)	**1,041 (54.4%)**

Note: Other*

NHSCT

10/10 staff members attended other training / awareness raising sessions and specified:

- Palliative Care (5 respondents)
- Palliative care keyworker training for community
- Final Journeys: Macmillan study days
- Palliative care awareness
- Bereavement counselling course with child bereavement trust
- Not recorded.

WHSCT

6/6 staff members attended other training / awareness raising sessions and specified:

- Sands study day
- Last offices as a student
- End of life care. Final journeys. Bereavement workshop
- Final Journeys Course
- SANDS training
- Specific courses on death and dying.

BHSCT

18/18 staff members attended other training / awareness raising sessions and specified:

- Palliative care course
- Bereavement study day
- Care after Death
- Online via email
- Social work network
- Bereavement Workshops
- Specialist practice and MSC Palliative care
- Bereavement induction classes
- Care after death
- Care of Duty. Palliative Care
- All Ireland Palliative care social work network.
- All selected recently accessed via Clic Sargent training. Previous bereavement care accessed via NI Hospice. Have never accessed training etc. via Trust
- Cruse awareness training approx. 8 years ago.
- In house bereavement study day, taught by clinical psychologist
- SANDS charity teaching sessions on care of the dying baby and family.
- In service half day bereavement
- End of life palliative care in the community
- Not recorded.

SHSCT

6/6 staff members attended other training / awareness raising sessions and specified:

- Palliative Care
- Discussed issues whilst working with Palliative Care at a meeting x 2 hours
- Attend updates with SHSCT Bereavement Coordinator
- SANDS Study Bereavement Conference
- Palliative Care training days and workshops, palliative modules at degree level
- Palliative Care course

SEHSCT

2/2 staff members attended other training / awareness raising sessions and specified:

- Care of the dying patient QUB
- PG modules in University of Ulster, towards masters in advancing practice

Q13.1 Please describe any issues that may have prevented your access to relevant training:

NHSCT

73 staff members with different roles described issues:

Role	**Issue**
AHP	Didn't feel training was relevant to my job
Chaplain	N/A
Chaplain	N/A
Doctor	Not advertised. Not included in regular mandatory training. Not aware of any regularly scheduled training. We get updates from the Coroners' service, at least once a year
Doctor	Getting leave from rota
Doctor	There are only so many hours in the day and often the arranged training is at a time when it is impossible to attend
Doctor	Workload
Doctor	Not knowing about it
Doctor	Lack of space in job plan for anything other than clinics and core clinical work
Dom/H'care Staff	Unaware the training existed
Dom/H'care Staff	Not offered by Trust
Dom/H'care Staff	Not Offered.
Dom/H'care Staff	Not offered by trust
Dom/H'care Staff	Unaware of its existence
Dom/H'care Staff	Unaware of its existence
Dom/H'care Staff	Not been offered
HCA	Never been offered
HCA	Palliative care course always cancelled
HCA	Have not been offered this training
HCA	Have never been informed of any training
HCA	Lack of resources on ward
Nurse / Midwife	Not offered
Nurse / Midwife	Not offered
Nurse / Midwife	Team to be released from the team to attend training
Nurse / Midwife	Time
Nurse / Midwife	Staff shortages/Timing
Nurse / Midwife	Staffing issues and mandatory training only
Nurse / Midwife	New to the trust and as of yet have not been offered this training
Nurse / Midwife	Unaware of any training
Nurse / Midwife	Staffing issues in clinical areas
Nurse / Midwife	Didn't know any was available
Nurse / Midwife	Not relevant to my role
Nurse / Midwife	Workload and busy ward
Nurse / Midwife	Time issues
Nurse / Midwife	Infrequent deaths in working area, training not prioritised

Nurse / Midwife	Mandatory Training
Nurse / Midwife	Never been offered in community setting
Nurse / Midwife	Availability of training
Nurse / Midwife	Busy workload, shortage of staff
Nurse / Midwife	Not aware of any available training
Nurse / Midwife	Off Duty
Nurse / Midwife	Didn't know this all
Nurse / Midwife	Any training I have had was through self funded education
Nurse / Midwife	Short staffed
Nurse / Midwife	Not aware of any training on bereavement care
Nurse / Midwife	Not mandatory. Staffing levels limit opportunities.
Nurse / Midwife	Relevant training has not been highlighted as being required. There is a feeling as if end stages of life has become less important.
Nurse / Midwife	Unable to attend course - fully booked
Nurse / Midwife	Not being aware of this type of training
Nurse / Midwife	Non-existent
Nurse / Midwife	None
Nurse / Midwife	Time
Nurse / Midwife	Management will not release staff to attend due to low staffing
Nurse / Midwife	No time to access training
Nurse / Midwife	Department can be busy and does not allow for in house training
Nurse / Midwife	Have not seen or been made aware of any training relating to these issues
Nurse / Midwife	Lack of staff
Nurse / Midwife	Staff shortage
Nurse / Midwife	Shortness of staff on the ward
Nurse / Midwife	Short of staff on ward
Nurse / Midwife	Management do not appear to see this field as important. I previously applied for a study day covering this topic. I was denied access/attendance by my manager
Nurse / Midwife	None
Nurse / Midwife	lack of awareness and time away from ward
Nurse / Midwife	Staffing levels at ward level of recent, and therefore limited time to complete tasks as I would wish at ward level
Nurse / Midwife	Getting freed up to attend. the subject covers a wide range which does not always suit the specific area I work in
Other	Workload, staff sickness, Time
Other	Perhaps thought to be not applicable
Other	In training for a different post at present
Other	Workload, courses cancelled due to finances
Other	Not applicable
Porter	Unaware of training
Social Worker	Time. Staff shortages
Social Worker	Lack of information about available training

WHSCT
52 staff members with different roles described issues

AHP	We don't do any of this training
Doctor	Not aware of training available except from online guidance/updates on intranet
Doctor	Unable to get time off
Doctor	Demands of job, lack of available free time, lack of awareness when occurring
Doctor	N/A

Doctor	Release from clinical commitments
Doctor	All above training was done prior to my current post Difficult to education sessions in current posts due to clinical commitments, job plan and being short staffed
Doctor	Too much computer tick box information
Doctor	Time to attend training Not aware of training opportunities
Doctor	Unaware of other training availability
Doctor	N/A
HCA	lack of courses
HCA	Until now I didn't know there was training available
HCA	Midwifes get to go on the courses before msw/na
Nurse / Midwife	I've never seen any of these advertised
Nurse / Midwife	Time issues
Nurse / Midwife	Financial constraints
Nurse / Midwife	Not really relevant to the rehab ward which I work in
Nurse / Midwife	New start. Access to courses very limited and seem to be poorly organised.
Nurse / Midwife	Never knew it was available. Ward manager has never sent staff
Nurse / Midwife	Training course availability
Nurse / Midwife	Not aware of
Nurse / Midwife	Lack of knowledge of trainings existence
Nurse / Midwife	Staff shortage on ward and demands of mandatory training
Nurse / Midwife	Not specific to care of a dying child
Nurse / Midwife	I am not aware of how/ where to access the training
Nurse / Midwife	Very little training specifically in relation to children
Nurse / Midwife	Short staffed on ward
Nurse / Midwife	Accessibility off ward. Time. Workload. Not aware of relevant training
Nurse / Midwife	None available/none emphasised
Nurse / Midwife	Not aware of any training
Nurse / Midwife	Not aware of any sessions
Nurse / Midwife	Staffing levels, no training offered that I have been aware of
Nurse / Midwife	Not aware of training on other aspects being available
Nurse / Midwife	Busy ward environment. Staff shortages
Nurse / Midwife	We are an acute unit which very rarely has deaths
Nurse / Midwife	Just being aware of services available
Nurse / Midwife	Lack of courses available at the AAH suite
Nurse / Midwife	Referrals have just been received recently
Nurse / Midwife	Didn't know about them
Nurse / Midwife	trust withdrawing courses to save money
Nurse / Midwife	Not in the clinical providing direct care
Nurse / Midwife	Not made aware of training
Nurse / Midwife	Has never been offered
Nurse / Midwife	Documentation/skills updates in this area of care are rarely advertised, but it would be an idea to add into combination study day for nurses or perhaps CEC could liaise with Manual handling team and make there updates a full day for staff?
Nurse / Midwife	Trust not releasing staff to training
Nurse / Midwife	Staff, lack of availability/.awareness of potential training re: death and dying
Nurse / Midwife	Busy ward
Nurse / Midwife	Not aware needed to go all training/care picked up on ward
Other	Last reporting of coroner's death involved everyone in northern Ireland in training
Social Worker	Trust is not funding training at present due to resource pressures

Social Worker	Heavy workload

BHSCT
181 staff members with different roles described issues

Admin Staff	N/A
Admin Staff	N/A
Admin Staff	None
Admin Staff	Hostility of other staff- Attitude that only nursing staff are upset by death of patient/ have contact with relatives
AHP	Not applicable
AHP	Lack of awareness of available training
AHP	Being aware of what training is available
AHP	Time away from work
AHP	Working as Locum - Limited training
AHP	Financial constraints and demands on service
Doctor	Unsure what training is available
Doctor	Medical staffing levels
Doctor	Rota constraints
Doctor	Study leave not available for F1 Doctors
Doctor	Available time
Doctor	Not aware of availability
Doctor	Too little time and lack of information
Doctor	Unaware training was available.
Doctor	Time and availability
Dom/H'care Staff	Never required before
HCA	No training courses offered
HCA	Never been offered any training
HCA	No advice on training available
HCA	Was not aware that training was available
HCA	Short staffing
HCA	Unaware of training. Ward too busy to allow for attendance
HCA	Staff levels on ward - too busy
HCA	Unaware of relevant training
HCA	Wasn't aware any existed
HCA	Wasn't aware that training was available
HCA	No training offered
HCA	No training offered
HCA	Only been in post 5 months
HCA	Time constraints and learning opportunities
Mortuary Tec	Not relevant to current role
Mortuary Tec	Staffing issues from time to time
Nurse / Midwife	Haven't received any training yet
Nurse / Midwife	Staffing
Nurse / Midwife	Staff shortages
Nurse / Midwife	Too busy with patients to attend training. Staff shortages
Nurse / Midwife	Student Nurse
Nurse / Midwife	Unaware of training available. Time pressures of workload
Nurse / Midwife	None
Nurse / Midwife	Perhaps not available in community

Nurse / Midwife	Busy unit, short staffed
Nurse / Midwife	Time and courses available
Nurse / Midwife	Time constraints - time to attend other study days as well as mandatory ones
Nurse / Midwife	Not appropriate for my role
Nurse / Midwife	Time
Nurse / Midwife	Not needed for current
Nurse / Midwife	Not directly involved in patient care in current role
Nurse / Midwife	Didn't know it was available
Nurse / Midwife	Did not know training was available
Nurse / Midwife	Unaware of relevant training or the availability of sessions
Nurse / Midwife	Unaware of any training available
Nurse / Midwife	When I last approached my manager about training in this area it was declined
Nurse / Midwife	Didn't know it was available
Nurse / Midwife	Working nights/ weekends. Unable to leave ward staff levels
Nurse / Midwife	Newly started student nurse
Nurse / Midwife	Busy ward. Under staffed on occasions
Nurse / Midwife	Busy ward. Staffing issues
Nurse / Midwife	Not aware of them
Nurse / Midwife	Unsure what courses are available
Nurse / Midwife	Unable to gain time away from ward
Nurse / Midwife	None offered
Nurse / Midwife	Not aware of any training
Nurse / Midwife	I was unaware it was available
Nurse / Midwife	Not aware of same
Nurse / Midwife	Unaware of care of the dying training
Nurse / Midwife	Time constraints/ training dates and venues
Nurse / Midwife	Available time and not enough staff on wards
Nurse / Midwife	Leave from work - eg maternity
Nurse / Midwife	Not enough information
Nurse / Midwife	Staff levels do not allow this
Nurse / Midwife	Unaware of training
Nurse / Midwife	Didn't know there were sessions available
Nurse / Midwife	I have never been offered this training
Nurse / Midwife	I've never been offered bereavement care training
Nurse / Midwife	I was never offered training before
Nurse / Midwife	Unaware of training
Nurse / Midwife	Unaware that training was available. Should be required as mandatory
Nurse / Midwife	Lack of awareness, staffing issue on ward
Nurse / Midwife	Not always aware of its availability in relation to death
Nurse / Midwife	None available, ward demands
Nurse / Midwife	Not appropriate
Nurse / Midwife	Staffing issues. Available training
Nurse / Midwife	Unaware of training dates
Nurse / Midwife	Unaware of relevant training
Nurse / Midwife	Lack of awareness that training is available
Nurse / Midwife	New start- not yet attended
Nurse / Midwife	Didn't know there was training in this area
Nurse / Midwife	Unaware of any available
Nurse / Midwife	Nil available
Nurse / Midwife	Lack of awareness. Not on mandatory training file

Nurse / Midwife	Didn't know it was available
Nurse / Midwife	Training given while a student nurse @ QUB
Nurse / Midwife	Not available
Nurse / Midwife	Not put on courses to attend
Nurse / Midwife	So much mandatory training to complete
Nurse / Midwife	Work pressures prevent attendance at training
Nurse / Midwife	Do not have patients on the ward that require care of the dying
Nurse / Midwife	Unaware that training is available
Nurse / Midwife	Unaware of how to access training
Nurse / Midwife	Lack of awareness. Lack of available staff cover
Nurse / Midwife	Not aware of any training
Nurse / Midwife	Not provided to nurses
Nurse / Midwife	Lack of staff
Nurse / Midwife	Unaware of available training
Nurse / Midwife	Not aware of training
Nurse / Midwife	Booklets not always available on wards
Nurse / Midwife	Unaware of availability
Nurse / Midwife	Unaware of relevant training
Nurse / Midwife	Did not know training was available
Nurse / Midwife	Not aware of available training
Nurse / Midwife	Didn't know there was training
Nurse / Midwife	As not mandatory - Not a priority
Nurse / Midwife	Not having an awareness of these programmes existing or time to go from work
Nurse / Midwife	There is an evident lack of available training in this area
Nurse / Midwife	Training Opportunities not offered at ward level
Nurse / Midwife	Newly qualified
Nurse / Midwife	Lack of notice - ie short notice of available training unable to leave department as too busy
Nurse / Midwife	Limited dates/ training tutorials
Nurse / Midwife	Not mandatory so therefore no time to avail of sessions
Nurse / Midwife	Lack of study days available
Nurse / Midwife	Not mandatory and therefore difficult to get time to attend
Nurse / Midwife	Unaware of any training
Nurse / Midwife	Not aware of any training in this area
Nurse / Midwife	Unaware of what is available
Nurse / Midwife	Unaware of any available courses
Nurse / Midwife	Never needed to
Nurse / Midwife	Very few study days related to bereavement
Nurse / Midwife	Lack of staff/Opportunity
Nurse / Midwife	Not seen as a high priority in area of work
Nurse / Midwife	Staffing levels and appointments to go to training
Nurse / Midwife	I am not aware of relevant training
Nurse / Midwife	Unaware of such training
Nurse / Midwife	Death uncommon on ward
Nurse / Midwife	New start- no training has happened yet
Nurse / Midwife	Haven't been aware of training available
Nurse / Midwife	Not aware these courses existed
Nurse / Midwife	Unaware of training programmes
Nurse / Midwife	No mandatory training in this area. Follow procedures and hospital policy
	Lack of training available. Awareness of training. Funding for training

Nurse / Midwife	Lack of awareness of training
Nurse / Midwife	Not aware of such training
Nurse / Midwife	My role does not necessarily have me involved in end of life care, we become involved as we have built up a relationship with the patient previously
Nurse / Midwife	Staff shortages
Nurse / Midwife	Not aware of formal training. Knowledge is what has been acquired through experience/ observation and practice
Nurse / Midwife	Poor information about training. Training sessions unexpectedly cancelled
Nurse / Midwife	Relevancy to role
Nurse / Midwife	Not usually relevant to the area I am currently working in
Nurse / Midwife	Did not look for it; working in rehab patient death is thankfully a rare occurrence
Nurse / Midwife	We do not often have deaths on the ward
Nurse / Midwife	Lack of staff. Lack of time. Not mandatory
Nurse / Midwife	Time Constraints. Learning opportunity
Nurse / Midwife	Not enough space on training slots
Nurse / Midwife	Unaware training was available
Nurse / Midwife	My nursing position and job specification
Nurse / Midwife	Study days are not a priority. Bereavements are rare in non-acute wards
Nurse / Midwife	Time
Nurse / Midwife	Bank staff member - limited time/access to audit day training etc.
Nurse / Midwife	staffing issues
Nurse / Midwife	Not aware of formal training
Nurse / Midwife	Unaware that they existed
Nurse / Midwife	Unable to attend training session as out of the country
Nurse / Midwife	Time and poor staffing levels
Nurse / Midwife	Not sure it's available
Nurse / Midwife	Didn't know they were available
Nurse / Midwife	Getting time out of the clinical area
Nurse / Midwife	No time
Nurse / Midwife	Did not know it was there
Other	Not qualified yet
Other	Was not aware
Other	Not relevant
Other	Workload pressures
Social Worker	Not necessary in my role
Social Worker	Not child-death specific: too general Caseload pressures
Social Worker	No issues. I would welcome any further training if it was offered
Social Worker	Hard to access specific training for social workers
Social Worker	Pressure of workload. Poor networking of new developments. Lack of resources. Lack of relevant courses that are easily accessed
Social Worker	No Specialist Training Specific to working with Teenagers and Young Adults CLIC Sargent recently provided training in Glasgow

SHSCT
51 staff members with different roles described issues

Admin Staff	Not appropriate to job role
AHP	Not appropriate
Chaplain	None
Chaplain	Access to information and relevance at times of courses offered within clinical setting for chaplaincy discipline

Doctor	Also funding - most of my training I have funded myself initially due to no information re funding and now due to cutbacks
Doctor	Training awareness
Doctor	Advertisement of said courses
Doctor	Course being already booked up when I tried to get on it. next course - 2016
Doctor	Limited availability for Sage and Thyme
Doctor	Not offered
Doctor	Not enough time
HCA	Communication re: Training
HCA	Lack of training and communication
HCA	Very little training provided
Nurse / Midwife	Only newly qualified 6 months
Nurse / Midwife	Departmental pressures
Nurse / Midwife	Courses not available
Nurse / Midwife	Not aware of what training is available
Nurse / Midwife	Time to attend
Nurse / Midwife	Not my role
Nurse / Midwife	Bank nurse only sent on mandatory training
Nurse / Midwife	Cut backs
Nurse / Midwife	None. I am aware of the policies
Nurse / Midwife	Staff shortages and not being able to be released due to pressure on the service
Nurse / Midwife	I work evenings and have other commitments during the day
Nurse / Midwife	On A/L
Nurse / Midwife	Not aware of them
Nurse / Midwife	Staff shortages. Not aware this was available
Nurse / Midwife	Not available
Nurse / Midwife	Don’t know of any available training
Nurse / Midwife	Very little training provided that I am aware of
Nurse / Midwife	Too much other training to complete mainly on own time
Nurse / Midwife	Lack of dates and staffing on ward
Nurse / Midwife	Not aware of where to access the training
Nurse / Midwife	None
Nurse / Midwife	Time and financial constraints
Nurse / Midwife	Not aware of such training specific to maternity care
Nurse / Midwife	So much mandatory training for midwives every week. Difficult to get time/time back
Nurse / Midwife	Funding
Nurse / Midwife	Time
Nurse / Midwife	Time
Nurse / Midwife	Death of a patient within the day surgery setting would be extremely rare, training has not been required until lately
Nurse / Midwife	Not dealing with dying patients
Nurse / Midwife	Lack of knowledge
Other	I am not ward/department based
Other	N/A
Other	Training not offered to student nurses whilst on placement
Other	N/A
Other	None
Other	Not relevant to my role
Social Worker	Work/case load
Role not recorded	I perceived the training was not directed at me. Other issues preventing attendance include being released from other duties to attend training and travel expenses

SEHSCT
70 staff members with different roles described issues

Administrative Staff	None has ever been offered to me
Chaplain	Lack of notification
Doctor	Didn't know it existed
Doctor	Time and staffing constraints
Doctor	Heavy Workload/ no time
Doctor	Unaware of available training
Doctor	Lack of awareness of training opportunities
Doctor	Not compulsory so hard to get off work to attend. Staff pressures
Doctor	Not aware - and there is so much mandatory training to keep on top of!
Doctor	Time and locality
Doctor	Lack of awareness of what is available
HCA	Has not been made available
HCA	We have not been given any training
HCA	No training given
HCA	Training in this area not offered
HCA	Didn't know there was any training
HCA	No time
HCA	It has never been accessed for HCA to attend such training
HCA	Unaware of location to find training
Nurse / Midwife	Did not know that it was available
Nurse / Midwife	Conflicting times with other training
Nurse / Midwife	Releasing staff from ward. We rarely have patients dying on the ward
Nurse / Midwife	Getting time off ward to attend training and training number availability
Nurse / Midwife	Time Factors
Nurse / Midwife	None specific
Nurse / Midwife	Wasn't aware that training was available
Nurse / Midwife	Was not aware of any training that was available
Nurse / Midwife	Newly in post
Nurse / Midwife	Not notified of any
Nurse / Midwife	Protected time for training for ALL staff
Nurse / Midwife	Hasn't been made available to us
Nurse / Midwife	Wasn't aware that training was available
Nurse / Midwife	None available at present
Nurse / Midwife	Lack of awareness of available courses
Nurse / Midwife	Staffing levels- unable to attend
Nurse / Midwife	Staff shortages. Not aware of training taking place
Nurse / Midwife	Non mandatory, not advertised
Nurse / Midwife	Time. Staffing arrangements.
Nurse / Midwife	Bereavement box at ward level.
Nurse / Midwife	Getting time to attend study day
Nurse / Midwife	Ward short staffed
Nurse / Midwife	Hard to get appropriate training
Nurse / Midwife	Staff shortages
Nurse / Midwife	No time
Nurse / Midwife	Didn't know there was training available. Knew about policies
Nurse / Midwife	Unaware of training

Nurse / Midwife	Not aware of training
Nurse / Midwife	New to Job, Doctors would be on hand constantly
Nurse / Midwife	As a student I have not been notified of any of these training courses
Nurse / Midwife	Never been offered or informed of existence
Nurse / Midwife	Newly qualified - have not yet experienced looking after dying
Nurse / Midwife	Unaware what training is available
Nurse / Midwife	Not aware of training or have been sent for training
Nurse / Midwife	Time and Awareness
Nurse / Midwife	Having time to attend courses due to staffing levels
Nurse / Midwife	Not availed nor aware of
Nurse / Midwife	Bed pressures/staffing levels
Nurse / Midwife	Time
Nurse / Midwife	Not offered senior staff seem to think it unimportant
Nurse / Midwife	Wasn't aware of any courses re above
Nurse / Midwife	Not aware of and not offered
Nurse / Midwife	N/A
Nurse / Midwife	Time. Hard to even get mandatory training completed
Other	Not yet a registered nurse
Other	Not yet qualified
Other	Unknown Student Nurse
Other	Students can't access this training
Other	Not eligible for training
Other	I am unaware of where/ how to access these
Social Worker	I must admit it has only been recently that I have been involved with families/clients who have died, and I have not been previously aware or had the time to source Trust information regarding policies procedures and written information to give to the bereaved

Q14.0 Since 2009 have there been any changes or initiatives to improve care before, or at the time of, or after death in your area of practice? (n=1,457)*

** Of 1,914 total respondents 457 of these indicated that this question was 'not applicable' to them*

Answer	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Yes	149 (45%)	50 (37.6%)	181 (31%)	88 (48.6%)	101 (44.1%)	**569 (39%)**
No	117 (35.4%)	66 (49.6%)	327 (56.1%)	62 (34.2%)	115 (50.2%)	**687 (47.2%)**
Not recorded	65 (19.6%)	17 (12.8%)	75 (12.9%)	31 (17.1%)	13 (5.7%)	**201 (13.8%)**
Total	**331 (100%)**	**133 (100%)**	**583 (100%)**	**181 (100%)**	**229 (100%)**	**1,457 (100%)**

If 'Yes' – Analysis by Work Role, Trust and Overall (n=569)	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Doctor	21 (14.1%)	9 (18%)	9 (5%)	12 (13.6%)	7 (6.9%)	**58 (10.2%)**
Nurse/Midwife	113 (75.8%)	38 (76%)	137 (75.7%)	61 (69.3%)	82 (81.2%)	**431 (75.7%)**
Social Worker	3 (2%)	1 (2%)	6 (3.3%)	1 (1.1%)	1 (1%)	**12 (2.1%)**
Chaplain	3 (2%)	-	2 (1.1%)	2 (2.3%)	2 (2%)	**9 (1.6%)**
Health Care Assistant	3 (2%)	2 (4%)	13 (7.2%)	2 (2.3%)	7 (6.9%)	**27 (4.7%)**
Allied Health Professional	1 (0.7%)	-	2 (1.1%)	2 (2.3%)	1 (1%)	**6 (1.1%)**
Mortuary Technician	-	-	1 (0.6%)	2 (2.3%)	1 (1%)	**4 (0.7%)**
Porter	1 (0.7%)	-	-	-	-	**1 (0.2%)**
Administrative staff	-	-	3 (1.7%)	-	-	**3 (0.5%)**
Other	4 (2.7%)	-	8 (4.4%)	6 (6.8%)	-	**18 (3.2%)**
Total	**149 (100%)**	**50 (100%)**	**181 (100%)**	**88 (100%)**	**101 (100%)**	**569 (100%)**

If 'Yes' – Analysis by Work Area by Trust and Overall (n=569)	Trust					
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
Acute Hospital	94 (63.1%)	39 (78%)	154 (85.1%)	54 (61.4%)	94 (93.1%)	**435 (76.4%)**
Non-Acute Hospital	14 (9.4%)	6 (12%)	7 (3.9%)	9 (10.2%)	1 (1%)	**37 (6.5%)**
Community	37 (24.8%)	2 (4%)	13 (7.2%)	21 (23.9%)	6 (5.9%)	**79 (13.9%)**
Other	3 (2%)	3 (6%)	7 (3.9%)	4 (4.5%)	-	**17 (3%)**
Not recorded	1 (0.7%)	-	-	-	-	**1 (0.2%)**
Total	**149 (100%)**	**50 (100%)**	**181 (100%)**	**88 (100%)**	**101 (100%)**	**569 (30.1%)**

Q14.0 If Yes, please give examples of changes or initiatives to improve care:

Changes or initiatives to improve care are detailed below and have also been themed and listed at ***Appendix B***

NHSCT

136/149 staff members provided examples

AHP	Removal of LCP
Chaplain	This is on-going through training seminars, chaplaincy meetings and paediatric bereavement committee
Chaplain	The introduction of the bereavement forum and the excellent work that has been coordinated through it along with the awareness of the issues around end of life that has been raised by the work of the forum
Doctor	Greater awareness of locally enhanced services. Palliative care pathway
Doctor	Excellent medical teaching from members of the palliative care team
Doctor	Advanced care planning
Doctor	New information from the coroner new issues surrounding organ donation and not beating heart donation
Doctor	COTD pathway
Doctor	Palliative care updates Lily sign for bed space of deceased patients
Doctor	Organ donation
Doctor	Better awareness of issues around bereavement
Doctor	More information regarding bereavement counselling changes to coroner reporting SAI in progress. Made it more difficult
Doctor	Improved guidelines
Doctor	Introduction of Do not resuscitate form
Doctor	Bereavement coordinator
Doctor	Increased awareness of bereavement issues
Doctor	Dedicated relatives room and viewing area for bereaved families
Doctor	Introduction LCP - now withdrawn
Doctor	Improved awareness of advanced care planning and use of DNACPR orders in dementia care
Doctor	Standards of care have become more formalised. Closer working with Macmillan nurses for advice and support
HCA	Liverpool care pathway - not now in use
HCA	Lily's on patient's door. Purple patients' property bags. Purple sheets
HCA	The water lily Purple patient property bag
Nurse / Midwife	Lily poster to highlight a death on the ward
Nurse / Midwife	Lily picture
Nurse / Midwife	Introduction of the lily picture
Nurse / Midwife	Living well dying well
Nurse / Midwife	Advanced Care Planning. Palliative care meetings. Review of bereavement strategy
Nurse / Midwife	Sands boxes revamped. New leaflets. New checklist to complete
Nurse / Midwife	Maternal death guidelines - NHSCT
Nurse / Midwife	Care of the dying pathway
Nurse / Midwife	Care of the dying pathway
Nurse / Midwife	Purple bags/leaflets/lily poster from bereavement co-ordinator
Nurse / Midwife	Liverpool care of the dying pathway
Nurse / Midwife	Care of the dying pathway
Nurse / Midwife	Booklet
Nurse / Midwife	Better communication
Nurse / Midwife	Care of the dying pathway
Nurse / Midwife	Joint ecm/ sands conference. Sands study day- taking pictures of still born babies
Nurse / Midwife	Water lily
Nurse / Midwife	More openness for relatives and including them in planned care
Nurse / Midwife	Checklists Bereavement training is mandatory
Nurse / Midwife	Better communication with GPs, Marie Curie and Hospice Nurses
Nurse / Midwife	Policy updates, standardised syringe drivers to cut down on errors, improved Marie

	Curie service
Nurse / Midwife	Booklets available
Nurse / Midwife	More discussions with staff
Nurse / Midwife	Yes some initiatives such a purple bag for belongings, leaflets, better liaison with colleagues within the Trust, discussion re dementia and terminal care e.g. registers, lily flower to put on front door
Nurse / Midwife	Lily scheme Purple bags for property Purple "sheet" Transfer documentation
Nurse / Midwife	More staff awareness. Guidance paperwork/checklists for when an infant dies. Debriefing
Nurse / Midwife	Awareness of Bereavement coordinator and bereavement services
Nurse / Midwife	Bereavement Co-ordinator
Nurse / Midwife	Better information giving. Improved checklist in delivery suite. Use of bereavement coordinator
Nurse / Midwife	Implementation of living matters dying maters strategic plans to community
Nurse / Midwife	Advanced care planning and LCID palliative care register
Nurse / Midwife	Palliative care key worker update
Nurse / Midwife	More integrated working
Nurse / Midwife	New stillbirth care pathways
Nurse / Midwife	More information available via intranet and booklets
Nurse / Midwife	Guidelines affecting stillborns
Nurse / Midwife	Guidance on coroner referral, unexpected death, debrief following mother and baby incident within maternity involving bereavement co-ordinator
Nurse / Midwife	Lily Scheme. Purple bereavement bags
Nurse / Midwife	Updated checklist to complete. Questionnaire for parents to provide feedback.
Nurse / Midwife	New Guidelines. Bereavement update study day
Nurse / Midwife	Use of purple cover for bed and use of trolley afterwards. Mini locker type altar for use in room if applicable in the event of dying
Nurse / Midwife	Ensuring that study days are mandatory on this. Written policy now available.
Nurse / Midwife	Water Lily
Nurse / Midwife	Newly refurbished relative’s room for relatives to use around the time of death. Palliative link nurses are great
Nurse / Midwife	More information available to carers
Nurse / Midwife	Bereavement co-ordinator input. The water lily has been a good initiative.
Nurse / Midwife	NIPEC Checklist provided on still birth
Nurse / Midwife	Purple property bags. Notifying out of hours
Nurse / Midwife	White flower symbol to be pinned on the curtain/ door to ward to alert staff/ visitors of a death on the ward
Nurse / Midwife	Pin white flower to curtain and door to let others know that there has been a death.
Nurse / Midwife	Verification of death. Breaking bad news to family
Nurse / Midwife	Purple (disposable) very undignified
Nurse / Midwife	Use of water lily. Change of paperwork. No longer sellotaping labels to body
Nurse / Midwife	Liverpool care pathway when used appropriately
Nurse / Midwife	More robust documentation and information given
Nurse / Midwife	Study day on McKinley syringe driver
Nurse / Midwife	Community support teams
Nurse / Midwife	Not sure
Nurse / Midwife	Debrief + Carecall
Nurse / Midwife	Cold cot for neo-natal deaths. Information given to parents
Nurse / Midwife	Care is routinely reviewed. Since 2009 there have been many new initiatives to guide staff to better care
Nurse / Midwife	Care is continuously being reviewed and updated. Verification of life - undertaken by nursing staff
Nurse / Midwife	Introduction of the Lily scheme
Nurse / Midwife	Water lily scheme
Nurse / Midwife	We now have a trust bereavement co-ordinator who is an excellent help.
Nurse / Midwife	The Lily scheme including patient belongings bag
Nurse / Midwife	Lily Scheme
Nurse / Midwife	Intranet for information and the introduction of the Lily scheme
Nurse / Midwife	Patients purple property bags. Patients purple sheet - used for wrapping body in.

	Water lily for outside room to indicate a death has taken place on the ward
Nurse / Midwife	Patients' property bags (purple) Water lily for outside the room
Nurse / Midwife	Water Lily, Bereavement bags for belongings
Nurse / Midwife	More support from all involved
Nurse / Midwife	Unsure though
Nurse / Midwife	Ongoing updates
Nurse / Midwife	Lily Identification labelling
Nurse / Midwife	Checklist. Nominated point of contact. Policy
Nurse / Midwife	dedicated facilities for family to stay over
Nurse / Midwife	Enhanced training given by Palliative nursing team. Mandatory training
Nurse / Midwife	Loss in early pregnancy- counselling
Nurse / Midwife	Body transfer forms initiated
Nurse / Midwife	Yes, body transfer forms were initiated
Nurse / Midwife	Pregnancy loss documentation has been formalised. Booklets updated & clear information on hospital ward available for patients and families
Nurse / Midwife	New dept
Nurse / Midwife	Liverpool care pathways
Nurse / Midwife	The water lily sign and patient bag
Nurse / Midwife	More focus on partnership with families, making memories and referral within maternity to Coroner
Nurse / Midwife	Introduction of snowdrop walk for bereaved parents. More time offered to parents which enables them to be supported to spend more time with their infant. More choice offered to whether infant goes home or not immediately following death.
Nurse / Midwife	Removal of Liverpool Care Pathway. Strategy for Bereavement Care
Nurse / Midwife	Water lily to alert staff to situation
Nurse / Midwife	Online training, Picture of Lily
Nurse / Midwife	Medical staff need to be more pro - active in the decision to place DNAR on patients earlier with multiple co -morbidities so that this procedure is not carried out and the patient is allowed to pass away with dignity and respect
Nurse / Midwife	Introduction of the lily and purple bag for personal effects
Nurse / Midwife	Bereavement training and awareness sessions
Nurse / Midwife	Bereavement box for staff
Nurse / Midwife	Bereavement box for staff
Nurse / Midwife	They changed the transportation in which the patient's body was transferred from ward to mortuary from box to trolley - much more dignified
Nurse / Midwife	New policies and procedures
Nurse / Midwife	Bereavement booklets and coordinator
Nurse / Midwife	Lily for awareness lack of sideroom/privacy always a problem
Nurse / Midwife	Bereavement box in place
Nurse / Midwife	Photography
Nurse / Midwife	More open conversations with patients and families that treatment is not working and therefore a move into the terminal phase
Nurse / Midwife	Advanced care planning
Nurse / Midwife	More knowledgeable on reporting of death i.e. Coroner
Nurse / Midwife	Maternal death policy Bereavement leaflet for parents
Nurse / Midwife	With children there has been considerable work. If parents do not wish a child to go to the funeral director's, the body can be prepared in the home. Also parents can take a dead child home from hospital if they wish to spend time alone with their child. Certain people need to be notified of this request however
Other	Spending allocated time with family after bereavement
Other	Palliative care meetings with palliative care consultant in renal unit. Conservative care clinics with palliative care consultants
Other	Introduction of the lily scheme
Other	Tightening of procedures in relation to releasing bodies to funeral directors. Tightening of procedures in relation to the completion of paperwork from transfer from ward to mortuary
Porter	Lily scheme on wards
Social Worker	Development of advanced care planning for adults
Social Worker	Am aware GP practices meet with nursing staff and hospice nurse but SW not

	included in this, even though we are responsible for providing care packages for end of life care

WHSCT
42/50 staff members provided examples

Doctor	Availability of printed documents and training and support from bereavement coordinator
Doctor	Although recently it has received bad press, the Care if the Dying pathway was useful in ensuring patients were on relevant medication when entering the final stages of their life
Doctor	Living matters dying matters embarking on audit in hospital to see care at end of life after LCP stopped Passport system ACP advanced care planning
Doctor	Support by bereavement coordinator to ward staff following deaths of some patients
Doctor	Re: death certification
Doctor	Introduction of checklist for notification of deaths
HCA	Attended bereavement workshop which helped in our area of care practice
HCA	Purple bags for relatives. Purple drape for transfer of body. Small alter for room of dying patient
Nurse / Midwife	Sands photography. Study day to improve memories/pictures
Nurse / Midwife	The introduction of ccos - this team provides our ward with amazing support for people/patients while they are very ill
Nurse / Midwife	Workshops provided by NHS Blood and Transplant on Consent for Organ Donation Training
Nurse / Midwife	New documentation to accompany the body from the ward to morgue Discontinuation of Liverpool care pathway
Nurse / Midwife	New pathways and policies for care after miscarriage or death of a newborn baby
Nurse / Midwife	Issuing of bags for the removal of deceased patient's personal effects from the ward (but no longer available)
Nurse / Midwife	There is a bereavement box kept in sister's office that all staff have access to
Nurse / Midwife	End of Liverpool care pathway
Nurse / Midwife	Policies and information easily accessed
Nurse / Midwife	Booklets - End of life. Only one change to get it right. Final journey programme moving the deceased with 4 people
Nurse / Midwife	Staff training. End of life guide booklet. Final journey programme. Only one chance to get it right document. Moving and handling of deceased for staff
Nurse / Midwife	Use of purple robe + end of life symbol. Provision of religious artefacts.
Nurse / Midwife	We are encouraged to attend courses such as advanced communication, final journeys course
Nurse / Midwife	In our ward staff are encouraged to attend courses. Many have completed advanced communication course, attended "final journey's" course, palliative care module. We also have a number of staff nurses who are link palliative care nurses and attend regular updates
Nurse / Midwife	New last offices
Nurse / Midwife	A death of a child is automatically a serious adverse incident
Nurse / Midwife	Bereavement folder
Nurse / Midwife	Trust bereavement booklet Liverpool care pathway last offices policy DNRCPR Policy
Nurse / Midwife	Care of the dying pathway implemented
Nurse / Midwife	Clear guidelines on recording miscarriages and where fetuses/poc and forms are and have gone
Nurse / Midwife	New information booklets and ward bereavement resource pack
Nurse / Midwife	Have not had to implement any of the policies
Nurse / Midwife	The Liverpool care pathway improved palliative care services
Nurse / Midwife	It is a great help having the McMillian cancer nurses in the hospital as we can access their help readily
Nurse / Midwife	New forms to send with body

Nurse / Midwife	Palliative care input referrals have increased
Nurse / Midwife	Palliative care
Nurse / Midwife	The provision of pathways for provision of care
Nurse / Midwife	Palliative care team input which is of great value
Nurse / Midwife	New Mortuary service in SWAH. Better facilities for the bereaved families when bodies leaving hospital
Nurse / Midwife	Patients no longer put into white gowns but can have their own night clothes on them. Waterproof bags now available for the deceased to be transported to the mortuary
Nurse / Midwife	Final journeys programme. Introduction of intranet site with palliative care info. Trust 'home to die' policy Marie curie rapid response out of hour Macmillan GP facilitator
Nurse / Midwife	Updates new information leaflets access to information/leaflets on share point
Social Worker	Support for terminally ill service users is given priority where multidisciplinary working is to the fore in supporting the dying person and their carers

BHSCT
151/181 staff members provided examples

Admin Staff	Bereavement co-ordinator. Care of the dying pathway
Admin Staff	Establishment of a group of VOLE within community team
Admin Staff	Written information booklets provide co-ordination
AHP	No longer use the care of the dying pathway @ ward level
AHP	Outreach to families bereaved by suicide. Working closer with voluntary and community groups
Chaplain	More awareness of other faiths and their particular needs at time of death.
Chaplain	Purple boxes on wards. Bereavement & Chaplaincy websites. Trust leaflets/booklets
Doctor	Training in care pathway
Doctor	Liverpool care pathway
Doctor	LCP has been discontinued
Doctor	Improved use of checklists, development of M&M meetings which has assisted in improving quality of palliative care offered, developing advance care planning awareness
Doctor	We have implemented monthly mortality review meetings in our unit
Doctor	The introduction and withdrawal of a care pathway
HCA	"Essence of care programme" mouth care for very ill and dying patients.
HCA	Changes to the preparation of body for transfer
HCA	Last offices training
HCA	New training for all staff on last offices and relevant information to be given to family
HCA	Mandatory training on care after death
HCA	The staff made aware of policy changes and introduction of bereavement co-ordinator.
HCA	Yes, made aware of changes and co-ordinator role.
HCA	Staff made aware of policy changes. Introduction of bereavement co-ordinator
HCA	Reflective Practice
HCA	Reflective practice
MortTech	Management of bariatric patients. Review of last offices. Body transfer forms.
Nurse / Midwife	Care of the dying pathway. Final journeys
Nurse / Midwife	Care planning. Palliative care team/ hospice involvement
Nurse / Midwife	Unsure
Nurse / Midwife	Syringe pump study days, Palliative care team support, Dying matters information leaflet
Nurse / Midwife	Team meeting - updates.
Nurse / Midwife	Better palliative care training and courses
Nurse / Midwife	Purple boxes/bags. More talks being given to staff
Nurse / Midwife	Care pathway improvements

Nurse / Midwife	Care pathway changes
Nurse / Midwife	Removal of Liverpool care pathway
Nurse / Midwife	Palliative care training for staff
Nurse / Midwife	Bereavement and loss group in unit has made huge improvements i.e. memory boxes, Moses basket
Nurse / Midwife	Memory boxes. Hand prints. Moses basket
Nurse / Midwife	Body transfer form. More convenient
Nurse / Midwife	Updated bereavement guidelines for the unit, step by step guide in completing paperwork
Nurse / Midwife	A bereavement care team has since been set up
Nurse / Midwife	Bereavement cards are sent to families after death to show support
Nurse / Midwife	Corporate input for removal of deceased
Nurse / Midwife	Body Transfer with trust undertakers
Nurse / Midwife	Transfer body book. Funeral undertakers collecting bodies instead of porters.
Nurse / Midwife	New purple property bags for purple effects. Body transfer forms. Booklets made available
Nurse / Midwife	Transfer Book
Nurse / Midwife	Bereavement co-ordinator provided purple boxes to contain relevant info and kept together on ward. Use of better quality bags for family to take home deceased clothing/belongings
Nurse / Midwife	New booklets and checks for body transfer off ward
Nurse / Midwife	Provision of body bags, purple sheets and bags. Provision of Trust booklet
Nurse / Midwife	Discontinuation of the Liverpool care pathway
Nurse / Midwife	Organ Donation Nurse
Nurse / Midwife	Body transfer form. Funeral Home removal
Nurse / Midwife	Purple bag and leaflets
Nurse / Midwife	More emphasis on organ donation with specialist organ donation nurse on site
Nurse / Midwife	Quiet room has been made available for grieving relatives
Nurse / Midwife	Identification and transfer of bodies
Nurse / Midwife	More involvement from the palliative care team
Nurse / Midwife	Care of the dying pathway stopped
Nurse / Midwife	Improvements to documentation
Nurse / Midwife	Improvements to documentation
Nurse / Midwife	Transfer of body
Nurse / Midwife	Last offices and body transfer have been improved
Nurse / Midwife	Liverpool care pathway has been removed
Nurse / Midwife	Care of the dying pathway has been removed
Nurse / Midwife	Bereavement information available for family members
Nurse / Midwife	More training
Nurse / Midwife	There had been the Liverpool Care Pathway
Nurse / Midwife	Workshops and meetings
Nurse / Midwife	The introduction of body transfer form
Nurse / Midwife	Body transfer book
Nurse / Midwife	Completion of checklist and body transfer form
Nurse / Midwife	Information leaflets, use of purple bags for patients belongings
Nurse / Midwife	Purple boxes used on wards. Bereavement co-ordinator in place information this
Nurse / Midwife	Attending Bereavement Care Training
Nurse / Midwife	Debriefing, greater involvement with palliative care team and hospice, staff doing specific management of dying courses
Nurse / Midwife	Purple Box, Literature
Nurse / Midwife	Liverpool care pathway
Nurse / Midwife	Use of Liverpool Care Pathway abolished
Nurse / Midwife	Organ donation nurse
Nurse / Midwife	Removal of Liverpool Pathway
Nurse / Midwife	More staff support. More information on the HUB
Nurse / Midwife	No longer using the integrated pathway for dying
Nurse / Midwife	Bereavement co-ordinator introduced
Nurse / Midwife	Bereavement co-ordinator available
Nurse / Midwife	Checklist

Nurse / Midwife	Bereavement box, awareness sessions
Nurse / Midwife	Sands Box. Purple bag of personal belongings. Card sent to parents
Nurse / Midwife	Designated specialist nurses in organ donation
Nurse / Midwife	More specific guidelines for staff, all info put together in files in one place. Use of Sands boxes for death of infant/child
Nurse / Midwife	Not sure if applicable but debriefing sessions introduced post death of patient resus situation
Nurse / Midwife	Improvement to documentation
Nurse / Midwife	Sand boxes introduced
Nurse / Midwife	More detailed consent form for PM developed
Nurse / Midwife	Cooling mattress
Nurse / Midwife	Simpler documentation
Nurse / Midwife	Contacting GP. Record death on Apad. Death discussed at meeting
Nurse / Midwife	Body transfer form
Nurse / Midwife	Bereavement co-ordinator now in post
Nurse / Midwife	Guidelines - End of life care
Nurse / Midwife	As nursing development lead I am part of the adult bereavement forum
Nurse / Midwife	New body transfer form
Nurse / Midwife	Bereavement team of nurses
Nurse / Midwife	Introduction of body bags, introduction of further mortuary documentation.
Nurse / Midwife	Body transfer form
Nurse / Midwife	Use of body bags. Corneal donation forms
Nurse / Midwife	Trust end of life care guidelines introduced
Nurse / Midwife	Patients' property bag changed
Nurse / Midwife	Principles of Liverpool care pathway/ guidance now devised within End of life guidance - work in progress
Nurse / Midwife	Purple Bereavement box with the protocol for actions to be taken after death is in office with lots of valuable information
Nurse / Midwife	Bereavement file located on ward. Dignity and Dying in care of elderly
Nurse / Midwife	Staff trained in Palliative care
Nurse / Midwife	Advance care planning dying matters awareness week
Nurse / Midwife	Reflective Practice. How to access services
Nurse / Midwife	New policies in place
Nurse / Midwife	Relevant documentation to be found at the nurses' station.
Nurse / Midwife	Bereavement file at nurses station
Nurse / Midwife	Recently introduced sympathy cards. Purple bags for patients' property.
Nurse / Midwife	Link Nurse
Nurse / Midwife	New bereavement booklets
Nurse / Midwife	Water lily. Card
Nurse / Midwife	Supplying cards to relatives 3 months after death
Nurse / Midwife	Flower on resus door
Nurse / Midwife	Telephone for relatives. Self catering for relatives
Nurse / Midwife	Bereavement information. Also have been working closer with Heather Russell with regards to last offices
Nurse / Midwife	Hospital undertakers Process more streamlined
Nurse / Midwife	Supportive care coordinator in post in my area - raises awareness about EOL care
Nurse / Midwife	Greater awareness of bereavement services both locally and regionally
Nurse / Midwife	Body transfer form
Nurse / Midwife	Important paperwork was streamlined and made more user friendly,
Nurse / Midwife	Policies & guidelines
Nurse / Midwife	Donation from parents of the most beautiful baby bereavement boxes for making memories with clay mould etc. Parents have been so delighted that the trust fund now replenishes stock
Nurse / Midwife	Better communication and organisation of paperwork and checklists and private clinical areas for counselling and clinical care plus procedures
Nurse / Midwife	More information leaflets available. Checklist developed
Nurse / Midwife	Guidelines on storing and transferring remains within the quiet room
Nurse / Midwife	Ongoing end of life palliative care training Peer supervision session at team

	level
Nurse / Midwife	Bereavement team within Trust
Nurse / Midwife	Sudden death in theatre. A file was produced to ensure all staff were aware of procedures to follow and steps to take
Other	Clear identifiable pathways on how to respond when someone dies and has no relatives or funeral plans in place
Other	Dying matters etc.
Other	Unsure
Other	Maternity services
Other	Policies have been updated and staff made aware of the changes
Other	Purple boxes and bags on wards
Other	Updating of booklets on bereavement
Other	Bereavement boxes contained within all units updated leaflets / bereavement forum
Social Worker	Better bereavement support via new bereavement co-ordinator
Social Worker	Policies - Promotion of importance of grieving process
Social Worker	Advanced care planning. Development of specialist community, palliative care social work team. Initiatives developed by Marie Curie & Macmillan charities.
Social Worker	Bereavement training from the trust's bereavement co-ordinator
Social Worker	More information about this area of practice has been distributed throughout the trust. I am aware that training courses have been provided
Social Worker	Training for staff in caring for someone at the end of their life

SHSCT
69/88 staff members provided examples

AHP	More training and awareness for staff. More support for staff. Change living will.
AHP	Bereavement Care Policy
Chaplain	Better awareness & good communication with more timely action taken by primary care staff & ourselves on issues relating to end of life care and OOHRS medical staff. Improved awareness and action taken for patients who have expressed a wish to die at home between health care staff in primary & secondary care settings in making this happen although still a work in progress at present for all patients and their families/carers
Chaplain	Greater effort to put dying patient in side room. Support re parking - is there support re: food for NOK? Still need to develop the contacting of chaplaincy earlier in the dying process so they can call back again and not just at point of crisis/death
Doctor	Training and counselling
Doctor	Non doctor registration, release of body, improved documentation of certification. coroners medical officer
Doctor	Changes related to palliative care and recent update within the Trust
Doctor	Increased input from Bereavement Coordinator who now coordinates all services
Doctor	End of life and limitation of care in ICU document; now used regionally
Doctor	More emphasis on recognising the dying patient and discussion with staff and family. Use of the back pages of the LCP
Doctor	Removal of Liverpool care of the dying pathway Replaced with an alternative but have not used as yet
HCA	Purple sheets to dress the bodies. Green bags for personal effects. Bereavement box
HCA	I thought the Liverpool care pathway was beneficial when being used
Mort Tech	All bodies entering the mortuary dept must have a body transfer form with all relevant details on it, no bodies can be released from the mortuary until either a death cert is issued, a release letter from a doctor, or the coroners permission
Nurse / Midwife	On audit days we have got the mortician up to speak to staff on how to prepare the body for chapel of rest and have had Anne Coyle up to speak to staff re-

	organ donation (N.B.H) and organ retrieval team have spoken to staff.
Nurse / Midwife	Bereavement box, body transfer form
Nurse / Midwife	New post death certificate
Nurse / Midwife	Care of the dying pathway info booklet
Nurse / Midwife	Care of the dying pathway
Nurse / Midwife	Care of the dying pathway
Nurse / Midwife	Improvements in department cascaded training
Nurse / Midwife	Easier access to Palliative care team
Nurse / Midwife	Withdrawal of Liverpool care pathway
Nurse / Midwife	Bereavement booklets. Transfer of bodies form. Checklist after death to improve communication
Nurse / Midwife	Labelling of patient
Nurse / Midwife	Support on ward
Nurse / Midwife	Specific comprehensive care pathway introduced to navigate staff through the process
Nurse / Midwife	Bereavement book with all current information
Nurse / Midwife	Advanced care planning
Nurse / Midwife	Liverpool care pathway (now no longer used). New syringe drivers and documentation
Nurse / Midwife	Study days
Nurse / Midwife	Written info. Bereavement co-ordinator. Staff training
Nurse / Midwife	Training re Miscarriage and obtaining consent. Training for awareness of care of the dying. Breaking bad news/ advanced communication
Nurse / Midwife	Working group looking at a pathway for the dying patient
Nurse / Midwife	Care of the dying pathway
Nurse / Midwife	Detailed care pathway
Nurse / Midwife	Sands memory boxes
Nurse / Midwife	New booklet/ Documentation/ guidance on flexibility Re parents taking their dead baby home
Nurse / Midwife	More training for staff. Pack in place for stillbirths or IUD's
Nurse / Midwife	Care of the dying pathway
Nurse / Midwife	With children with life limiting illness input from Hospice staff, sudden deaths, debriefing and peer support
Nurse / Midwife	Working collaboratively in a buddying system with our Macmillan nurses for patients who have chronic conditions
Nurse / Midwife	Debriefing advanced care planning Information leaflets
Nurse / Midwife	Update on bereavement, emotional defusing + taking care of you.
Nurse / Midwife	Providing relatives/carers with booklets/ bag provided for belongings
Nurse / Midwife	Update of paper work
Nurse / Midwife	Memory box
Nurse / Midwife	Full bereavement co-ordinator support. Introduction of purple bags to take home belongings. So much more dignified. More regularly updated leaflets of information for families
Nurse / Midwife	Advanced care planning
Nurse / Midwife	We have made significant changes to the care of families who are suffering an early pregnancy loss, and attend the EPPC
Nurse / Midwife	Clarification on policies to verify death Provision of a cold cot for parents of stillborn babies or neonatal deaths
Nurse / Midwife	Care pathway is fantastic for us to ensure all relevant steps are completed.
Nurse / Midwife	Care Pathways
Nurse / Midwife	Bereavement booklet bags for returning property to relatives
Nurse / Midwife	Information boxes available at ward level with relevant information
Nurse / Midwife	ACP and LCP
Nurse / Midwife	Discussions have taken place
Nurse / Midwife	VOLE
Nurse / Midwife	Advanced care plans
Nurse / Midwife	Advanced communication training
Nurse / Midwife	Forward planning for breakthrough medication for symptom control which is very effective practice in my area of care

Nurse / Midwife	Global emails informing staff of support available
Other	Resuscitation Procedure Bereavement forum
Other	Kept up to date with literature and a recent training course was excellent
Other	The introduction of the Sudden death 1 form developed in partnership with the PHA, HSCB, HSCT's and the PSNI has been rolled out regionally and has allowed for the early identification of suspected suicide in the community. This process also allows for the identification of a NOK and follow up support can be offered if requested. An information card has also been developed that allows PSNI, Undertakers to provide information to those who may decline support initially but who may require support at some time in the future
Other	Links with Bereavement Co-ordinator in each Trust's Feedback from families
Other	Trust Bereavement Forum - Introduction to Bereavement Section on Trust Intranet site with very useful information and guideline – Introduction of Bereavement Information Booklet for Families - Having access to a Bereavement Co-ordinator for advice, guidance, support and training
Other	PPI Patient Client Experience Standards 10,000 voices Releasing Time to Care
Social Worker	Social worker for Oncology / PCT specifically DN / Conventional SS putting in POC's to expedite the discharge process (as opposed to ICS) An additional MDT for PCT Regular Oncology meeting with Heads of Service to voice any issues encountered

SEHSCT
89/101 staff members provided examples

AHP	New policies
Chaplain	Appointment of Lead Chaplain in South Eastern Trust
Chaplain	Bereavement booklet and coordinator
Doctor	Creation of a bereavement box on ward
Doctor	Bereavement Box
Doctor	Introduction of a centralised area (Box) with all forms/ documentation related to death within each ward
Doctor	More advance care planning
Doctor	Care of dying pathway
Doctor	Procedures have been clarified, particularly regarding logistics of removal of children from the ward after death. Also I hope that we are quicker to organise debriefing and support for trainees
HCA	New policies
HCA	Purple sheet to aid transfer of bodies. Green bags for family. Bereavement box
HCA	Purple sheet to aid transfer of body. Green bag for patients' property. Bereavement box
HCA	Bereavement Box
HCA	Bereavement Box
HCA	Bereavement booklet
HCA	A bereavement box for staff on the ward
Mort Tech	Updating off sops and on job training
Nurse / Midwife	All relevant paperwork and forms are kept in a designated place
Nurse / Midwife	Bereavement Box
Nurse / Midwife	Retraining for staff re marriage etc.
Nurse / Midwife	Better identification
Nurse / Midwife	The same staff member should complete all paperwork on deceased to reduce error and body transfer book again to reduce error
Nurse / Midwife	Body transfer sheet
Nurse / Midwife	Updated policies and documentation
Nurse / Midwife	Completing of "Care after death" pathway
Nurse / Midwife	Involvement in palliative care register updates with GP. Better access to Macmillan support services /Marie curie services/ volunteer/carer/day therapy

	services
Nurse / Midwife	Bereavement box containing all relevant information for staff and family members
Nurse / Midwife	Bereavement box containing related documentation and guidance notes
Nurse / Midwife	We make it a priority that no patient is left alone when dying
Nurse / Midwife	SQE Project- Bereavement Box
Nurse / Midwife	Changes to documentation
Nurse / Midwife	Changes in last offices form- Format changed
Nurse / Midwife	Bereavement box
Nurse / Midwife	Bereavement boxes. Bereavement counselling
Nurse / Midwife	New care after death checklist implemented
Nurse / Midwife	Patient property bags, documentation, purple sheets to wrap remains in
Nurse / Midwife	Bereavement box
Nurse / Midwife	Bereavement Booklet
Nurse / Midwife	Introduction of bereavement box
Nurse / Midwife	Study Days
Nurse / Midwife	Guidance from the DOH on EOLC after CODP was discontinued
Nurse / Midwife	Bereavement box now on ward
Nurse / Midwife	Identification, Body transfer form
Nurse / Midwife	New bereavement box
Nurse / Midwife	New checklist after death
Nurse / Midwife	New bereavement co-ordinator in post
Nurse / Midwife	Sage and tyme training though palliative care team, increased focus on planning with patient and family end of life care wishes
Nurse / Midwife	Palliative care team involvement - pain team, body transfer form
Nurse / Midwife	Body transfer form
Nurse / Midwife	Information booklet. How to register death leaflets
Nurse / Midwife	Care pathways
Nurse / Midwife	Introduction of care pathways and improved documentation
Nurse / Midwife	New bereavement suite in D/S
Nurse / Midwife	Bereavement room. Care pathways
Nurse / Midwife	Introduction of care pathway at each stage of pregnancy
Nurse / Midwife	Revamp of policy, checklist for after care of body. A lot of education regarding dying patient
Nurse / Midwife	Removal of care of the dying pathway
Nurse / Midwife	Introduction to bereavement box which contains all relevant information
Nurse / Midwife	We now have a box that contains all the information required when a death occurs
Nurse / Midwife	Bereavement file. Transfer of body booklet. Inform GP via telephone and letter
Nurse / Midwife	New care pathway
Nurse / Midwife	Bereavement Box
Nurse / Midwife	We now have the bereavement box with all relevant information in it available on the ward
Nurse / Midwife	Bereavement box on ward to help staff
Nurse / Midwife	Bereavement documents streamlined and documents all in one place
Nurse / Midwife	Care of the dying pathway abolished
Nurse / Midwife	Verification of death. Use of care after death documentation. Bereavement booklets
Nurse / Midwife	New care pathway
Nurse / Midwife	Bereavement Leaflets
Nurse / Midwife	New care of the dying patient pathway
Nurse / Midwife	appointment of bereavement coordinator new leaflets developed for bereaved relatives
Nurse / Midwife	Bereavement boxes check list to ensure relative parties are informed of the death appointment of lead Chaplin to coordinate spiritual care
Nurse / Midwife	Students are now provided with training
Nurse / Midwife	The care of the dying pathway has been removed and I have been involved in developing a new care after death

Nurse / Midwife	Body transfer book
Nurse / Midwife	Communication with relatives
Nurse / Midwife	The Liverpool pathway is no longer used
Nurse / Midwife	Introduction of a bereavement box containing all the necessary documentation and polices pertaining to care of the deceased
Nurse / Midwife	We now send all our staff to 'Care of the Dying' and 'Breaking bad news' study days
Nurse / Midwife	Advanced care planning, regional syringe driver docs, sage. Removal of the Liverpool care pathway
Nurse / Midwife	Bereavement box. Also more information written provided for families
Nurse / Midwife	Training available
Nurse / Midwife	Workplace initiatives
Nurse / Midwife	Updated policy on bereavement
Nurse / Midwife	Bereavement box
Nurse / Midwife	Checklist
Nurse / Midwife	Pregnancy loss pathways Maternity bereavement suite Forget me Not bereaved parents liaison group
Nurse / Midwife	Bereavement box
Social Worker	Improved awareness of available services and information. Trust policies on intranet

Q15.0 Have you any suggestions about how death, dying and bereavement information, resources or services could be improved

Suggestions on how to improve information, resources or services are detailed below and have also been themed and listed at ***Appendix C***

NHSCT
97 of 419 (23.2%) staff members provided suggestions for improvements

- A relatives' room would be very beneficial
- Ensuring relatives have a quiet room where they can talk to a nurse if needed
- A relatives' room would be very good
- Management of sudden or expected death to be included in palliative care training
- Management of sudden death and breaking of bad news should be included in palliative care training
- I feel we should go through this training to all staff
- Booklets easily accessed and available
- Should be covered at study days. More leaflets available for families
- More courses for community teams on bereavement
- It would be beneficial for relevant disciplinary team members to meet with the nursing staff to discuss the best way forward
- More staff training and support
- Offered to pharmacists working with dying patients
- Invite bereavement co-ordinator to team meetings. Make training mandatory
- Info for social workers who may have limited contact with families and how best to support them
- Workshops + Scenarios to allow staff time to digest the theory and put into practice in a protected environment
- Sometimes it can be difficult to find private rooms for grieving relatives and space to have private conversation

- Yes, we need a care of the dying pathway
- More training and feedback
- We should be provided with training on the management of sudden death in an acute hospital setting, especially mental health.
- I was on the unit when a patient suddenly died due to a physical illness. This was dealt with by management - working in an acute setting it would benefit all staff to have training in sudden death/suicide - what to do after death
- Better provision of cameras, printing facilities for pictures to be given to patients. In-house training as not always possible to attend study days due to staffing issues
- More training for nurses. More information made more accessible to be distributed to relatives
- I think it is horrendous that patients are allowed to die in a six bed bay because of a lack of side rooms (used for infections) no privacy at all for dying patient or their relatives
- Chaplain/ spiritual needs should be available all the time
- These patients need to be priority for getting carers and professionals need to listen to what the patient wants and not what they think is best
- Mandatory bi annual information sessions
- Private areas provided for grieving relatives
- Information to d/n re patient has passed away getting to d/n quicker to avoid d/n calling out to the patients house and not knowing the patient has passed away
- Possibly further information booklets for some
- Yes more training
- Any relevant training that we can take to better able us to help improve our care
- E learning
- Ideally: Great need for specialised suite in delivery suite for bereaved families to include clinical bed, units, unsuited, tea/ coffee facility, sitting room for family. Perhaps signs/ symbol on main doors to alert staff coming on shift that there is a bereaved family within delivery suite
- A nurse trained in bereavement to be named worker rather than a social worker. As a social worker, I feel I am not the correct professional to be named worker as most issues are related to nursing rather than social
- Bring back the LCP
- I think the training of juniors on bereavement, breaking bad news, coroner reports, and all aspects of the dying process are very well dealt with in medical school. Given the amount of remedial modules in all areas of practice these days I don’t think there is a major issue with any of these processes that require extra training. Optional courses may be useful for those not confident in processes
- A visit from palliative care team. Maybe 3-4 weeks after death, when activity has settled down and reality is setting in. I know they visit shortly after death; when everything is fine
- We could do with a staff support service
- A major problem in caring for dying patients in the acute hospital setting is the lack of access to single rooms for these patients and their families
- More training should be made available

- Someone to contact next of kin of deceased perhaps a couple of months after death to ask if they are coping and if anyone in the family would need further help
- The booklets etc. are fine. Complaints arise when family are not given enough information on the patient journey and is the only occasion in the past where any complaints have arisen
- I really don't like the water lily
- Irrespective of how many dying patients you care for, you just have to get on with it and little acknowledgement given to the fact that nurses grieve when a patient who they have been very involved with, dies. No recovery time. You are expected to just move on to the next dying patient as if your feelings and emotions are irrelevant. No matter what Strategies are created, this will be unlikely to change
- It would be useful to have a booklet only indicating end of life signs + symptoms for families and adults with learning difficulties
- We think staff would find face to face information sessions more beneficial + meaningful than written policies as it would provide an opportunity for staff to ask questions relevant to this area of practice
- Staff to gain information or attend studies days on breaking bad news
- A hospital bereavement day for midwives relating to neo natal death and stillborn
- More training provided. Particularly for doctors
- Leaflets left @ doctors surgery
- Dealing with the dying patients and bereaved relatives is a very large part of the role of a district nurse. I feel there is not enough training made available to staff. It is very much learned through personal experience
- Support for staff needs improved. Easier access to support
- Training specific related to helping children. More generalised training for all staff.
- More training for generalised staff
- Easier access to training. Regular "mandatory" trust training on bereavement care
- Provide easy access training days. Provide examples and sources that you can use to help families/ patient through difficult times
- A sleeping area with kitchen and toilet facilities would help the relatives of those who are dying
- Need to increase awareness of tools and literature both on the wards but in the trust in general
- Staff could be updated through online and face to face training sessions
- There needs to be more training available for all staff. By having a staff member on each ward with a keen interest in improving standards who will update others. Link nurse. The same as infection control and dementia services
- More open study days
- E-learning on the above, with a documentation available via pdf for print out within one site for ease of access
- Making yourself available to answer questions, seeking appropriate advice
- It would be beneficial to know what support is available for coping with an increased amount of death in my day to day working
- A card posted To the Nook out signed by ward manager at a later stage, passing on condolences on behalf of all staff
- Let us attend workshops. Unable to attend workshops due to lack of staff.

- some people have never had to deal with personal bereavement /they can sympathise but they have no insight into the devastation bereavement can cause to those directly affected
- More awareness of the services available and information available in department for relatives to access
- More access to info/leaflets, possibly online so it can be accessed quickly
- I think it is something that you learn through experience and every situation is very different
- Available in other languages
- Provide more aftercare post discharge especially in relation
- Allow staff to attend information days. support staff by allowing debriefing via caseload or one to one meetings
- More leaflets for the department that we do not have
- A leaflet to give to the family to support them
- Being made aware of courses or study days available
- Policy available at ward level. Pass on communication to other staff when you research or read a relevant article
- Policy available on ward. More contact with/for relatives with patient at end of life stage
- Yes - feel that there should be a follow up service for parents after a patient's death. Think CCN teams could benefit from further training- to gain a basic knowledge of palliative care
- I think all staff require this training. I worked for BHSCT for 17 years and have dealt with dying children and bereavement on quite a few occasions and so feel confident to nurse a dying child. However many staff I worked with/liaise with have not. This affects continuity of care I feel, and have experienced this
- Leaflets be more readily available
- Don't like the white lily. Think it is not appropriate
- I think all wards should have a room that they can have the opportunity to stay with the patient. We are lucky that we do have a room but not all wards have one
- Good to have information display boards
- Training which is tailored to specific areas because if this is not the case there is a reluctance to release staff
- Services: Too many elderly demented and dying patients are admitted to hospital from nursing homes who die within 1, 2, or 3 days of admission instead of managing them in the nursing home with advance care plans and providing a dignified death void of the upheaval and distress associated with emergency admission to hospital, lots of tests - only to confirm what we already know that the patient has reached the end of their life. This is an area that with a bit of training, planning and foresight could save significant resources and more importantly enhance the quality of death and indeed the whole experience of dying for all concerned. We have become very good at prolonging death and increasing the suffering as a result and some simple measures could transform this
- Training
- More publicity about them
- There needs to be better access to single rooms for dying patients

- For relatives of patients who die or who experience significant harm as a result of suicide easy access to counselling. Hospital should phone after few days to offer same
- With the changes in legislation relating to the reporting of all still births to the coroner there needs to be an adjustment in the care pathway provided for women when experiencing pregnancy loss
- I think it's fine as it is. This is something that is taught very well in medical school and for post grad exams. I'm not sure any further mandatory training would be beneficial into already packed training schedules. Training tracker modules are a completely useless box ticking exercise and should be abandoned immediately. Suggestions would include - standardising all bereavement documentation, processes, practices, M&M and everything province wide. As we change jobs every 6 months it's more bother than it's worth to get too familiar with local practices, and easier to learn it as you go along
- Unfortunately, national audits have revealed there is not always recognition in from highly trained hospital staff that a patient is in the active phase of dying. Inappropriate comments to relations from staff, correctly preoccupied with the discharge process, may follow, such as "this is an acute bed", or "I'm worried that your relation may get a hospital acquired infection if they stay any longer". Such phrases are probably best avoided
- Presently we are looking at having a church service for bereaved families of children through pregnancy loss or bereavement of a child in the Causeway locality of the Trust. Previously this only took place in the Antrim area
- More publicity and training. Need more integrated working to include SW in discussions or planning for a dying service user. We are often excluded from this information
- I have an idea for providing colleagues in the community with advanced training on how to deal with a person in distress after they have been given a prognosis that they are dying. To help improve the experience for the patient and to help support the staff who face this distress when they visit this person at home (housebound)
- There needs to be better provision for relatives when staying with their terminally ill relatives there isn't even a comfortable chair for them to sit on overnight

WHSCT
65 of 169 (38.5%) staff members provided suggestions for improvements

- Mandatory training for this topic. Included in study days
- I feel it would be beneficial if the final journeys programme was rolled out more extensively.
- Raise awareness of the various supporting bodies throughout wards
- Think there are enough services available. Training needs to be encouraged by line managers to make people more aware
- More courses in house could be available. More information for patients and relatives about dying and bereavement on how to cope
- Provision of secluded quiet area for relatives @ ward level. Increased training both medical and nursing staff
- A bereavement or last offices link nurse to the wards may help

- Bereavement midwife
- Short presentations at our Paediatric teaching sessions on Wednesdays at 11am until noon.
- Increased training- training awareness
- Improve Communications skills of some clinicians in breaking bad news. Have noticed a lack of written information for families following death of a loved one, was unable to provide a family with the Trust Bereavement booklet recently, none available in Critical Care/ ED. Mortuary provision in WHSCT less than in other Trusts that I work in. Can be very disappointing for families that bodies cannot be released to them out of hours - I find this very unnecessarily insensitive to bereaved families, not in keeping with our cultural needs in N Ireland
- Every time a child dies we have to get the family to sign a form whereby they either consent or do not consent to a post mortem. This is a practice that I am very uncomfortable with especially if all the family want to do is take their baby home. To have to sign a form saying that you do not want a PM is in my view horrible and just adding to the pain that families are going through
- Children's Hospice could be used as a resource for the staff in the Children's Ward and the ED Department
- Mandatory training on death, dying and bereavement for all staff would be beneficial
- Make training more readily available. Easier to access
- Good open communication with relatives
- Open communication with next of kin and family networks
- Promotion of access to all available services can be highlighted when needed
- Regular updates on new policies
- A yearly update would be beneficial on showing staff where we can get the appropriate resources
- Further training
- Close collaboration between medical staff and chaplaincy team
- Information /resources are not easily accessible
- To make the wards aware that these services exist
- Better information and appropriate tools for learning should be distributed amongst staff
- Training needs to be more accessible to nursing staff. Online or face to face at ward level. Link nurses to link with bereavement co-ordinator on a regular basis. Resources at ward level and none available
- Training for new staff at induction
- Providing facilities for relatives of dying patients onsite for wards, other than icu/ccu,
- Regular short training sessions at ward level
- More support for community staff death and dying now becoming a major part of our workload and increasing number of patients of all ages increasing number of younger persons
- Always having good up to date information on bereavement for family members of the patient who has died
- Sometimes due to pressures on the ward I feel we do not have the time to talk to relatives enough and that is why we appreciate the Macmillan service so much

- If we were made more aware & had training in what is currently available, feel it would be more than adequate
- Lack of courses/ training updates at the Altnagelvin site
- I think a meeting with the doctors and nurses involved with the care of the deceased should be offered to all families two weeks after the event
- The mortuary opening and closing hours at the SWAH need to be reviewed - they close at 5pm which may prevent relatives taking their loved one home in a timely manner
- GP should offer Information and support line numbers appropriate to same
- Use of the internet for WHSST newsletter and on site on internet page topics related
- Training on these matters would be great
- More readily available .rare in paediatrics so resources not used regularly so information often difficult to locate quickly and often concerned that everything available is there and up to date
- Link people
- Previously used care of dying pathway which is no longer available found this a very beneficial and helpful tool to plan care of the dying patient and feel it should not have been removed
- I am involved in bereavement changes
- Staff would benefit of regular training either in-service or other
- The intranet resource is very accessible where this information could be updated so it can be accessed for on-going training in ensuring good practice
- More support and information sessions on dealing with the dying patient and communication with relatives, so that staff are up to date with relevant information and training
- Study updates for staff as above... Thank You
- More information booklets available in wards
- I have experienced Bereavement via my partner having breast cancer (she has had treatment for 2 years and thankfully is on the mend). My suggestion with regards to this is that Bereavement is not just about people dying, it is also about the impact of life threatening illness and how this affects families. I have worked through my wife's illness for the past two years and this is still on-going. I feel that there is no support on offer for myself or colleagues other than occupational Health. this is a supper service but support is limited and when you are temp employed then you a somewhat restricted in sharing info about illness and how this has been affecting people
- Certainly within CAMHS we work with the young person and their family who have not been coping well in relation to managing their bereavement. We would find that referrers to our service, especially GP's want us to provide early intervention, which we would feel that the timing is not appropriate, as they will be moving through the stages of grieving and this is best done within their family, friends and community. We would only accept these referrals if there are clear mental health issues where they present as a risk to themselves or others.
- More advertising re same and use of social media
- Good communication must be central to patient and family care

- Training for newly qualified staff coming to wards and especially emergency departments as majority deaths are sudden, traumatic and ages can vary from newborn, children and upwards. Also dealing with suicides
- I have given leaflets to relatives in past and found that sometimes the information takes away from the experience. Verbal information tends to work best in my experience but have written information available for relatives to browse on each ward or to access on a patient and relative friendly website might be helpful. (now we have free WIFI)
- More training in the SWAH for final journeys
- Education, training for ED staff specific to department. To give us training on paediatric death and support for families as this is particularly challenging for all involved. Also re: tragic circumstances or sudden death of adults. To know where to find leaflets/advice for bereaved relatives
- I feel that bereaved relatives should be able to access support via telephone/one to one from member of hospital team following death of a loved one in the hospital even if death is expected
- This is a really useful audit. The Bereavement Coordinator within the trust has been doing an excellent job and hopefully this exercise will also raise the profile of this important area prompting an improvement in care. A suggestion I have is that the intranet needs to be more user friendly and easy to access in general - including with regard to death, dying and bereavement information. A search function on the homepage of the intranet which is fit for purpose is essential. Therefore, there is work to be done on IT within the Trust. Thank you
- Not analysing death as an SAI. Audit of death using objective criteria to see if deficient e.g. memory box, taking footprints
- The biggest problem is not having access to side rooms
- Breaking bad news/advanced communication training should be widely available
- More availability of written information for relatives
- By providing updated information leaflet to families of what to expect
- Checklist/overall guidelines applicable to each ward could be available so nothing is missed
- One of the big issues is issuing death certificate over a holiday period - like a weekend or bank holiday - when the treating doctors are not working. Relatives want the remains for funeral, but morgue won't release the body unless certificate is issued. Coroner does not want to get involved as they say it is not their job. Public awareness is limited about this issue and all the stress falls on doctors and nurses, and at times trust managers. This is a deficiency of the law that needs law makers to sort out. In the absence of it, Trusts should be able to issue a clear policy of what should be done

BHSCT
183 of 765 (23.9%) staff members provided suggestions for improvements

- Team meeting at earlier stage regarding care plan for such patients
- Base training which involves all staff in team
- More training made available. Better awareness of same

- In certain circumstances should Liverpool care pathway be in place. Worked well in appropriate settings e.g. cancer centre
- Need to make staff aware of changes in policy via e-mail
- Seeing what has been done right and using it as examples
- More leaflets available
- Include more mandatory sessions and updates
- Could be made mandatory. More easily accessible
- Procedure covered at clinical supervision
- Targeted training to each specific clinical area. Needs to be more relevant to the area of work
- Need to be more practice for supporting staff on the ground
- Needs to be made mandatory
- Respect the patient's wishes at all times
- Trust intranet service is now very useful and easily accessible source of information
- Training on how to care for bereaved parents
- Relevant counselling for nursing and medical staff affected by this area. Very difficult topic for relatives and staff.
- Mandatory training would be my only solution
- In house study days are now up and running. Greater ability to access these would be good.
- Part of the mandatory training schedule with additional training days relevant to each clinical area
- Improvements on training need to be made
- Opportunity for junior nurses to shadow senior nurses who are experienced at caring for the dying patient
- More feedback. Good practice guidelines. Reflective practice. Parents input is not improving service information training environment
- Having a tool such as the dying pathway - so that everyone is Woking from the same document and providing the same standard of care
- In house training relevant to this area
- Reintroduction of the Liverpool care pathway would help. I thought it was an excellent system
- No place to discuss bad news with relatives on the ward
- Quiet rooms available for relatives. More staff to spend time with patients and family. Quick palliative care sessions at ward level
- It might be interesting/ supportive for staff to have the opportunity for a "Death Cafe" (see www.deathcafe.com) to explore their own views, perceptions, fears
- Better awareness of resources and training
- More training please
- I know that the final journeys programme is used in some areas and feel that this should be more easily available for all staff working in acute care settings
- Training day dealing with death, policies and procedures and communication between staff and relatives regarding bereavement
- Easier access to policies and telephone numbers e.g. out of hours chaplaincy services. Leaflets. More training for staff

- A specific liaison officer to help relatives and staff post death may be beneficial
- More easily accessed training for staff
- Updating staff of any changes in bereavement
- Some information on counselling after a relative has died
- I would be happy to attend training days if they were available
- Work in ICU. End of life care is a major issue re: communication with DNR and family withdrawal of treatment. Even after withdrawal patients are still receiving treatment
- Previously I had difficulty accessing counselling support families coming to terms with poor outcomes
- More training for staff in this area. I would be keen to avail of such training but it has never been offered to me
- Needs to be more awareness of available services. Better training for staff would improve the service delivered
- Contact details for information should be readily available. Further training should be provided to staff
- On-going training at regular intervals
- Provide training for staff
- Have never met or been aware of a bereavement co-ordinator. Perhaps they could make themselves known to ward staff
- A website for the same. Information Board on ward and throughout the hospital
- Information should be made more accessible to staff
- Formal training in these areas
- More information booklets should be available for staff and relatives. More training available for staff
- I haven't been on any study days regarding bereavement - this would be helpful
- Increased information about available sessions. Link in with sisters meetings to filter information to staff
- More palliative involvement
- Study days
- A place on any relevant training would help
- All staff should have this training during their induction
- Relevant training
- More relevant information made available
- Quiet area for family members
- Re-introduction of the Liverpool care pathway
- Need to bring back Liverpool care pathway. The service delivered to patients since its removal has deteriorated
- Better communication between medical and nursing staff as well as families
- Attending study days with updated information
- Bring back the Liverpool care pathway. I thought it was great
- Specific to each ward and each area of work
- I think sometimes people forget or do not ask has the patient has any spiritual needs working with elderly people you see sometimes it is very important to them and also comfort to them and family
- Better information and better training

- A stock of literature could be left out to the teams who work within the community and may not have ready access to these resources
- More leaflets at ward level
- More training for ward staff in dealing with bereavement. Re-introduction of the care of the dying pathway
- Could be made mandatory
- Make it mandatory
- Made mandatory training. Talk sessions with bereavement co-ordinator. E-learning
- Better education pre-registration and students on placement
- Areas were they do not have deaths or have very little deaths staff should be trained yearly to keep them updated
- Training for all staff on bereavement should be compulsory- not just doctors and senior nurses
- Study day for bereavement
- Included in mandatory training days
- More and better training available to all level of staff and covering legal, moral and ethical situations
- More information to be made available. Training highlighted and more accessible
- Better information. Better training
- Care pathway for the dying was a great tool
- Providing nursing staff with training regarding bereavement. Care of the dying pathway should be brought back for certain individuals
- Staff should get updated more on how to deal with palliative patients and their families
- Ease of access to booklets/ Info
- Greater availability of staff training would help
- Better information. Better training. Better access to both
- Needs to be mandatory
- More training days for staff
- Education and training
- Provide more literature that can benefit, staff, patient and family. Provide more training specific to dealing with death
- More specific training. Made mandatory
- Debriefing
- More booklets made available. Check list laminated in the dept
- Increased awareness of service for staff and relatives
- Easier accessed training. More training made available
- Study days. Reflective practice. More info on the hub
- More training would help
- All information combined in a handy pack available to appropriate nursing staff
- Proper training being made available and put in as a mandatory training session for all staff levels from domestics to sisters
- More information leaflets made more widely available
- Create a site on the hub
- Create a site on HUB where resources are in one place

- More training and awareness because very rarely patient dying in my working area.
- An accessible information pack.
- I think we need "Champions" in each department that will disseminate the relevant information and knowledge amongst ward staff
- More debriefing sessions. Training on last offices. Training on post mortem
- More training required to help deal with this sensitive issue
- Very difficult to know what study/ training are available?
- Within our place of work all investigations and information needed together in one pack and easily accessible
- Better new start training for staff new to A+E department. Include in staff induction packs. Improved quiet room facilities. Inclusive medical and nursing training
- Severe lack of training. More needs to be done in this area
- Better debriefing
- Better coordination between bereavement co-ordinator and ward staff. More Training
- More info for staff
- Debrief should be done as a team following a sudden death. Training on sudden death should be compulsory for ED staff
- Feedback non-existent in Belfast trust but has been in other up wide trusts for many years. Disappointing
- I would benefit on having some more training with regards to talking with families/ parents at end of life of child
- Policy handbook to relate to would be a great idea
- Widely available, all staff aware of course of action/ paperwork/ information for parents.
- Bereavement midwife to co-ordinate service. More study days
- More training. More support for staff
- More room for families especially when relative in process of dying or just passed. No privacy at times or a room to sit and be alone
- Increased awareness of training courses. Should be mandatory for specific staff
- In theatres there is no room where relatives can sit. They end up sitting outside theatres until they are allowed in to see their relatives. A quiet room would help
- Could be great to have psychologist to talk with
- More training
- Staff could receive training
- Yes, more training supplied to staff. None offered currently at all
- Need to be made aware of training of policies available
- Care pathways to approach different situations. More training for staff
- I feel there should be a family room for families to have some privacy at a time of mourning
- Should have a room for the family of the dying with tea and coffee making facilities
- More private spaces for grieving families
- There should be more private areas for families to be able to grieve
- I think the information should be presented to all new staff
- Increased awareness of training courses among staff

- More information would be provided on how staff can care for patient/family during the dying period/after death
- Improved access and awareness of available courses
- More support for staff
- Training days. Handbooks
- Peer support is excellent from colleagues. Sometimes feel that a patient dies and within a short space of time a new patient is in the bed. Mentally and emotionally challenging and can be difficult to deal with deaths of people who you have cared for a long period of time
- More structured service. More than one bereavement co-ordinator for the trust. Timely debriefing. Regular debriefing
- Regular training, updates. Increased support for staff dealing with bereavement as some death leave a lasting effect on staff
- No, from my experience dealing with dying/deceased patients, each ward + the staff were fantastic the care for the patients was commendable + made as respectable as they could possibly make it
- More training and awareness of how death, dying and bereavement information and resources. Some follow up + audit to ensure that this is disseminated as there appears to be little available resources
- A sympathy card should be standby sent from the ward/ department to relatives/carers following death of a patient. Mandatory update for staff on death/dying/bereavement i.e. every 2 years
- Co-ordinated approach within hospital sites/Trust e.g. notifies GP after death - different practice on each individual ward
- Supervision support and discussion from colleagues and other services. Palliative care nurses
- More awareness of training. More streamlined sessions
- More visible in the Trust
- New training session
- More written resources should be available at ward level
- We need to standardise the information regionally
- More documentation about the protocol
- A consultant should always talk to all nursing and medical staff when he/she wants to implement care of the dying pathway and this should always be discussed with family first
- More access to site specific training
- Training and information for staff
- More awareness of information available
- More training
- Have a named nurse which relatives can have to talk to. Have in house training for bereavement
- More training
- More training
- More emphasis needs to be placed on staff self-care to assist workers in coping with the demands of carrying out bereavement work. A directory specific to parent/sibling bereavement services needs to be drawn up. Clearer policies need to be developed

in relation to how long families are to be supported post-bereavement. Further involvement from front-line staff providing bereavement care needs to be considered
- I have experienced a few deaths on the wards to date. In my experience all staff treated these situations as respectfully and dignified as they could
- I would like training to be included in future online training programmes
- More specific training in this area is needed
- Some specific guidance and literature focusing upon on death/loss of a baby
- No appropriate rooms and space in acute wards in RVH to allow professionals to meet with families and carers - interview rooms used by staff for breaks and Sister's Office not always available or appropriate
- Staff should get chaplains involved with dying patients and their families before the death, as oftentimes we are called at the time of death
- A coordinated approach to maternity bereavement care, improved staff awareness of facilities and protocols
- Proper training in counselling. Debriefing for staff
- Should be a routine part of staff support rather than only when staff displaying stress or in crisis
- More attendance from ward staff
- Policies, guidance and information leaflets are adequate. The real deficit in the service lies with not enough staff, appropriate staff and space/private rooms for the family to grieve in private
- GP should be notified by email at time of death. Training should be provided to all staff new to the Trust. Online training is difficult to complete due to lack of resources
- Time and communication
- Please bring back Liverpool Care Pathway for the Dying Patient
- Pressure of work in dealing with the new living referrals means dealing with death and bereavement is not prioritised
- More time for families & patients
- As a relative of a dying person I have concerns that ward based staff do not always provide patient centred care and the patients' needs gets lost/overlooked/delayed because of other ward activities
- Readily available study days. Easy access to same. Seminars

SHSCT
53 of 249 (21.3%) staff members provided suggestions for improvements

- Yes there should be mandatory training for all new members of staff to attend when joining the Trust
- More availability of training
- A printed folder with all relevant information accessible at ward level would be very helpful I think
- I feel as a health care assistant we could have more training and information on care of the dying
- More availability of leaflets in clinics
- We need more information at ward level. We need this training to be incorporated into study days and also made mandatory

- More training e.g. group scenarios on how to deal with the situation in real time
- More training
- Annual training and updates for staff
- Many health care staff would need to view dying with dignity at home as a manageable process instead of working through obstacles and end up admitting patients to hospital for whatever reasons with the patient dying in hospital/arena where the choice has been taken from them
- More training needed
- Support and help to staff needs to be promoted and training must be more easily accessible
- Provide training
- Sometimes you feel that you need more time with the care of the dying and with relatives. I know this cannot happen
- Keep as a core competency for staff and as an agenda item in supervision (not necessarily in every SV session)
- Email copies of policy and procedure to all staff on global email
- Offer these training initiatives to students as well as qualifies staff
- Should be mandatory learning
- Possibly a pre made pack for relatives to encourage staff to give same by including it on the checklist
- More training made available for staff
- Staff need to be more aware of the need for peer support as an important resource
- Should be readily available on Trust Internet
- Offer update training
- Greater support from line managers. Recognising time spent and that you need support as well
- More written support for families. Access to side wards for dignity
- Leaflets ordered for relatives and available on wards
- A lot more training
- More training for all staff
- More courses suitable for paeds
- More knowledge re how/where to access these
- I feel there are generally not enough private rooms or resources on the ward to take families away from the clinical setting; I also feel where possibly community setting is much better.
- Replacement for LCP is long overdue, in pipeline but taking far too long.
- I feel when someone has been caring for someone with a chronic condition for a long time such as dementia and there have been multiple services involved that the bereavement process can be very difficult. All carers need closure and I think that a post bereavement visit should be carried out by the team that were involved. At present there is not the capacity in community teams to do this
- Guidance and support for community nurses and health visiting
- Found information/advice and support from Anne Coyle invaluable
- Southern Trust has lots of resources that staff can access

- Provision of a specialist midwife for maternity provision of a dedicated room for delivering stillborn babies where the parents could stay postnatally, away from the postnatal area
- Better up-to date care plans
- The provision of same at ward level as well as for the MDT would be useful
- Family should be given daily updates about condition
- Feedback from families
    - regular updates for staff who "break bad news" especially medical staff - Information available in other languages and formats
- Staff to continue to link with bereavement coordinator. Services to learn from patient feedback and experience. Use this learning to shape how services are planned, developed and delivered
- Better relatives' room in the ED. More information for patient's relatives to take away.
- Further training/support from management for coping with the dying child/relatives in the community
- Collaborative working with Macmillan team
- Training given to staff would be an advantage to help cope with the stress and questions from families
- Looked After Children need to be accompanied and supported through the actual process of wake, burial/cremation and not simply notified that it is happening
- Run more information sessions to inform staff of requirements and keep them up to date with any new changes
- Provide opportunities for various disciplines "together" to inform policy and practice - I recognise this survey is a practical step as is the Bereavement Forum. Identify how we might contact Bereavement Forum etc. to offer feedback etc.
- Regular training for district nursing
- We in the mortuary department experience delays in the issuing of death certs or their relevant other, sometimes up to 24hrs. This puts the mortuary staff under huge strain not only from undertakers but the family of the deceased, who are already understandably distressed
- Community staff should have access to relevant courses, particularly post bereavement work with relatives
- GPs should cover their own patients OOH as continuity is vital in end of life care. Some GPs do give access to their personal details and this makes a massive impact on care. Macmillan nurse is a vital member of the palliative MDT and provides excellent advice and support to district nursing

SEHSCT
56 of 312 (17.9%) staff members provided suggestions for improvements

- More information on past death services for relatives and nursing staff
- E-Learning
- Difficulty accessing medical staff at weekends and out of hours to change syringe drivers and PRN medication. Link nurse to be created for nursing staff to directly contact appropriate medical staff
- Better support for staff dealing with bereavement on a regular basis. Better information made available for distribution to relatives

- Previous care pathway was a useful resource for staff to refer to. Needs to be a new pathway developed
- Pathways are useful to clarify appropriate needs for individual patients who are dying
- Previous pathway which was removed was helpful for end of life patients
- I feel that there should be mandatory training factored into corporate training so that staff are better equipped themselves to deal with these situations and can give informed information to relatives/carers to signpost them to relevant palliative/bereavement services
- Yearly training courses
- Yearly training and updates
- Make time for the relatives after the death to give them the opportunity to talk to the nursing staff for support if needed
- Training would be good
- More training would be good
- Mortuary should be attached to main hospital. Family should be given plenty of time with dead relative
- Mortuary - should have an adjoining corridor. Do not like the idea of a patient being wheeled across car park
- Mandatory training and updates
- The trolley used to remove remains is very undignified
- Provide a quiet room for relatives to grieve in private
- Training
- Nominated link nurses for palliative care
- There needs to an increased awareness of available information which can be delivered to relatives of those recently deceased
- More training made available to HCA
- More training should be delivered to staff and more information should be on display
- Increased support available for staff who care for palliative patients and their families
- Handbooks with care pathways distributed between staff
- I would like to receive further training
- I thought the Liverpool care of the dying pathway was very useful to nursing staff
- Training on care pathways and documentation with bereavement
- More training
- Process streamlined. More training for staff
- Make the process simpler. Less paperwork equals more time with patients
- Discussions within department meetings and guest sponsors. Sharing of information between peers and professionals
- Guest speakers to attend team meetings to discuss policies/pathways
- No information for staff. Needs to be more training and awareness in this area
- Limited facilities which need improved. Quiet room for grieving relatives etc.
- More information needed and more training needed
- Better guidelines on signing of death certificate. Better guidelines on who goes for post mortem and who does not
- Issue of death certificates and cremation forms at weekends and bank holidays

- Bereavement Box has been an excellent tool for improving process and information. Chaplaincy Service involvement at an early stage with patient and family
- Being more aware of services and info available
- Highlight availability of help and care for staff. Build links with Nursing Homes
- Knowing where to access information from, via the intranet?
- Greater integration with chaplaincy services
- A checklist for staff should be available to advise them what to consider when the patient is nearing the end of their life
- Make it part of corporate induction, mandatory training
- Better awareness on location of training being held More training sessions to attend
- Study days please
- More time to spend with patient prior to death and family after death - no increased resources available when end stage palliative care patients come on to caseload. Getting equipment not always easy and getting time to order same also problematic as has to be written referral
- Mandatory training for nurses
- More community staff to be able to sit and listen to the families of the dying and talk over their areas of concern. A ten minute call is not conducive to anyone opening up about sensitive issues like lack of money for example
- Specialist teams both in the hospital and in the community. The teams would need to be well resourced, allowing early identification to enable to take the journey with the patient and family. Also the teams would need to be 24/7 allowing patients to have the same team during the evening & during the night. I feel that the service we provide is very good however there still a lot of fragmentation
- Increased training
- Doctor/nurses need to be more proactive and able to talk to relatives
- Made more accessible to staff in busy work area who cannot be released to attend training easily
- There are a wide variety of forms which could be brought together/ consolidated more appropriately. Need to replace the LCP take a planned death easier to manage for junior staff
- Clone Hilary Patterson and Paul McCloskey

Appendix A

Work Role of respondents following Dying, Death and Bereavement related Trust policies, procedures or guidance as detailed in the table at Q4.0

Policies, procedures or guidance	Number and % of respondents who answered 'Yes' out of total respondents (1,914)	Breakdown of respondents by Work Role	Number and % of total respondents by identified Work Role
Last offices	969 (50.6%)	Nurse/Midwife – 828 HCA – 100 Chaplain – 8 Doctor – 6 Mortuary Tech – 5 AHP- 1 Domiciliary/Homecare – 1 Other - 20	**Nurses/Midwives** 828 of 1,207 (68.6%) **HCAs** 100 of 189 (52.9%)
Identification and transfer of bodies	923 (48.2%)	Nurse/Midwife – 799 HCA – 69 Doctor - 18 Mortuary Tech - 14 Porter - 12 Social Worker – 1 Other - 10	**Nurses/Midwives** 799 of 1,207 (66.2%) **HCAs** 69 of 189 (36.5%) **Porters** 12 of 14 (85.7%)
Storage, viewing and release of bodies	262 (13.7%)	Porter - 7 Doctor - 7 Nurse/Midwife – 214 HCA – 16 Mortuary Tech – 14 Other - 4	**Porters** 7 of 14 (50%) **Doctors** 7 of 182 (3.8%)
Verification of death	542 (28.3%)	Nurse/Midwife – 383 Doctor – 128 HCA - 16 Mortuary Tech – 4 Porter - 2 AHP- 1 Domiciliary/Homecare – 1 Other – 7	**Nurses/Midwives** 383 of 1,207 (31.7%) **Doctors** 128 of 182 (70.3%)
Issuing of Medical Certificate of Cause of death	501 (26.2%)	Nurse/Midwife – 327 Doctor - 157 HCA – 7 Mortuary Tech – 4	**Nurses/Midwives** 327 of 1,207 (27.1%) **Doctors**

Policies, procedures or guidance	Number and % of respondents who answered 'Yes' out of total respondents (1,914)	Breakdown of respondents by Work Role	Number and % of total respondents by identified Work Role
		Porter - 2 AHP- 1 Other - 3	157 of 182 (86.3%)
Management of sudden / unexpected death	627 (32.8%)	Nurse/Midwife – 496 Doctor – 86 HCA - 19 Mortuary Tech – 3 Domiciliary/Homecare – 3 Porter – 2 AHP - 1 Administrative staff – 1 Chaplain - 1 Social Care staff - 1 Other - 14	**Nurses/Midwives** 496 of 1,207 (41.1%) **Doctors** 86 of 182 (47.3%)
Reporting deaths to the coroner	451 (23.6%)	Nurse/Midwife – 272 Doctor – 147 HCA - 9 Mortuary Tech – 9 Administrative staff - 2 Porter – 2 AHP - 1 Other - 9	**Nurses/Midwives** 272 of 1,207 (22.5%) **Doctors** 147 of 182 (80.8%)
Preservation of evidence in forensic cases	250 (13.1%)	Nurse/Midwife – 184 Doctor – 43 Mortuary Tech – 6 HCA - 9 Administrative staff - 1 AHP – 1 Social Care staff - 1 Other - 5	**Nurses/Midwives** 184 of 1,207 (15.2%) **Doctors** 43 of 182 (23.6%) **Mortuary Techs** 6 of 15 (40%)

Policies, procedures or guidance	Number and % of respondents who answered 'Yes' out of total respondents (1,914)	Breakdown of respondents by Work Role	Number and % of total respondents by identified Work Role
Seeking and obtaining consent for hospital post mortem examination	297 (15.5%)	Nurse/Midwife – 203 Doctor – 80 HCA - 5 Mortuary Tech – 3 AHP – 1 Porter - 1 Other – 4	**Nurses/Midwives** 203 of 1,207 (16.8%) **Doctors** 80 of 182 (44%)
Organ donation	312 (16.3%)	Nurse/Midwife – 233 Doctor – 54 Mortuary Tech – 8 HCA – 9 Chaplain - 2 AHP – 1 Other – 5	**Nurses/Midwives** 233 of 1,207 (19.3%) **Doctors** 54 of 182 (29.7%) **Mortuary Techs** 8 of 15 (53.3%)
Chaplaincy / Spiritual care	702 (36.7%)	Nurse/Midwife – 599 HCA - 41 Chaplain - 25 Doctor – 17 Administrative staff - 2 AHP – 2 Mortuary Tech - 1 Social Worker - 1 Other – 14	**All Acute Hospital staff groups** 610 of 1,456 (41.9%)
Do not attempt cardio pulmonary resuscitation	923 (48.2%)	Nurse/Midwife – 710 Doctor – 125 HCA - 47 AHP – 17 Chaplain - 1 Domiciliary/Homecare - 1 Porter – 1 Social Worker - 1 Other – 20	**Nurses/Midwives** 710 of 1,207 (58.8%) **Doctors** 125 of 182 (68.7%)

Policies, procedures or guidance	Number and % of respondents who answered 'Yes' out of total respondents (1,914)	Breakdown of respondents by Work Role	Number and % of total respondents by identified Work Role
Advanced care planning for adults	477 (24.9%)	Nurse/Midwife – 354 Doctor – 67 Social Workers - 13 HCA – 14 AHP – 8 Domiciliary/Homecare – 4 Chaplain - 3 Social Care staff - 1 Other – 13	**Nurses/Midwives** 354 of 1,207 (29.3%) **Doctors** 67 of 182 (36.8%) **Social Workers** 13 of 61 (21.3%)
Advanced care planning for children	97 (5.1%)	Nurse/Midwife – 74 Doctor – 14 Social Worker - 4 AHP - 2 HCA - 2 Chaplain - 1	**Children's Nurses** 37 of 50 (74%) **Doctors (working within Children's)** 9 of 50 (18%)
Breaking bad news	934 (48.8%)	Nurse/Midwife – 738 Doctor – 125 AHP – 10 HCA – 15 Chaplain - 12 Social Workers - 5 Domiciliary/Homecare – 3 Administrative staff - 2 Social Care staff – 2 Mortuary Tech - 1 Other – 21	**Nurses/Midwives** 738 of 1,207 (61.1%) **Doctors** 125 of 182 (68.7%) **AHPs** 10 of 72 (13.9%)
Bereavement care	801 (41.9%)	Nurse/Midwife – 647 HCA - 46 Doctor – 36 Social Workers -15 Chaplain - 12 AHP - 7 Mortuary Tech - 7 Administrative staff - 4 Domiciliary/Homecare – 1 Social Care staff – 1 Other – 25	**All staff groups** 801 of 1,914 (41.9%)

Appendix B

Q14.0 Examples of changes or initiatives to improve care were themed as follows:

Changes/Initiatives Identified	Number of respondents					Total respondents
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	
Bereavement box for staff	3	3	13	4	28	**51**
Bereavement Booklet	5	5	13	9	9	**41**
Water Lily Symbol	33	2	2			**37**
Bereavement Training and awareness sessions.	9	2	9	9	5	**34**
Purple patients' property bags.	12	1	12	4	3	**32**
Bereavement Coordinator	7	2	11	5	3	**28**
Improvements to documentation/guidelines	9	3	10	3	3	**28**
Body transfer forms initiated	1	2	15	4	6	**28**
Care of the dying pathway implemented	2	3	12	7	3	**27**
Removal of LCP	2	2	10	3	4	**21**
Policies and procedures	4	2	6	3	5	**20**
Palliative Care	4	3	9	1	2	**19**
Introduction of LCP - now withdrawn	9	2	4	2		**17**
Palliative Care Updates / Training	4	4	4	1	2	**15**
Better communication	7		2	2	2	**13**
New stillbirth care pathways	3	1			8	**12**
Better awareness of issues around bereavement	5		1	3		**9**
Purple sheets	4	1		1	3	**9**

Changes/Initiatives Identified	Number of respondents					Total respondents
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	
Organ donation	2	1	5	1		**9**
Marie Curie/Macmillan cancer nurses	3	2		2	2	**9**
Advanced Care Pathway	3			6		**9**
New last offices		2	5		1	**8**
New checklist after death	3		2		3	**8**
Maternity services including cots/mattresses	1		2	2	3	**8**
Debrief and Carecall	2		1	3	1	**7**
Advanced care planning and LCID palliative care register	3	1		1	2	**7**
Sands boxes revamped.	1		3	2		**6**
Verification of Death. Breaking Bad News to family	2		1	2	1	**6**
Changes to the preparation of body for transfer	1		5			**6**
Introduction of intranet site	2	1	2			**5**
Bereavement cards are sent to families after death to show support			5			**5**
Introduction of Bereavement forum and the excellent work that has been coordinated through it along with the awareness of the issues around end of life that has been raised by the work of the forum.	1		2	2		**4**
Bereavement Counselling	3				1	**4**
Not sure	2		2			**4**
Death Certification		1		3		**4**
Body transfer with trust undertakers			4			**4**

Changes/Initiatives Identified	Number of respondents					Total respondents
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	
Labelling of patient/identification	1			1	2	**4**
Staff support			1	3		**4**
Replacement of new guidance on end of life care		1		1	2	**4**
implementation of living matters, dying matters	2	1	1			**4**
Chaplain meetings/Appointment of Lead Chaplain in South Eastern Trust	1				2	**3**
More integrated working	2	1				**3**
Introduction of Do no resuscitate form	2	1				**3**
Dedicated relatives room and viewing area for bereaved relatives	3					**3**
Reflective practice			3			**3**
Strategy for Bereavement Care	3					**3**
Photography	2	1				**3**
More knowledgeable on reporting death i.e. Coroner	2			1		**3**
Bereavement Care team has since been set up			3			**3**
Use of purple cover for bed and use of trolley afterwards. Mini locker type altar for use in room if applicable in the event of dying	1	1				**2**
Development of M&M meetings which has assisted in improving quality of palliative care offered			2			**2**
With children there has been considerable work. If parents do not wish a child to go to the funeral directors, the body can be prepared in the home. Also parents can take dead child home from hospital if they wish to spend time alone with their child. Certain people need to be notified of this request however.	1				1	**2**
Spending allocated time with family after bereavement	2					**2**

Changes/Initiatives Identified	Number of respondents					Total respondents
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	
Provision of religious artefacts		2				**2**
Waterproof bags now available for the deceased to be transported to the mortuary		1	1			**2**
Bereavement and loss group in unit has made huge improvements i.e. memory boxes. Moses baskets			2			**2**
Quiet room has been made available for grieving relatives			2			**2**
Only one chance to get it right.		2				**2**
Paediatric bereavement committee	1					**1**
Bereavement website			1			**1**
Changes to coroner reporting SAI in progress. Made it more difficult	1					**1**
More openness for relatives and including them in planned care	1					**1**
Questionnaire for parents to provide feedback	1					**1**
Purple (disposable) very undignified	1					**1**
Community support teams	1					**1**
New department	1					**1**
Introduction of snowdrop walk for bereaved parents. More time offered to parents which enables them to be supported to spend time with their infant. More choice offered to whether infant goes home or not immediately following death.	1					**1**
Medical staff need to be more proactive in the decision to place DNAR on patients earlier with multiple co-morbidities so that this procedure is not carried out and the patient is allowed to pass away with dignity and respect.	1					**1**
We make it a priority that no patient is left alone when dying					1	**1**

Changes/Initiatives Identified	Number of respondents					Total respondents
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	
Am aware of GP practices meet with nursing staff and hospice nurse but SW not included in this, even though we are responsible for providing care packages for end of life care	1					**1**
PPI. Patient client experience standards 10,000 voices.				1		**1**
Improved discharged to community				1		**1**
Issuing of bags for the removal of deceased patient's personal effects from the ward (but no longer available)		1				**1**
New mortuary service in SWAH. Better facilities for the bereaved families when bodies leaving hospital		1				**1**
Patients no longer put into white gowns but can have their own night clothes on them.		1				**1**
Outreach to families bereaved by suicide			1			**1**
More awareness of other faiths and their particular needs at time of death			1			**1**
Workplace initiatives					1	**1**
Management of bariatric patients			1			**1**
Donation from parents of the most beautiful baby bereavement boxes for making memories with clay mould etc. Parents have been so delighted that this trust fund now replenished stock.			1			**1**
Improved awareness and action taken for patients who have expressed a wish to die at home between health care staff in primary & Secondary care settings in making this happen although still a work in progress at present for all patients and their families/carers				1		**1**
Greater effort to put dying patient in side room. Support re parking - is there support re food for NOK? Still need to develop the contacting of chaplaincy earlier in the dying process so they can call back again and not just at point of crisis/death.				1		**1**

Changes/Initiatives Identified	Number of respondents					Total respondents
	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	
Forget me Not bereaved parents liaison group					1	**1**
Introduction of ccos - this team provides our ward with amazing support for people/patients while they are very ill		1				**1**
"Essence of care programme" mouth care for very ill and dying patients			1			**1**
Working group looking at a pathway for the dying patient				1		**1**

Appendix C

Q15.0 Suggestions on how to improve death, dying and bereavement information, resources or services have been themed in order of most frequently stated as follows:

NHSCT

97 of 419 (23.2%) staff members provided suggestions for improvements

Number of responses	Suggestions - themed in order of most frequently stated
41	More (mandatory and optional) bereavement training and updates should be available and accessible: i.e. workshops/study days/in-house training/e-learning, for staff working in all areas (e.g. Palliative Care/Acute/Pharmacy/Community/Midwifery/District Nursing
7	Provision of Relatives' Room in Wards
6	Easy access to and availability of up to date booklets/leaflets/information for relatives and staff
6	Staff support/Support service/Debriefing
4	Provision of side rooms for dying patient and their relatives.
2	Integrated working: Disciplinary teams should meet with nursing staff/social worker, for discussions
2	Someone to contact next of kin/family 1-2 months after death to ask if further help needed
2	Don't like the water lily
3	More awareness of services and information available
2	More awareness of training courses or study days available / encouragement to attend.
2	Policy available at ward level
2	Family should be given enough contact and information on the patient end-of life journey
1	Invite Bereavement Co-ordinator to team meetings
1	More information for social workers
1	Provision of Care of the Dying Pathway
1	Bring back the Liverpool Care Pathway
1	Provision of cameras/printing facilities
1	Information re a death of patient passed more quickly to district nurse
1	Further information booklets
1	Specialised suite and sitting room in Delivery Ward for patient/family
1	Sign/symbol for main doors in Delivery Ward to indicate bereaved family inside
1	Nurse trained in bereavement to be named worker rather than a social worker
1	Availability of chaplain for spiritual needs/close collaboration between staff and chaplaincy team
1	Church service for bereaved relatives re pregnancy loss or child bereavement
1	Dying patients given priority for getting carers and professionals. Listen to what patient wants
1	A booklet to indicate end of life signs and symptoms for people with learning difficulties
1	Leaflets/support line numbers should be provided at GP surgeries
1	Training related to helping children
1	Bereavement/Last Offices Link Nurse.
1	Card offering condolences sent to families.
1	Availability of information in other languages
1	Aftercare post-discharge

Number of responses	Suggestions - themed in order of most frequently stated
1	A leaflet to give to family to support them
1	Staff passing on communication to other staff when research done or relevant article read
1	Follow up service for parents after a patient's death
1	Information display boards
1	Training tailored to specific areas
1	Allowing patients to die in nursing homes instead of being transferred to hospital for last few days of their lives
1	Easy access to / offers of counselling for relatives of suicide victims
1	Adjustment in care pathway for women who experience pregnancy loss
1	Training tracker modules should be abandoned
1	Standardisation of all bereavement documentation, processes, practices, M&M, and everything province-wide
1	More recognition from hospital staff that a patient is in active phase of dying, to avoid inappropriate comments to families
1	Feedback for staff
1	Staff making themselves available/having the time to answer questions/seek appropriate advice

WHSCT

65 of 169 (38.5%) staff members provided suggestions for improvements

Number of responses	Suggestions - themed in order of most frequently stated
18	More (mandatory and optional) bereavement training and updates should be available and accessible: i.e. workshops/study days/in-house training/e-learning, for staff working in all areas
7	Easy access to and availability of up to date booklets/leaflets/information for relatives and staff
2	More awareness of training courses or study days available / encouragement to attend
2	Bereavement/Last Offices Link Nurse
2	Provision of Relatives' Room in Wards
2	Breaking bad news/advanced communication training for clinicians
2	Bring back the Liverpool Care Pathway
2	Good, open communication with relatives
2	Better Mortuary provision in WHSCT/provision for body to be released out of hours
2	More awareness of services and information available
1	Training for new staff at induction
2	Rolling out/Training in/availability of Final Journeys programme
1	Raise awareness of various supporting bodies throughout the wards
1	Bereavement midwife
1	Provision of side rooms for dying patient and their relatives
1	Staff making themselves available/having the time to answer questions/seek appropriate advice
1	Use of Children's Hospice as a resource for staff in Children's Ward and Emergency Department
1	Training tailored to specific areas
1	Training re tragic circumstances or sudden deaths
1	Family should be given enough contact and information on the patient end-of life

Number of responses	Suggestions - themed in order of most frequently stated
	journey
1	Withdrawal of practice of family having to sign Consent/Do Not Consent to Post Mortem form when a child has die
1	Short presentations at Paediatric teaching sessions
1	More information for patients and relatives about dying and how to cope
1	A yearly update to show staff where they can get appropriate resources
1	Promotion of access to all available services
1	Availability of chaplain for spiritual needs/close collaboration between staff and chaplaincy team
1	Checklist/overall guidelines applicable to each ward could be available so nothing is missed
1	A clear policy of what to do re issuing of death certificate over holiday period/weekends
1	Not analysing death as an SAI
1	Audit of death using objective criteria to see if deficient, e.g. memory box, taking footprints
1	Telephone /one-to-one support for relatives from member of hospital team following death of loved one
1	Intranet needs to be more user-friendly and easy to access, esp. search function
1	Written information/access to patient and relative-friendly website available for relatives to browse on each ward
1	To delay referral to CAMHS unless there are clear mental health issues
1	More advertising and use of social media
1	Better communication between staff
1	Better information and appropriate tools to be distributed amongst staff
1	Link nurses to link with bereavement co-ordinator on regular basis
1	Meeting with the doctors and nurses involved with care of deceased should be offered to families two weeks after event
1	Leaflets/support line numbers should be provided at GP surgeries
1	Use of internet for WHSST newsletter and on-site on internet page topics related
1	Better support and information for staff whose relative is suffering a life-threatening illness
1	Provision of Care of the Dying Pathway

BHSCT

183 of 765 (23.9%) staff members provided suggestions for improvements

Number of responses	Suggestions - themed in order of most frequently stated
76	More (mandatory and optional) bereavement training and updates should be available and accessible: i.e. workshops/study days/in-house training/e-learning, for staff working in all areas
17	Staff support/Support service/Timely and regular Debriefing/'Death Café'
13	Easy access to and availability of up to date booklets/leaflets/information for relatives and staff
12	Provision of Relatives' Room in Wards
10	More awareness of training courses or study days available / encouragement to attend
9	Bring back the Liverpool Care Pathway
5	Training for new staff at induction/pre-registration/placement

Number of responses	Suggestions - themed in order of most frequently stated
5	More awareness of services and information available
4	Bereavement Co-ordinator – More contact with and awareness of/provide more than one in Trust
4	More information on the hub (where resources are in one place)
3	Training tailored to specific areas
3	Better information
3	More staff/time and communication
2	Provision of Care of the Dying Pathway
2	Staff making themselves available/having the time to answer questions/seek appropriate advice
2	Availability of chaplain for spiritual needs/close collaboration between staff and chaplaincy team
2	Training in counselling
2	Palliative care nurses/involvement
2	Reflective practice
2	All information combined in a handy pack available to appropriate nursing staff
2	Feedback for staff
1	Team should meet at earlier stage regarding care plans
1	Rolling out/training in/availability of Final Journeys Programme
1	GP should be notified by email at time of death
1	Consultant should talk to all nursing and medical staff when wanting to implement care of dying pathway and it should be discussed with family first
1	Card offering condolences sent to families/carers
1	Standardise information regionally
1	Respect patient's wishes at all times
1	Training on how to care for bereaved parents
1	Procedure covered at clinical supervision
1	Staff should be made aware of changes in policy via email
1	Seeing what has been done right and using it as examples
1	Base training which involves all staff in team
1	Opportunity for junior nurses to shadow senior nurses who are experienced at caring for the dying patient
1	Quick palliative care sessions at ward level
1	Information display board on ward and throughout hospital
1	Stock of literature left out for teams who work in community
1	More patient-centred care
1	Include bereavement training in future online training programmes
1	Named nurse for relatives to talk to
1	A co-ordinated approach to maternity bereavement care, improved staff awareness of facilities and protocols
1	More priority for dealing with death and bereavement
1	Some specific guidance and literature focusing on death/loss of a baby
1	A directory specific to parent/sibling bereavement services
1	Follow-up/audit to ensure training/awareness of resources and information is disseminated
1	Co-ordinated approach within hospital sites/Trust (egg notifies GP after death – different practice on each ward)
1	More information provided on how staff can care for patient/family during dying period/after death
1	Handbooks

Number of responses	Suggestions - themed in order of most frequently stated
1	More streamlined training
1	Clearer policies in relation to how long families are to be supported post-bereavement. Further involvement from front-line staff providing bereavement care needs to be considered
1	Seminars
1	More documentation about the protocol
1	More structured service
1	'Champions' in each department who will disseminate the relevant information/knowledge
1	Check list laminated in the department
1	Within our place of work all investigations and information needed together in one pack and easily accessible
1	Policy handbook to relate to
1	Bereavement midwife
1	Availability of a psychologist
1	Better communication between medical and nursing staff as well as families
1	Areas where few deaths should be trained annually
1	More and better training to all staff and covering legal, moral and ethical situations
1	Easier access to policies and telephone numbers, egg out of hours chaplaincy services
1	A specific liaison officer to help relatives and staff post death
1	Information on counselling after a relative has died
1	Work in ICU. End of life care is a major issue re: communication with DNR and family withdrawal of treatment. Even after withdrawal patients are still receiving treatment
1	Contact details for information should be readily available
1	Link in with sisters meetings to filter information to staff
1	Good practice guidelines
1	Parents input is not improving service information training environment

SHSCT

53 of 249 (21.3%) staff members provided suggestions for improvements

Number of responses	Suggestions - themed in order of most frequently stated
18	More (mandatory and optional) bereavement training and updates should be available and accessible: i.e. workshops/study days/in-house training/e-learning, for staff working in all areas
3	Staff support/Support service/Timely and regular Debriefing/'Death Café'
5	Easy access to and availability of up to date booklets/leaflets/information for relatives and staff
2	Provision of Relatives' Room in Wards/better relatives' room
2	Continued Bereavement Co-ordinator support, advice and accessibility
2	Better up-to-date care plans (at ward level)
2	Health Care staff to view dying with dignity at home as a manageable process
2	Collaborative working with MacMillan team
2	Feedback from families/patients
1	Training for new staff at induction
1	A printed folder with all relevant information accessible at ward level
1	Replacement for the Liverpool Care Pathway

Number of responses	Suggestions - themed in order of most frequently stated
1	Bereavement midwife
1	Specialised suite and sitting room in Delivery Ward for patient/family
1	Staff making themselves available/having the time to answer questions/seek appropriate advice
1	Training available to students as well as qualified staff
1	Pre-made pack for relatives and have it included on checklist
1	Should be readily available on trust intranet
1	Provision of side rooms for dying patient and their relatives
1	Further training/support from management for coping with the dying child/relatives in the community
1	Better support for Looked After Children
1	Guidance and support for community nurses and health visiting
1	Regular updates for staff who 'break bad news'
1	Availability of information in other languages
1	Post-bereavement visit to carers by teams that were involved
1	Families should be given daily updates about condition
1	Provide opportunities for various disciplines 'together' to inform policy and practice
1	Identify how to identify how to contact Bereavement Forum etc. to offer feedback
1	A way of reducing delays in Mortuary Department for issuing death certificates
1	GPs should cover their own patients OOH as continuity is vital in end of life care. Some GPs do give access to their personal details and this makes a massive impact on care
1	Keep as a core competency for staff and as an agenda item in Supervision
1	More courses suitable for paediatrics and where to access these

SEHSCT

56 of 312 (17.9%) staff members provided suggestions for improvements

Number of responses	Suggestions - themed in order of most frequently stated
22	More (mandatory and optional) bereavement training and updates should be available and accessible: i.e. workshops/study days/in-house training/e-learning, for staff working in all areas
4	Replacement for Liverpool Care Pathway
4	Easy access to and availability of up to date booklets/leaflets/information for relatives and staff
3	Staff support/Support service/Timely and regular Debriefing/'Death Café' – improve awareness of service
3	More awareness of services and information available / how to access on intranet
2	Provision of Relatives' Room in Wards/better relatives' room
2	Process streamlined
2	Mortuary should have an adjoining corridor
2	Discussions within department meetings and guest sponsors. Sharing of information between peers and professionals. Discussion of policies/pathways
2	Availability of chaplain for spiritual needs/close collaboration between staff and chaplaincy team
1	Bring back Liverpool Care Pathway
1	Palliative care (link) nurses/involvement
1	Family should be given plenty of time with dead relative
1	Staff making themselves available/having the time to answer questions/seek

Number of responses	Suggestions - themed in order of most frequently stated
	appropriate advice
1	Difficulty accessing medical staff at weekends and out of hours to change syringe drivers and PRN medication. Link nurse to be created for nursing staff to directly contact appropriate medical staff
1	The trolley used to remove remains is very undignified
1	Handbooks with care pathways distributed between staff
1	Better guidelines on signing of death certificate
1	Better guidelines on who goes for post mortem and who does not
1	Issue of death certificates and cremation forms at weekends and bank holidays
1	Build links with nursing homes
1	A checklist for staff to advise them what to consider when patient is near end of life
1	More awareness of training courses or study days available / encouragement to attend
1	Staff making themselves available/having the time to answer questions/seek appropriate advice. More availability of resources
1	More community staff to be able to sit and listen to the families of the dying and talk over their areas of concern
1	Specialist teams in hospital and community, available 24/7
1	Doctors and nurses to be more proactive and be able to talk to relatives
1	Consolidation of forms more appropriately
1	Clone Hilary Patterson and Paul McCloskey