Past evidence examples

Level 3 APT Diploma

New - updated with:

- **CAS forms linked to evidence piece examples**
- **Includes objective and reflective evidence types**

Candidate Number: [redacted]

Candidate Assessment Summary Form

Level 3 Diploma in Anatomical Pathology Technology

Unit APT3.6 Preparation and operation of a mortuary

Learning Outcome/Assessment Criteria	Evidence for Achievement[1]	Assessor Decision[2]
Be able to carry out cleaning and disinfection of surfaces and equipment		
Prepare cleaning and disinfectant solutions	**Evidence 2 – Witness Statement** **Evidence 4 – Reflective Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 8 – Objective Evidence**	
Follow standard operating procedure in the cleaning and disinfection of surfaces	**Evidence 2 – Witness Statement** **Evidence 4 – Reflective Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 8 – Objective Evidence**	
Use appropriate techniques to disinfect or sterilise equipment	**Evidence 2 – Witness Statement** **Evidence 4 – Reflective Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 8 – Objective Evidence**	

1. Use this column to signpost the relevant evidence in the portfolio.
2. The assessor should tick this box if he/she believes the assessment criterion / learning outcome has been met.

Ensure disinfected and sterilised equipment is protected from contamination until required	**Evidence 2 – Witness Statement** **Evidence 4 – Reflective Statement** **Evidence 6 – Reflective Statement**	
Be able to store mortuary equipment and materials		
Follow standard operating procedures for the storage of equipment and materials	**Evidence 4 – Reflective Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement**	
Retrieve equipment and materials from storage as requested.	**Evidence 2 – Witness Statement** **Evidence 4 – Reflective Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement**	
Be able to store and retrieve records		
Follow standard operating procedures for the storage of records	**Evidence 6 – Reflective Statement**	
Follow standard operating procedures for the retrieval of records	**Evidence 3 – Witness Statement** **Evidence 6 – Reflective Statement** **Evidence 7 – Objective Evidence**	
Ensure records are only accessed by authorised staff	**Evidence 3 – Witness Statement** **Evidence 7 – Objective Evidence**	
Be able to record and carry out appropriate		

1. Use this column to signpost the relevant evidence in the portfolio.
2. The assessor should tick this box if he/she believes the assessment criterion / learning outcome has been met.

Candidate Number: [redacted]

maintenance of mortuary equipment		
Carry out routine maintenance of mortuary equipment	**Evidence 2 – Witness Statement** **Evidence 4 – Reflective Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 8 – Objective Statement** **Evidence 9 – Objective Statement** **Evidence 10 – Objective Statement**	
Record relevant details of equipment maintenance	**Evidence 2 – Witness Statement** **Evidence 4 – Reflective Statement** **Evidence 8 – Objective Evidence** **Evidence 9 – Objective Evidence** **Evidence 10 – Objective Evidence**	
Be able to receive and release the deceased		
Follow standard operating procedures for the receipt and release of the deceased	**Evidence 1 – Witness Statement** **Evidence 3 – Witness Statement** **Evidence 6 – Reflective Statement**	
Understand the importance of infection control and record management in the operation of a mortuary		
Explain the reasons for cleaning and disinfecting equipment and surfaces in the mortuary	**Evidence 2 – Witness Statement** **Evidence 4 – Reflective Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement**	
State why information governance is important in a mortuary	**Evidence 6 – Reflective Statement** **Evidence 7 – Objective Evidence**	

1. Use this column to signpost the relevant evidence in the portfolio.
2. The assessor should tick this box if he/she believes the assessment criterion / learning outcome has been met.

Candidate Number: [redacted]

Award of unit / qualification recommended:

	YES / NO	Name	Signature	Date
Assessor				
Internal Verifier				

1. Use this column to signpost the relevant evidence in the portfolio.
2. The assessor should tick this box if he/she believes the assessment criterion / learning outcome has been met.

Personal Reflective Learning Statement

Name: [redacted]	*RSPH candidate number:* [redacted]
Unit number: **3.6**	*Evidence number:* **5**
Activity date: [redacted]	*Evidence type:* **Full Reflection**

Activity Title/ Description you are reflecting on:

Cleaning the TST/PST trolleys

What I did:

I am aware of the daily, weekly and monthly cleaning duties around the mortuary. I located our cleaning log situated in a folder in the mortuary office and checked when the trolleys were last routinely cleaned. As they were due to be cleaned, I selected this task and took the trolley cleaning record with me to the fridge room where the trolleys were. We have a number of trolleys in the department, in order to make recording which has been cleaned or needs cleaning easier our mortuary staff has assigned names to each trolley which is translated in the cleaning log.

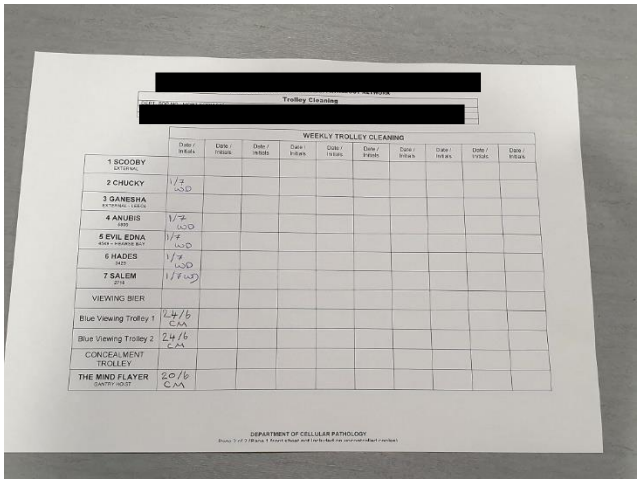
I donned the appropriate PPE (Personal Protective Equipment) for the task which was a theatre mask, nitril gloves and a disposable apron. For cleaning the trolleys, we use a mixture of two cleaning chemicals in a spray bottle, which we spray over the whole trolley and leave for a minimum of two minutes before wiping of with a towel. When performing a deep clean of the trolley as I was this day, the individual rollers can be removed which gives access to additional spaces that need cleaning as dirt and leaking bodily fluids can gather there. It is important that the trolleys are thoroughly cleaned with the appropriate chemicals as they are a high traffic area and can be a great source of cross contamination for infectious materials. For example, a colleague using the trolley to release a deceased patient will likely also touch the patient, the tray and the fridge door handle; by keeping the trolleys regularly cleaned it helps to stop the transmission of infections by contact.

I retrieved the trolley I was planning clean and drove it to a space that was not currently being used, I set the trolley to a waist height position that way I was able to clean the scissor mechanism and the underside of the main bed frame. I then went into the post mortem storeroom where our flame proof cabinets are located that contain all our flammable chemicals and items. I retrieved a 5L bottle of OneSpray Multipurpose Cleaning and Disinfectant and a 5L botte of OneSpray Stay Fresh. Following the departmental SOPs for cleaning and disinfecting I used the pre-measured pumps attached to the bottles so I could decant the correct volume of concentrated solution into an empty spray bottle that I sourced, I then diluted the mixture with water to the 1L mark on the spray bottle. Before continuing on to clean the trolley, I put back the two 5L chemical bottles into the flame proof cabinet and locked it as per our departmental SOP following COSHH (Control Of Substances Hazardous to Health) regulations, on the storage of flammable substances.

I removed the rollers and sprayed down both the trolley thoroughly in the cleaning solution and the removed rollers, I left the spray on for two minutes before I returned to start wiping it off, making sure I got in the gaps where the rollers sat and the scooped lip that collects dirt from the rubber roller at the end. While wiping down the trolley I visually checked it for any obvious defects such as rust or exposed wires. When I had wiped over the entire trolley, I placed the rollers back and then checked that the lifting/lowering and rolling function were operating correctly. I had noticed on lowering the trolley down to its resting position that the scales were not displaying the weight correctly that I was expecting to see. Our scales on our trolleys are maintained by an outside agency 'Fisher's Scales', which my deputy manager corresponds with, so I made sure to tell my deputy that they were not working as expected so they could arrange a service.

I then drove the trolley back to the fridge room where it was ready to be used by my colleagues. I took of my used gloves, placed them into the clinical waste bin and filled in the trolley cleaning record under the correct trolley.

Below is an example photo of our trolley cleaning record.


[redacted]
Trolley Cleaning
[redacted]
WEEKLY TROLLEY CLEANING

	Date / Initials	Date / Initials	Date / Initials	Date / Initials	Date / Initials	Date / Initials	Date / Initials	Date / Initials	Date / Initials	Date / Initials
1 SCOOBY EXTERNAL										
2 CHUCKY	1/7 WSD									
3 GANESHA EXTERNAL - LARGE										
4 ANUBIS BIER	1/7 WSD									
5 EVIL EDNA 45kg + HEAVIER BOY	1/7 WSD									
6 HADES HEP	1/7 WSD									
7 SALEM 2018	1/7 WSD									
VIEWING BIER										
Blue Viewing Trolley 1	24/6 CM									
Blue Viewing Trolley 2	24/6 CM									
CONCEALMENT TROLLEY										
THE MIND FLAYER GANTRY HOIST	20/6 CM									

DEPARTMENT OF CELLULAR PATHOLOGY

What did I do well?

I followed departmental SOPs and COSHH regulations when carrying out routine cleaning and maintenance. I correctly recorded cleaning I had performed on the weekly trolley cleaning record.

What would I do differently next time?

Next time I will ask to see through the process of requesting to have the scales serviced, that way in the future if they need reporting again and my deputy manager is not here, I would be able to do this myself.

What have I learned?

I have learnt why deep cleaning the trolleys regularly is important to staff health and safety as well as keeping up with the routine maintenance of the equipment.

Mentor/management comments if applicable:

[redacted] always provides a high standard quality clean to all areas and equipment in the department.

Candidate Signature: [redacted]	*Date:* **27.11.2023**
Mentor Signature: [redacted]	*Date:* ***08.01.2023***

Work Based Objective Evidence

Name: [redacted]	*RSPH candidate number:* [redacted]
Unit number: **3.6**	*Evidence number:* **10**
Activity date: [redacted]	*Evidence type:* **Photographs of document and equipment**
Department: **Mortuary**	*Hospital:* [redacted]
Evidence Title: **Air Quality Testing - Formalin**	

The evidence I am presenting is a photograph of the equipment used for air quality testing of Formaldehyde presence in our formalin station and the document used for recording the data. This evidence demonstrates that I am able to carry out routine maintenance of mortuary equipment and can record relevant details of mortuary maintenance.

Air Quality Testing Equipment

Gastec Detector Tube for Formaldehyde – the sampled air is drawn through the glass vial via the pump for the designated amount of times in the correct timing intervals, the glass vial has measuring units on the outside which tell me the level of formaldehyde present in the air. The expected unit level is 0, any more must be investigated.

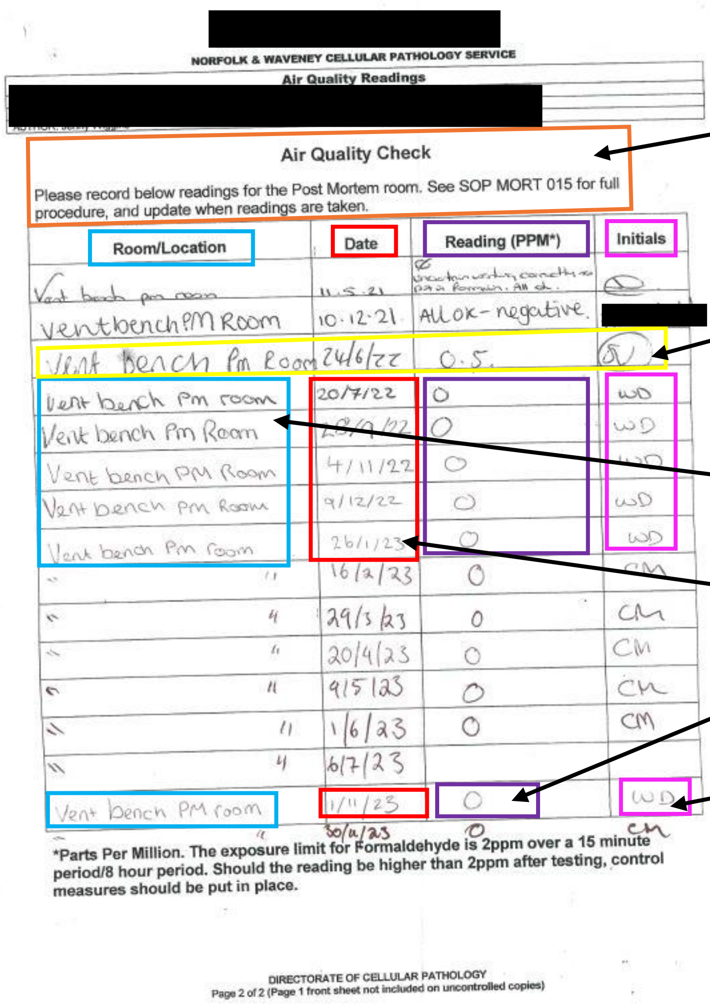
The plain end of the glass tube is placed into the black pump shown on the left of the picture with the air being drawn into the filtering medium on entry to the tube.

The timer used has prompt stickers to remind the user the timing intervals the pump needs to be drawn in order to obtain an accurate recording. The pump needs to be pulled in total of five times with a time of 1.5 minutes (90 seconds) in between each draw.

The pump the Gastec Detector Tube is placed into to draw the sampled air through

The area I tested for presence of Formaldehyde is in our Post Mortem room at the Formalin Station where two 5 Litre bottles of 10% and 20% Formalin are kept. One of the readings on the document below show a variance in a reading of 0.5 PPM (parts per million) instead of the expected 0. This reading was signed by another colleague at the time however I was present with them as a second witness to the elevated level. That afternoon when we took that particular reading our air extraction system had been turned off for maintenance and it showed the higher Formaldehyde reading. Although this reading is higher than expected it was still within safe limits as the maximum is 2ppm, so no additional action was needed and we ensured that the next reading a month later when the air extractor was operational showed a reading of 0 again, which it did.

The below photo is the Air Quality Readings document I use when recording the data of the levels of Formaldehyde in the air. It is laid out simply with four headings: Room/Location, Date, Reading (PPM) and Initials.


[redacted]
NORFOLK & WAVENEY CELLULAR PATHOLOGY SERVICE
Air Quality Readings
[redacted]

Air Quality Check

Please record below readings for the Post Mortem room. See SOP MORT 015 for full procedure, and update when readings are taken.

Room/Location	Date	Reading (PPM*)	Initials
Vent bench pm room	11.5.21	Ø Extraction working correctly no ppm Formalin. All ok.	[illegible]
Ventbench PM Room	10.12.21	All ok – negative	[redacted]
Vent Bench Pm Room	24/6/22	0.5.	[illegible]
Vent bench Pm room	20/7/22	0	WD
Vent bench Pm Room	28/9/22	0	WD
Vent bench PM Room	4/11/22	0	WD
Vent bench Pm Room	9/12/22	0	WD
Vent bench Pm room	26/1/23	0	WD
"	16/2/23	0	CM
"	29/3/23	0	CM
"	20/4/23	0	CM
"	9/5/23	0	CM
"	1/6/23	0	CM
"	6/7/23		
Vent bench PM room	1/11/23	0	WD
"	30/11/23	0	CM

*Parts Per Million. The exposure limit for Formaldehyde is 2ppm over a 15 minute period/8 hour period. Should the reading be higher than 2ppm after testing, control measures should be put in place.

DIRECTORATE OF CELLULAR PATHOLOGY
Page 2 of 2 (Page 1 front sheet not included on uncontrolled copies)

Air Quality Check – this form is where I record the readings taken in PPM (parts per million), the SOP is available to refer to if the reading is above 0 or further guidance is needed on how to test

This highlighted reading is the one mentioned above where the reading is higher due to the air extraction system being off at the time of testing, as described the next reading a month later is at 0 due to the extraction system being on again

Room/Location – Vent bench PM Room

Date – date the air sampling was tested

Reading (PPM – Parts Per Million)

Initials – of the APT staff that conducted the air testing, I have highlighted the tests I conducted

Candidate Signature: [redacted]	*Date:* **30.12.2023**
Mentor Signature: [redacted]	*Date:* ***11.01.2024***

Candidate Number: [redacted]

Candidate Assessment Summary Form

Level 3 Diploma in Anatomical Pathology Technology

Unit APT3.7 Prepare for post mortem examinations

Learning Outcome/Assessment Criteria	Evidence for Achievement[1]	Assessor Decision[2]
Be able to prepare a deceased person for a *post mortem* examination		
Assess risks to self and others that the deceased may present prior to preparing the body for *post mortem* examination	**Evidence 3 – Witness Statement** **Evidence 5 – Reflective Statement** **Evidence 8 – Objective Evidence**	
Establish the identity of the deceased	**Evidence 1 – Witness Statement** **Evidence 4 – Reflective Statement** **Evidence 5 – Reflective Statement**	
Ensure information relating to the deceased is made available to the pathologist	**Evidence 1 – Witness Statement** **Evidence 2 – Witness Statement** **Evidence 3 – Witness Statement** **Evidence 4 – Reflective Statement** **Evidence 5 – Reflective Statement**	
Prepare the deceased for *post mortem* examination according to relevant guidelines	**Evidence 1 – Witness Statement** **Evidence 4 – Reflective Statement** **Evidence 5 – Reflective Statement**	

1. Use this column to signpost the relevant evidence in the portfolio.
2. The assessor should tick this box if he/she believes the assessment criterion / learning outcome has been met.

Candidate Number: [redacted]

Be able to prepare the mortuary for *post mortem* examinations		
Identify materials required for the *post mortem* examination	**Evidence 1 – Witness Statement** **Evidence 2 – Witness Statement** **Evidence 3 – Witess Statement** **Evidence 4 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 7 – Objective Evidence** **Evidence 8 – Objective Evidence** **Evidence 9 – Objective Evidence** **Evidence 10 – Objective Evidence**	
Prepare materials required for the future assessment of any samples taken during *post mortem* examination	**Evidence 1 – Witness Statement** **Evidence 2 – Witness Statement** **Evidence 3 – Witess Statement** **Evidence 4 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 7 – Objective Evidence** **Evidence 8 – Objective Evidence** **Evidence 9 – Objective Evidence** **Evidence 10 – Objective Evidence**	
Ensure equipment required for the *post mortem* examination is available and ready for use	**Evidence 1 – Witness Statement** **Evidence 2 – Witness Statement** **Evidence 3 – Witess Statement** **Evidence 4 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 7 – Objective Evidence** **Evidence 8 – Objective Evidence** **Evidence 9 – Objective Evidence** **Evidence 10 – Objective Evidence**	

1. Use this column to signpost the relevant evidence in the portfolio.
2. The assessor should tick this box if he/she believes the assessment criterion / learning outcome has been met.

Candidate Number: [redacted]

Ensure equipment necessary for the recording of *post mortem* examination data is available and ready for use	**Evidence 1 – Witness Statement** **Evidence 2 – Witness Statement** **Evidence 4 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 7 – Objective Evidence** **Evidence 8 – Objective Evidence** **Evidence 9 – Objective Evidence** **Evidence 10 – Objective Evidence**	
Understand the risks to self and others if adequate preparations are not made for a *post mortem* examination		
Explain the risks of infection from the body of the deceased during a *post mortem* examination and how proper preparation can minimise these risks	**Evidence 3 – Witness Statement** **Evidence 4 – Reflective Statement** **Evidence 5 – Reflective Statement** **Evidence 7 – Objective Evidence** **Evidence 8 – Objective Evidence**	
Explain the health and safety risks due to materials and equipment used during a *post mortem* examination	**Evidence 4 – Reflective Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 7 – Objective Evidence** **Evidence 8 – Objective Evidence** **Evidence 9 – Objective Evidence**	

1. Use this column to signpost the relevant evidence in the portfolio.
2. The assessor should tick this box if he/she believes the assessment criterion / learning outcome has been met.

Candidate Number: [redacted]

Award of unit / qualification recommended:

	YES / NO	Name	Signature	Date
Assessor				
Internal Verifier				

1. Use this column to signpost the relevant evidence in the portfolio.
2. The assessor should tick this box if he/she believes the assessment criterion / learning outcome has been met.

Personal Reflective Learning Statement

Name: [redacted]	*RSPH candidate number:* [redacted]
Unit number: **3.7**	*Evidence number:* **4**
Activity date: [redacted]	*Evidence type:* **Full Reflection**

Activity Title/ Description you are reflecting on:

Setting up for a Paediatric Hospital Post Mortem

What I did:

My senior made me aware that we had a neonate scheduled for full post mortem the following morning, I volunteered to set up the post mortem so the examination would be ready to start when the pathologist arrived. I asked if the other processes had been completed such as, clinical photography, keepsakes, skeletal X-ray and if the medical records had been arranged to be delivered to the department, or if I should arrange this too, they confirmed these had been done and the medical records were all electronic so the pathologist would access these themselves.

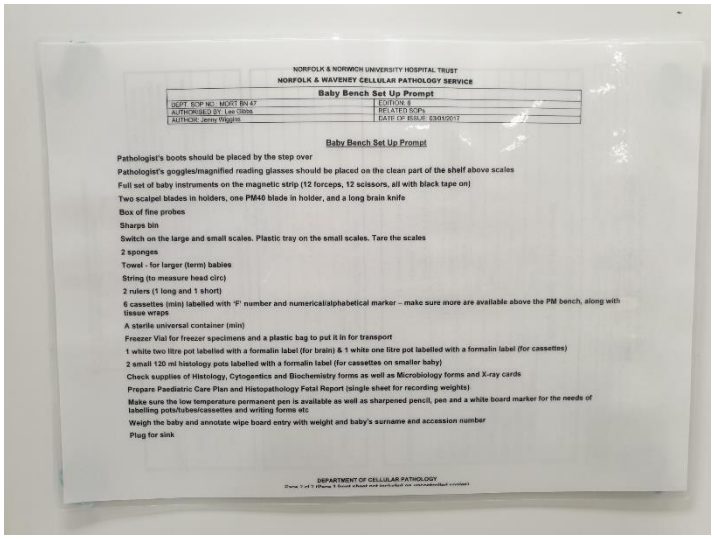
Whilst in the office I retrieved the following records for the patient: Notification of Death Form (NOD), Paediatric Care Plan and Consent documentation. This documentation allowed me to check the ID on all the paperwork matched with each other and allowed me to confirm that the neonate was due to have a full post mortem, the other two options being a limited external examination or no examination; I was happy that the documents matched, and a full examination had been consented to.

I took the documentation and placed it on the clean shelving units next to our paediatric dissection bench. We have a separate area for paediatric/neonatal post mortems that is away from our adult dissection bench, this if for reducing the risk of spreading infection between the two areas, especially if both are in use at the same time. By having two separate areas there is limited chance for infectious microorganisms to spread by splashing dirty water or touch contact between the two. Pathologists and APTs are reminded to change their PPE between the areas by having the physical space between them, this again helps to stop cross contamination to the neonatal bench.

We have a prompt sheet on our neonatal examination side that reminds the APT setting up the examination all the equipment that needs to be available. For a hospital post mortem the dissection equipment comprises of 12 forceps and 12 scissors, a selection of fine probes, 2 scalpel blades and 1 PM40 in their holders, 1 brain knife, 2 sets of weighing scales, head block, needles and string, 1 large ruler and 1 small ruler. I ensured that all of the equipment needed was clean, disinfected, functional and easily available for the pathologist to use. Any items that were not to standard I either cleaned and put into the washer disinfector or replaced entirely such as the brain knife that was showing some signs of rust around the join to the handle, this I placed in our large sharps bin and retrieved a new one from the box in

our storeroom. I was very careful when handling the blades and brain knife as they are able to cut through our disposable gloves and cause a significant sharps injury.

Below is the prompt sheet that I followed for setting up the post mortem.



NORFOLK & NORWICH UNIVERSITY HOSPITAL TRUST
NORFOLK & WAVENEY CELLULAR PATHOLOGY SERVICE

Baby Bench Set Up Prompt

DEPT. SOP NO.: MORT BN 47	EDITION: 6
AUTHORISED BY: Lee Gibbs	RELATED SOPs:
AUTHOR: Jenny Wiggins	DATE OF ISSUE: 03/12/2017

Baby Bench Set Up Prompt

Pathologist's boots should be placed by the step over
Pathologist's goggles/magnified reading glasses should be placed on the clean part of the shelf above scales
Full set of baby instruments on the magnetic strip (12 forceps, 12 scissors, all with black tape on)
Two scalpel blades in holders, one PM40 blade in holder, and a long brain knife
Box of fine probes
Sharps bin
Switch on the large and small scales. Plastic tray on the small scales. Tare the scales
2 sponges
Towel - for larger (term) babies
String (to measure head circ)
2 rulers (1 long and 1 short)
6 cassettes (min) labelled with 'F' number and numerical/alphabetical marker – make sure more are available above the PM bench, along with tissue wraps
A sterile universal container (min)
Freezer Vial for freezer specimens and a plastic bag to put it in for transport
1 white two litre pot labelled with a formalin label (for brain) & 1 white one litre pot labelled with a formalin label (for cassettes)
2 small 120 ml histology pots labelled with a formalin label (for cassettes on smaller baby)
Check supplies of Histology, Cytogentics and Biochemistry forms as well as Microbiology forms and X-ray cards
Prepare Paediatric Care Plan and Histopathology Fatal Report (single sheet for recording weights)
Make sure the low temperature permanent pen is available as well as sharpened pencil, pen and a white board marker for the needs of labelling pots/tubes/cassettes and writing forms etc
Weigh the baby and annotate wipe board entry with weight and baby's surname and accession number
Plug for sink

DEPARTMENT OF CELLULAR PATHOLOGY

I then moved on to preparing histology cassettes as histology samples are taken in neonatal post mortems, the prompt suggests 6, but in my experience the pathologist usually requires at least 10 for a larger gestation neonate. I labelled the cassettes ‘2A 2B 2C 2D’ etc with the foetal number following after the code. The ‘2’ tells the lab staff at histology what type of specimen the cassette contains, and the letter details which organ it came from. When labelling cassettes for the brain I prepare at least 6 for a large neonate and 4 for a smaller neonate; brain cassettes are labelled ‘3A 3B 3C 3D’ etc. I took a freezer vial container used for freezing either a liver or spleen sample for future genetic testing and universal container which is typically used to store samples for red oil stain and labelled them with the patient's details. I then sourced two yellow edged histology forms, and filled these out as fully as I could at that time with the patient's details. The first form was for recording the number of histology cassettes taken, the freezer vial and red oil stain, the second form was for recording any brain histology that was taken. I took two specimen labelling stickers from the roll and filled these in with the details I had available, leaving blank what and how many samples were taken.

Lastly for setting up the histology I retrieved two white histology pots ensuring that they were big enough so that the patient’s brain could fit into it with space around it. I donned the correct PPE for handling formalin, which is a mask, gloves and eye protection; and filled one pot with 10% formalin and the other with 20% formalin. The COSHH sheet for formalin specifies it has a number of health hazards associated with it, such as respiratory irritation, skin sensitivity, allergic reaction, eye irritation and carcinogenic to name a few. It is an unavoidable hazard in our work to use this chemical, therefore before exposure to it we must follow the COSHH guidelines found in our Post Mortem Specimens SOP and wear the correct PPE to minimise the hazards during exposure. I securely clipped the lids in place and carful to remember which was which I walked them to the clean shelving unit and using a

white board pen I wrote 10% and 20% on the respective lids. We have two separate pots with different formalin concentrations because when we need to fix a brain a stronger concentration (20%) is required whereas, the organ histology slides do not require this concentration (10%).

Using the patient's details, I created a space on the main neonate whiteboard where we record their weights during post mortem, and later transfer the data onto the foetal report, I wrote their surname and foetal number at the top. I then placed the white histology pot with 20% formalin (with the lid on) onto the larger scales to weigh it, I wrote this weight onto the board: "pot w/formalin: *weight*". This weight is important to record as during post mortem the brain would be highly distorted if it was weighed while fresh, so when the brain is removed it is placed directly into the formalin and weighed as a whole. The first weight taken without the brain is subtracted from the new weight and so the weight of the brain is revealed.

Next, I turned on both sets of scales (small and large) to check they were charged and in good working order. I sourced a Foetal Report which is used to record the weights of the organs and the external appearance of the patient, I placed this with the histology forms, paediatric care plan and consent form; I then ensured that there were working pens, pencils and whiteboard markers. I topped up the consumable items such as PPE, chemical cleaning solutions, reconstruction equipment and located the pathologist's wellies and placed these at the step over for them to change into when entering the post mortem room. By setting these aside for them in advance it helps with our infection control as the pathologist is not having to step on the post mortem flooring with their regular shoes and does not run the risk of having infectious material leave the post mortem room on their shoes and taken to different areas of the department and hospital.

Lastly, I prepared the neonatal patient for examination. I checked on their NOD form to what fridge space they were in and if they had any notifiable infection, so I could be aware to take extra health and safety precautions if necessary. There were not additional precautions needed so after checking their fridge space I donned a disposable apron and gloves and retrieved the patient from the neonatal fridge. I did not need any specialist lifting equipment to help me with the manual handling as I was able to slide the neonate out of the fridge and carry them to the examination bench by holding them in their body bag. I removed the patient from the bag and located their ID wrist band, I checked for three points of ID that matched their NOD and again I like to check the ID on the patient matches the ID on the consent form, just as an additional safety check. I was happy they matched, and proceeded to remove the property and clothing from the patient and stored them safely in the body bag. I carefully picked up the baby and placed them on the large weighing scale, I took note of the weight and immediately placed the baby back on the bench. I replaced my gloves and wrote on the white board and foetal report the weight of the neonate. I did not re-dress the patient, so they were ready for their examination, I wrapped them in a towel and placed them back into their body bag and returned them to their fridge space.

What did I do well?

I set up the neonatal post mortem examination in line with our departmental SOP by also using the prompt on the wall to ensure I had not missed anything.

What would I do differently next time?

Next time I would look ahead at the post mortem schedule and plan ahead to prepare for the post mortem without my senior needing to ask me to set it up.

What have I learned?

I have learnt there is more preparation work to setting up a paediatric/neonatal post mortem in comparison to an adult and I need to allow more time the day before to set it up.

Mentor/management comments if applicable:

[redacted] understands the importance of ensuring all equipment and resources are readily available for the Histopathologist, this is to prevent any delays and ensuring the examination is time effective. By completing additional tasks such as ensuring the scales are fully changed demonstrates [redacted] competence with assisting a pathologist, she thinks beyond what they could require and always learns from every examination she assists.

Candidate Signature: [redacted]	*Date:* **30.11.23**
Mentor Signature: [redacted]	*Date:* **11/01/2024**

Work Based Objective Evidence

Name: [redacted]	*RSPH candidate number:* [redacted]
Unit number: **3.7**	*Evidence number:* **9**
Activity date: [redacted]	*Evidence type:* **Photographs, Screenshots and Documents**
Department: **Mortuary**	*Hospital:* [redacted]

Evidence Title:

Sending and recording histology samples from post mortem

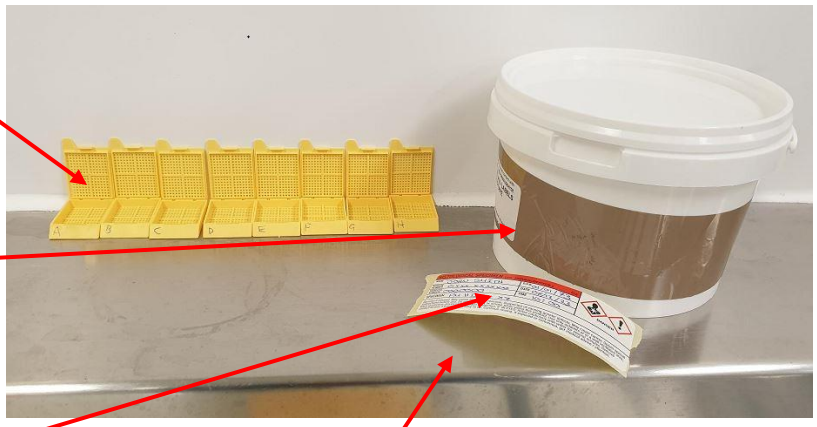
The evidence I am presenting is a series of photographs and screenshots showing the sending and recording of histology samples taken at post mortem. This includes the cassettes and pot, the histology form and sticker, the formalin station, the runner sheet and our electronic data base. This evidence serves to show that I can identify materials required for post mortem and ensure that it is available and ready for use. Also this evidence will show that I can prepare materials required for future assessment of samples taken and ensure that equipment needed for recording post mortem data is available and ready to use. ***The name and date of birth used is not of a real patient – it is an alias for example purpose only.***

Photo one – histology cassettes and tub for transport

Eight labelled histology cassettes open and ready on the dissection bench for the pathologist to use

Plastic histology tub with lid – half filled with 10% formalin to fix and transport the cassettes to the histology laboratory

Formalin Histology sticker – contains patients details, warning of formalin and specimens present inside

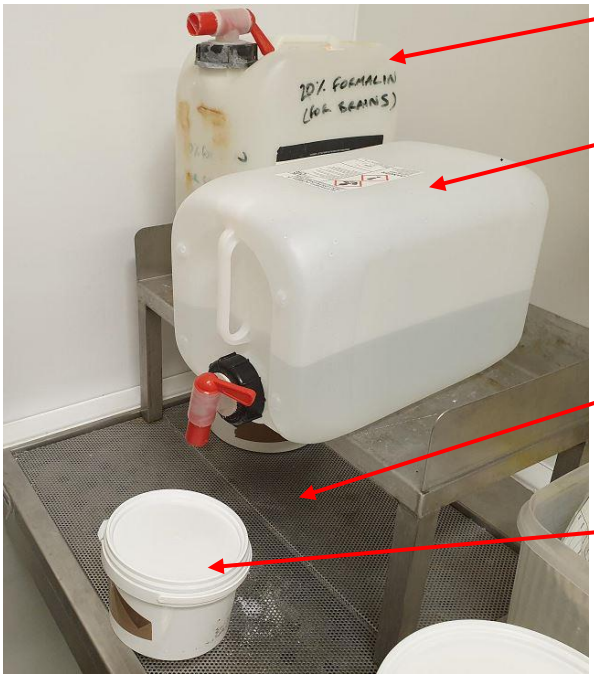


Elevated stainless steel bench above cut-up dissection boards – keeps materials out of pathologist's way and samples segregated

To prepare for post mortem I set out eight cassettes, if the pathologist required anymore these were topped up and ready for use near the dissection bench. Once the cassettes were

filled with the samples required, I closed the cassettes and placed them into the plastic histology tub above filled with 10% formalin.

Photo two – formalin station



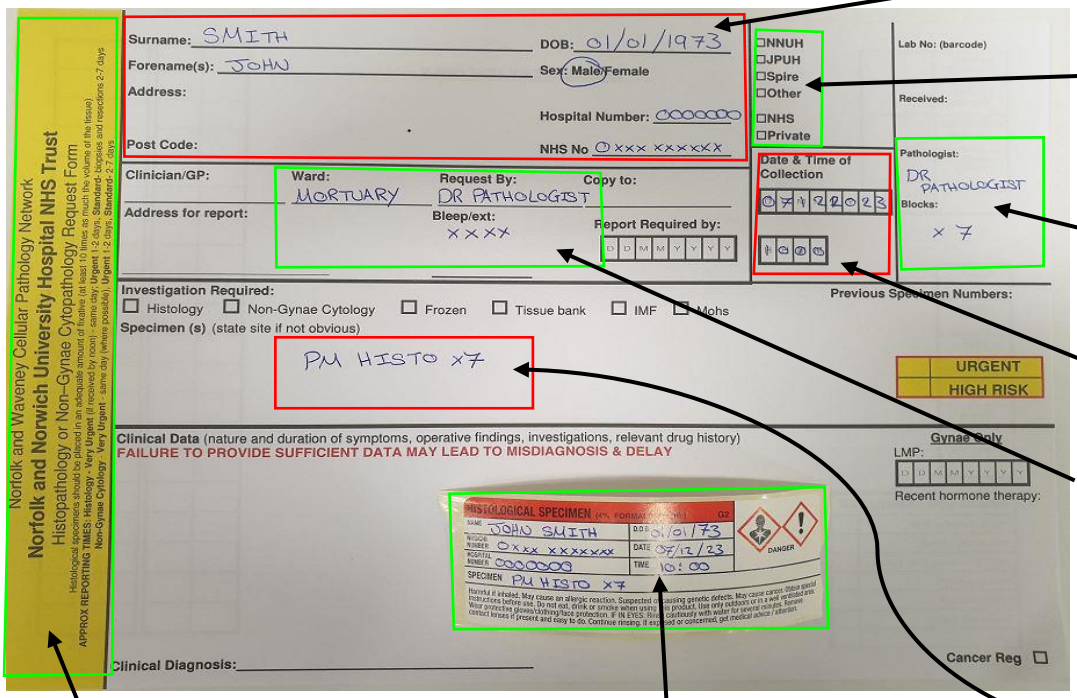
20% formalin – used for fixing whole brains

10% formalin – used for fixing organ cassettes

Ventilated bench and drip collection

Plastic histology tub – half filled with 10% formalin for the cassettes, lid firmly closed

When walking the filled histology pot over to the dissection bench to place the cassettes in, the lid is firmly clipped down. This is for health and safety so the formalin inside does not splash onto the APT or spill onto the floor, this also may also prevent spillage of formalin if the pot was dropped on route. Formalin has many health hazards made known on its COSHH sheet, some including respiratory irritation, allergic reaction and carcinogenic. The use of the formalin station should only be used when the APT is donned with the correct PPE (Personal Protective Equipment), including gloves, mask and eye protection, this is due to the previously mentioned health and safety issues formalin presents to the user if touched, inhaled or swallowed.



Patient's details – obtained by the coroner's approval form, address is not necessary

Hospital sample is being sent from and NHS or Private

Summary of details – Pathologist in charge and number of cassettes sent

Date and time of specimen sample collection

Pathologist's details – ward, name and contact number (bleep)

Photo three – histology form and formalin labelling sticker

Norfolk and Norwich University Hospital **Histopathology request form**

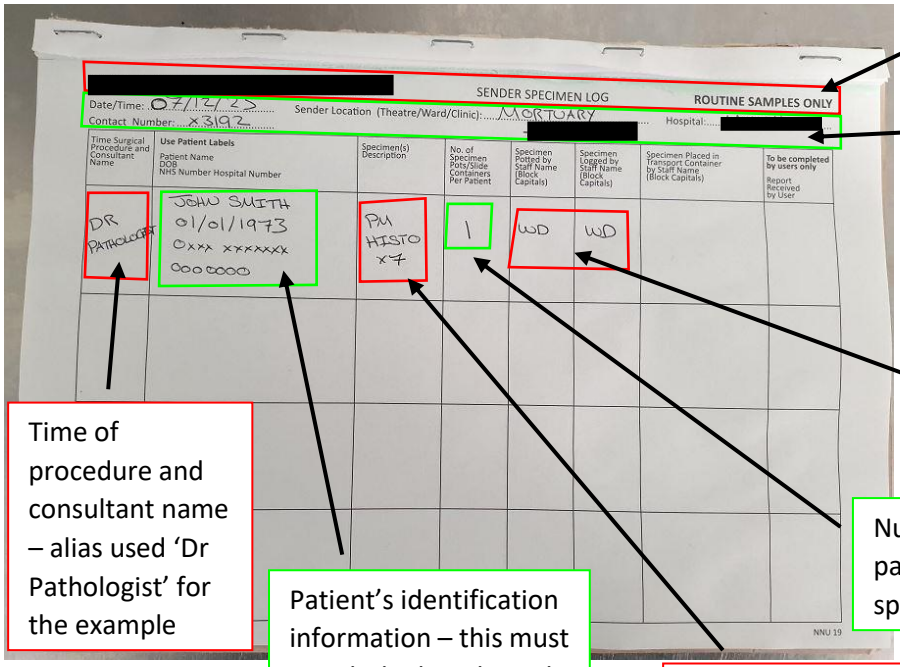
Formalin/histological specimen label – Patients identification details and date time sample taken and what the specimen contained is, i.e. – PM HISTO x7

Investigation required – 'PM HISTO' tells the pathologist what the cassettes are from and 'x7' tells them how many are contained

The above form 'Histopathology Request Form', I pre-fill out with as many details as possible before post mortem if I am aware there will be histology taken such as for a 'chest only 'post mortem. Information such as the patient's identification information and the pathologist information. This includes also pre-filling out the Histological specimen label with the same details. If taking histology is not known before post mortem I will ensure there is good supply of forms and stickers available for the day.

RSPH Diploma in APT – Level 3
Portfolio – Objective Evidence

Photo four – Histology sender log



Department Title, Document Title and Sample Type – correct form for post mortem samples to be recorded and sent on

Date, Location sent from, Hospital sent from and Department contact number – addition of [redacted] is to remind the collecting porter the required destination of the below samples

Specimen potted by, Specimen logged by – Who put the cassettes into the plastic histology pot with formalin and who wrote out the sender log

Number of specimen's pots/slide containers per patient – how many pots of this one type of specimen are being sent

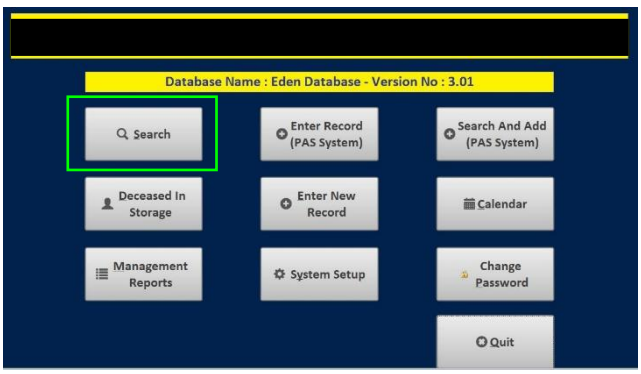
Time of procedure and consultant name – alias used 'Dr Pathologist' for the example

Patient's identification information – this must match the histological sample label on the specimen pot

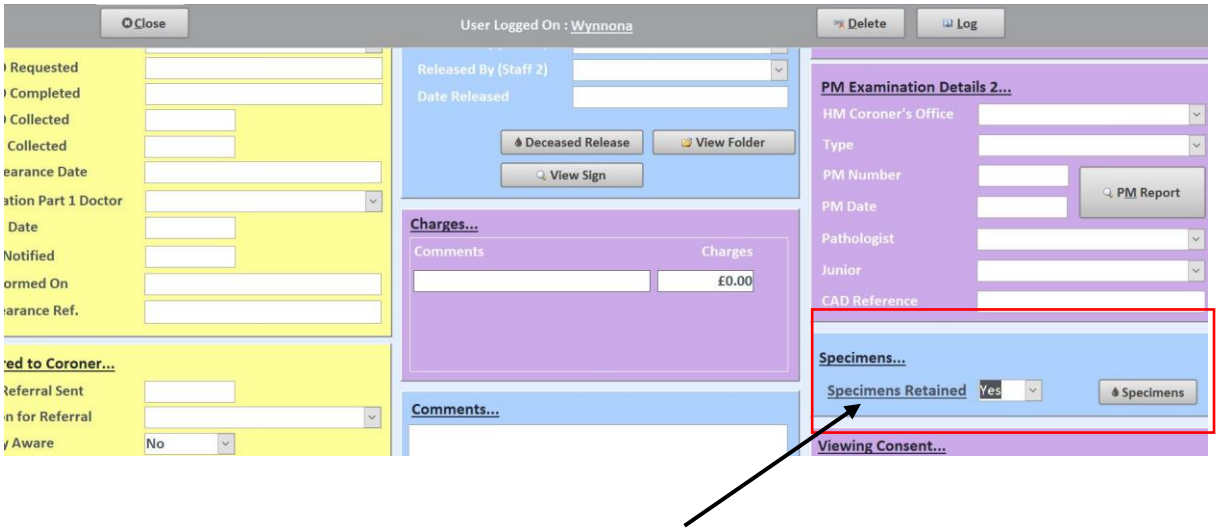
Specimen(s) description – what specimen is in the container and how many cassettes are in there

The sender log above is kept on a separate table in our fridge rom where the histopathology porter can easily access it. I filled out the log with the patient's identification information, description of the specimen and how many containers there were along with my initials for both potting and logging. The sender log prints a green carbon copy underneath when written on, the porter takes the top white copy to travel with the specimens and we keep the green copy as record of what we sent and when. This record is filed in our locked mortuary office.

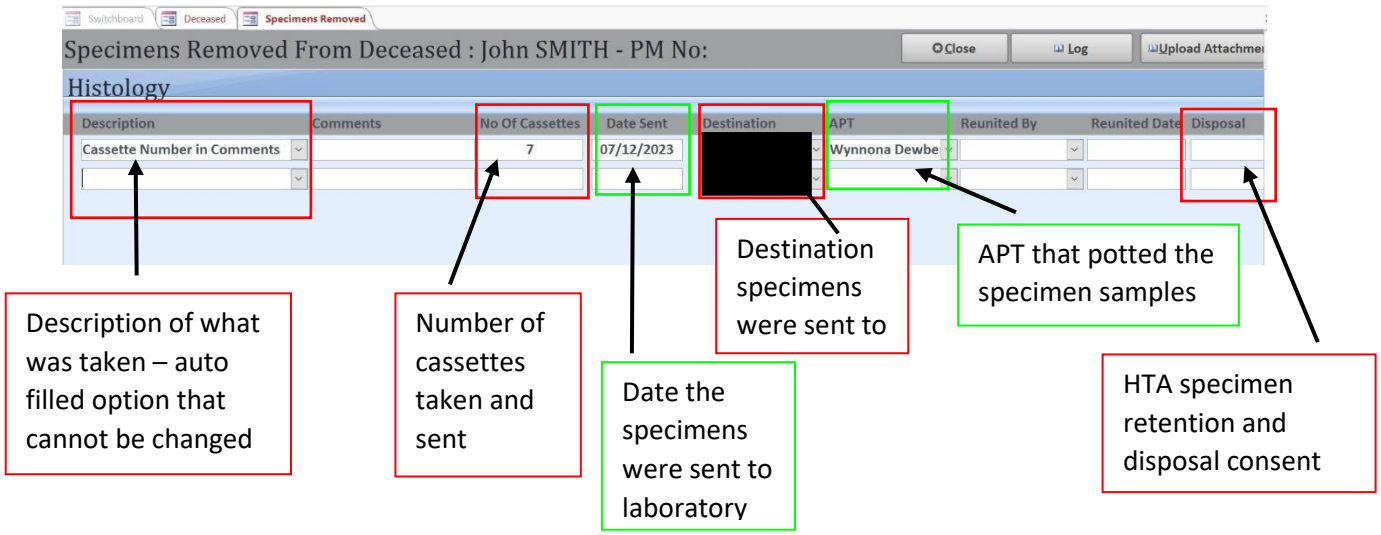
Photos five, six and seven – recording samples taken on EDEN (electronic database)



This screen shot is of the home screen of our electronic database EDEN that we store patient's details on, when recording histology samples taken I would access the patient's record through this by searching the patient's name.



Once I have located the correct patient record and entered it, I find the section named '**specimens**' and change the default 'no' to 'yes' on the drop down as seen above and then enter the specimens area of the record.



The last stage of logging the specimens is in the above section of the patient's record. The number of cassettes is logged and the date they were sent to the laboratory, where they were sent and the APT who took potted the sample. For our mortuary the histopathology laboratory is located as the [redacted], which is listed in the drop down list under destination.

The remaining three columns on the right are filled in when we receive the HTA consent form for specimen retention. When we know the consent for the samples, such as return to body, retain for medical records, disposal per departmental protocol etc. these are filled in if necessary. By recording this information on the patient's EDEN ensures accurate record keeping and a secure paper trail.

Candidate Signature: [redacted]	*Date:* 07.12.23
Mentor Signature: [redacted]	*Date: 20/01/2024*

Candidate Number: [redacted]

Candidate Assessment Summary Form

Level 3 Diploma in Anatomical Pathology Technology

Unit APT3.8: Assist with post mortem examinations

Learning Outcome/Assessment Criteria	Evidence for Achievement[1]	Assessor Decision[2]
Be able to carry out an external examination of a deceased person		
Identify from external examination of the deceased gross pathological features that may be related to the cause of death	**Evidence 2 – Witness Statement** **Evidence 3 – Witness Statement** **Evidence 6 – Reflective Statement** **Evidence 7 – Reflective Statement** **Evidence 8 – Objective Evidence**	
Record marks and injuries on the deceased using correct terminology	**Evidence 1 – Witness Statement** **Evidence 2 – Witness Statement** **Evidence 3 – Witness Statement** **Evidence 6 – Reflective Statement** **Evidence 7 – Reflective Statement** **Evidence 8 – Objective Evidence**	
Be able to carry out evisceration and dissection of a deceased person under the direction of supervisory staff		

1. Use this column to signpost the relevant evidence in the portfolio.
2. The assessor should tick this box if he/she believes the assessment criterion / learning outcome has been met.

Candidate Number: [redacted]

Remove the major organs from the deceased to include: Heart and great vessels Lungs Liver Spleen Brain	**Evidence 1 – Witness Statement** **Evidence 2 – Witness Statement** **Evidence 3 – Witness Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 11 – Objective Evidence**	
Remove the major structures from the deceased to include:: Gastro-intestinal tract Genito-urinary tract	**Evidence 1 – Witness Statement** **Evidence 2 – Witness Statement** **Evidence 3 – Witness Statement** **Evidence 6 – Reflective Statement** **Evidence 7 – Reflective Statement** **Evidence 11 – Objective Evidence**	
Be able to carry out an examination of dissected organs and structures		
Identify any gross pathological features of human organs and structures that may be related to the cause of death	**Evidence 1 – Witness Statement** **Evidence 2 – Witness Statement** **Evidence 6 – Reflective Statement** **Evidence 7 – Reflective Statement**	
Record relevant measurements and weights of organs and structures	**Evidence 1 – Witness Statement** **Evidence 2 – Witness Statement** **Evidence 3 – Witness Statement** **Evidence 6 – Reflective Statement**	
Be able to carry out reconstruction of a deceased person following post-mortem examination		

1. Use this column to signpost the relevant evidence in the portfolio.
2. The assessor should tick this box if he/she believes the assessment criterion / learning outcome has been met.

Reconstruct the deceased person following post mortem examination	**Evidence 3 – Witness Statement** **Evidence 4 – Witness Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 11 – Objective Evidence**	
Suture relevant incisions in the deceased person	**Evidence 3 – Witness Statement** **Evidence 4 – Witness Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 11 – Objective Evidence**	
Ensure the deceased person is suitable for viewing by relatives, friends and carers	**Evidence 3 – Witness Statement** **Evidence 4 – Witness Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 11 – Objective Evidence**	
Be able to carry out procedures for tissue retrieval under the direction of supervisory staff		
Prepare tissue and organ samples for further analysis	**Evidence 1 – Witness Statement** **Evidence 2 – Witness Statement** **Evidence 3 – Witness Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 11 – Objective Evidence**	
Retrieve tissues from a deceased person for donation or scientific research	**Evidence 1 – Witness Statement** **Evidence 2 – Witness Statement** **Evidence 5 – Reflective Statement** **Evidence 11 – Objective Evidence**	

1. Use this column to signpost the relevant evidence in the portfolio.
2. The assessor should tick this box if he/she believes the assessment criterion / learning outcome has been met.

Candidate Number: [redacted]

Comply with relevant legislation during tissue retrieval	**Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 11 – Objective Evidence**	
Maintain accurate records of tissue retained for analysis or scientific research	**Evidence 3 – Witness Statement** **Evidence 5 – Ref;ective Statement** **Evidence 6 – Reflective Statement** **Evidence 9 – Objective Evidence** **Evidence 11 – Objectice Evidence**	
Comply with local tissue retention and disposal standard operating procedures	**Evidence 6 – Reflective Statement** **Evidence 9 – Objective Evidence** **Evidence 11 – Objective Evidence**	
Understand health and safety, infection control, communication and record keeping requirements for post mortem examinations		
Explain why infection control is important during post mortem examinations	**Evidence 3 – Witness Statement** **Evidence 6 – Reflective Statement** **Evidence 10 – Objective Evidence**	
Explain why health and safety is important during post mortem examinations	**Evidence 3 – Witness Statement** **Evidence 6 – Reflective Statement** **Evidence 10 – Objective Evidence**	
State the reasons for accurate recording of information and maintenance of records during post mortem examinations	**Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement**	

1. Use this column to signpost the relevant evidence in the portfolio.
2. The assessor should tick this box if he/she believes the assessment criterion / learning outcome has been met.

Candidate Number: [redacted]

Explain why clear communication between team members is important during post mortem examinations	**Evidence 6 – Reflective Statement**	

Award of unit / qualification recommended:

	YES / NO	Name	Signature	Date
Assessor				
Internal Verifier				

1. Use this column to signpost the relevant evidence in the portfolio.
2. The assessor should tick this box if he/she believes the assessment criterion / learning outcome has been met.

Personal Reflective Learning Statement

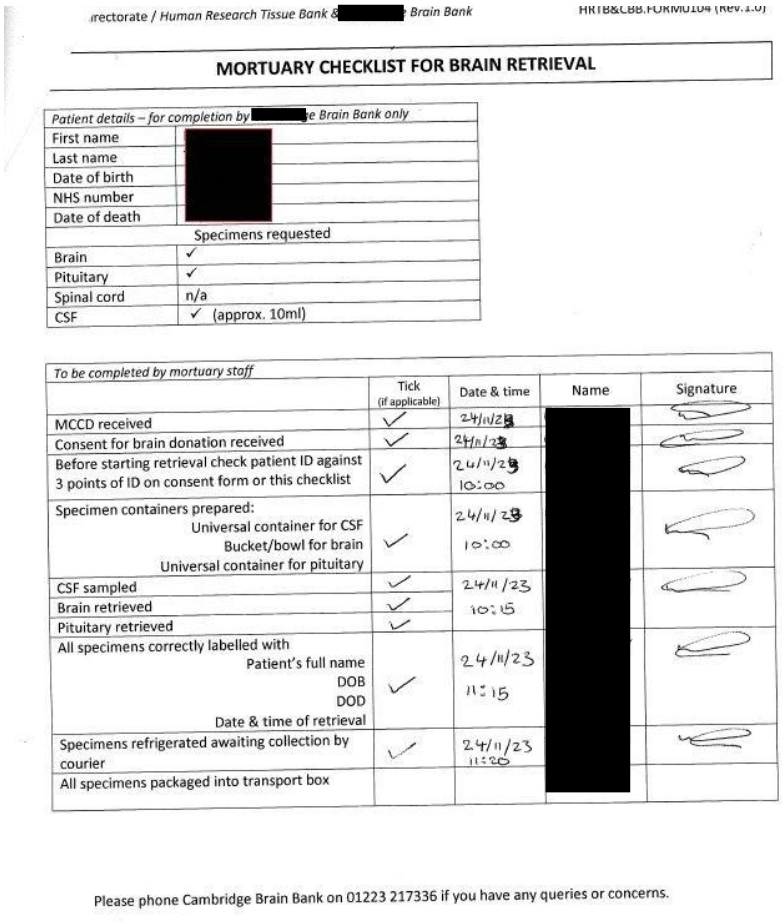
Name: [redacted]	*RSPH candidate number:* [redacted]
Unit number: **3.8**	*Evidence number:* **5**
Activity date: [redacted]	*Evidence type:* **Full Reflection**

Activity Title/ Description you are reflecting on:

Completing a brain donation for [redacted] Brain Bank

What I did:

When receiving the request via email for a brain donation on a deceased patient we had in our care, I made sure to take some time to read through all the documents that were sent ensuring everything was in place before starting. I read through the consent form the deceased had signed in life and the death certificate, the covering letter which detailed exactly what was required and how it should be packaged. The letter stated the time the courier would arrive to collect the brain and specimens, giving me a strict timescale in which to complete the donation. The last document in the pack was the 'Mortuary Checklist for Brain Retrieval' which had the patient's details used for the ID check of the patient and a breakdown, step by step, on how to prepare for donation and package the samples for donation.



irectorate / Human Research Tissue Bank & [redacted] Brain Bank HRTB&CBB.FORM0104 (Rev. 1.0)

MORTUARY CHECKLIST FOR BRAIN RETRIEVAL

Patient details – for completion by [redacted] Brain Bank only	
First name	[redacted]
Last name	
Date of birth	
NHS number	
Date of death	
Specimens requested	
Brain	✓
Pituitary	✓
Spinal cord	n/a
CSF	✓ (approx. 10ml)

To be completed by mortuary staff	Tick (if applicable)	Date & time	Name	Signature
MCCD received	✓	24/11/23	[redacted]	
Consent for brain donation received	✓	24/11/23		
Before starting retrieval check patient ID against 3 points of ID on consent form or this checklist	✓	24/11/23 10:00		
Specimen containers prepared: Universal container for CSF, Bucket/bowl for brain, Universal container for pituitary	✓	24/11/23 10:00		
CSF sampled	✓	24/11/23 10:15		
Brain retrieved	✓			
Pituitary retrieved	✓			
All specimens correctly labelled with Patient's full name, DOB, DOD, Date & time of retrieval	✓	24/11/23 11:15		
Specimens refrigerated awaiting collection by courier	✓	24/11/23 11:20		
All specimens packaged into transport box				

Please phone Cambridge Brain Bank on 01223 217336 if you have any queries or concerns.

Left is a scanned copy, anonymised, of the checklist I used for the donation

I was required to retrieve the brain, pituitary gland and sample approx. 10ml of Cerebral Spinal Fluid (CSF). I retrieved the patient's NOD form (Notification of Death form) and after donning the appropriate PPE (Personal Protective Equipment) for retrieving a brain, I got the deceased from their fridge space. Being mindful of manual handling techniques, I and another APT transferred the deceased onto the post mortem table using a PAT slide. My colleague and I used the checklist above with three points of ID to identify the patient against their hospital wristband. When we were satisfied this was the correct deceased patient, we undressed them and I placed a

towel over their torso and abdomen to maintain patient dignity as I would not be eviscerating them, they could be partially covered.
Before starting I sourced all of the equipment I would need, this included: scalpel, necropsy saw, T-piece, rubber mallet, two universal containers, needle and syringe, forceps, suture needle, thread, brain bowl, shampoo, conditioner, comb and body wash.

I placed a head block in the vertical position under the deceased's head for support and presentation of the area I would be incising. Because the deceased had mid-length hair, I took extra care in wetting the hair and applying conditioner to it before starting, this allowed me to trace an incision line first with a comb and brush away as much hair as possible so it would not be cut. By doing this it aids in reconstruction and ensuring the deceased is suitable for viewing by loved ones as it prevents hair being missing and helps to cover the suture site.

I took my scalpel and made an incision from around 1 centimetre behind and below the right ear and extended to a low point over the crown to a similar position behind the left ear. I then carefully reflected the scalp upward and forward over the face and away from the occipital region by dissecting away the connective tissue which attaches the scalp to the skull. I incised both temporal muscles around their boarders and reflected these forward using forceps and scalpel. Lastly, the rear portion of the scalp I dissected away from the occipital region down towards the head block, this allowed for easier reconstruction after.

Using the necropsy saw, a made a sawn incision around the calvarium/skull cap and ensured I made a 'V' shaped notch on the back of the occipital region, this is to prevent slippage of the skull when it is replaced and ensures better reconstruction. When sawing I made sure to try and keep the depth incised at two thirds the overall thickness of the skull, keeping at this depth should keep the dura matter intact around the brain and consequently mean that the saw did not penetrate and damage the brain in anyway. I then used a T-piece and rubber mallet to gently strike along the incision lines to loosen and fracture the calvarium, which allowed it to be removed, from the back in a forward and upward motion, exposing the dura, meninges and underlying brain. I removed the dura matter by dissecting along the sawn incision using forceps and scalpel.

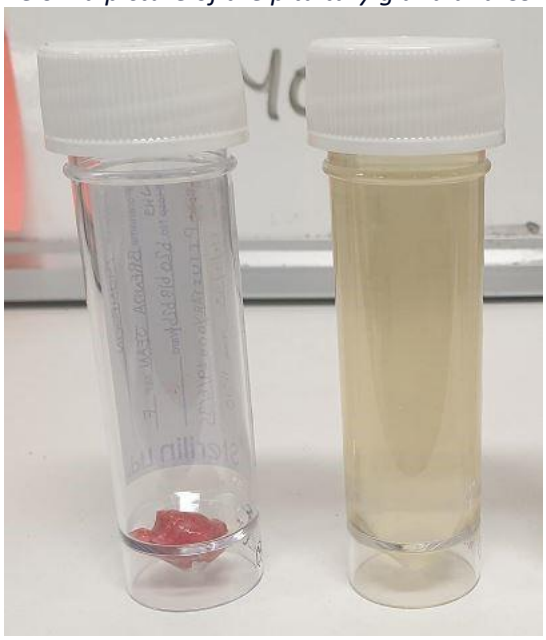
Before removing the brain, I took my needle and syringe and precisely punctured the brain in the right hemisphere close the great longitudinal fissure and angled the needle towards right lateral ventricle which contained CSF, I was able to obtain approximately 30ml in one attempt. This was the ideal situation as Cambridge Brain Bank had requested at least 10ml and I only needed to make one puncture mark into the brain. I decanted the CSF into a universal container I had already sourced and immediately placed my needle and syringe into the sharps bin to prevent receiving a needlestick injury, this injury could allow the transferring of pathogenic infection from the deceased to myself.

Next, I incised the falx cerebri and pulled it from between the cerebral hemispheres, as this came away, I gently pulled back the frontal lobes to expose the optic nerves, pituitary stalk, internal carotid arteries and oculomotor nerves which I then cut. I gently placed back down the right hemisphere and raised the left, making an incision through the tentorium cerebelli I followed the boundary of the temporal bone and exposed the left half of the cerebellum. I did the same procedure for the right side. I placed the two hemispheres of the brain back

into the skull and carefully removed the vertical head block and laid it horizontal, this allowed easier access to place my scalpel into the foramen magnum and laterally cut the spinal cord. I gently eased the brain from the cranial cavity front to back and placed the brain into the waiting brain bowl.

Next, I removed the pituitary gland. I did this by lining my T-piece chisel directly above the sella turcica of the sphenoid bone and gently fractured it of by hitting the T-piece chisel with the rubber mallet. This exposed the pituitary gland, I very gently using forceps held one area of the gland and applied a little forward pressure as I used my scalpel to dissect behind and remove it. When it was removed, I placed it into the other universal container.

Below a picture of the pituitary gland and CSF I took for the donation



I next began the reconstruction of the head. Firstly, I gently washed the cranial cavity out with clean water and packed it with an appropriate amount of cotton wool, this is done to absorb leakage from incised vessels and to help prevent leakage out of the suturing. I replaced the skull top, fitting it over the 'V' shaped notch I created earlier. I laid back over the temporal muscles I had previously reflected forwards, this helped to keep the calvarium in place at the front of the skull and prevents it slipping forward too easily. Carefully I reflected the scalp back onto the skull, I combed the hair forwards once more this was in an effort to help with the reconstruction as hair can easily get caught up and sutured along with the string, and this can look messy and unsightly for loved ones to view.

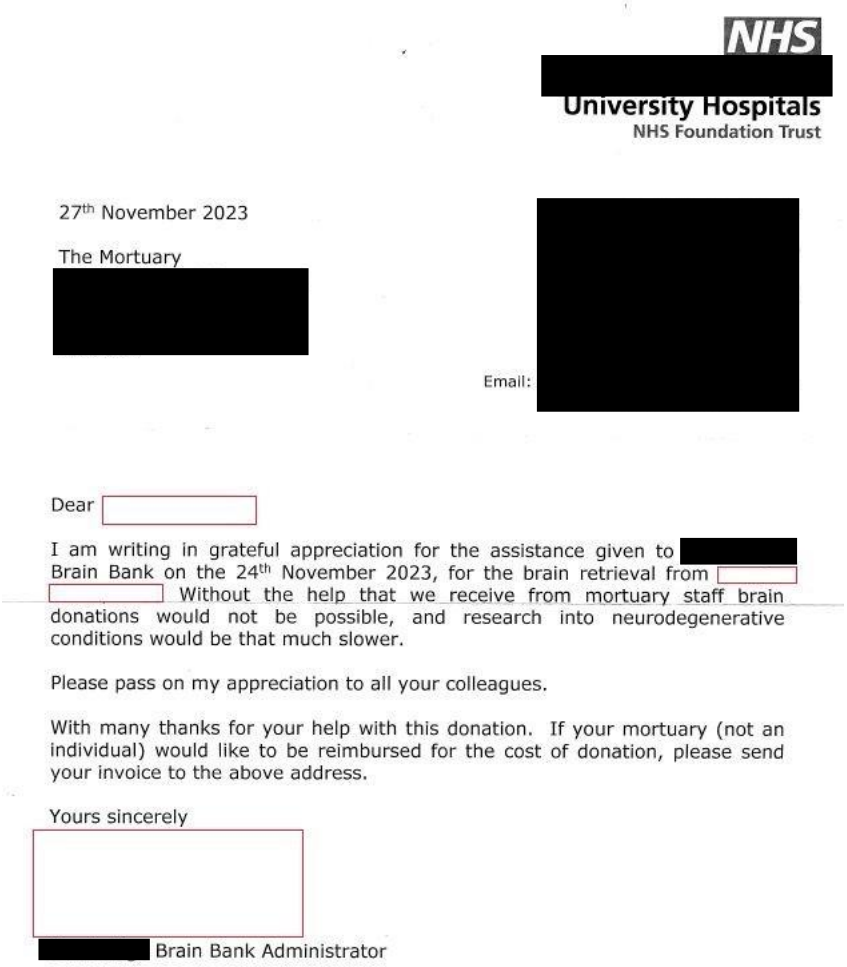
I triple knotted my string and began suturing the scalp back together and per my mortuary SOP (Standard Operating Procedures). The stitch I used is called a 'head stitch', the stitch unlike the body goes from the top of the skin and not the underneath. On entering the skin by the incision start the needle must not puncture all the way through the skin but run parallel to the incision for approximately one inch before then coming up through the skin again on exit. This is repeated on the other side and the string consistently pulled tight until the incision is fully closed by the other ear. It is important the string remains under tension as this helps to prevent leakage and maintains a natural look to the deceased, very important for loved ones in viewings.

I washed the deceased's hair with warm water and shampoo and removed the towel on their body to clean them down of any blood or tissue that may be on them. I, with the help of an APT using a PAT slide transferred the deceased onto a tray with a material sheet and plastic sheet under them. I towel dried the deceased including their hair, placed a modesty sheet over their torso and abdomen and then dressed them in a shroud. I placed a clean rolled up towel with an incontinence sheet over it under their head, this was to keep the head elevated and minimise leakage, and also to absorb any leakage should it happen and

slow natural after death changes such as congestion to the complexion of the face. I then placed them back into their fridge space.

Next, I took the samples to our clean work area and labelled them as specified on the checklist with the patient's full name, date of birth, date of death, NHS number and date and time of sample collection. They cover letter stated they wanted the brain fresh (no formalin) and with no packing materials covering it. On advice from my mentor, I saturated a towel with cold water and placed the brain on top to keep it moist until it was collected. I filled out the mortuary checklist and placed the brain in the tub and the samples into an empty fridge space ready to be collected by the courier who was bringing the packaging they required the brain to travel in. I scanned all documentation so there was a backup record, put it together in an envelope and told my seniors that it was ready to be collected.

Below is the thank you letter we received for retrieving the brain for donation



NHS
[redacted]
University Hospitals
NHS Foundation Trust

27th November 2023

The Mortuary
[redacted]

Email: [redacted]

Dear

I am writing in grateful appreciation for the assistance given to [redacted] Brain Bank on the 24th November 2023, for the brain retrieval from [redacted] Without the help that we receive from mortuary staff brain donations would not be possible, and research into neurodegenerative conditions would be that much slower.

Please pass on my appreciation to all your colleagues.

With many thanks for your help with this donation. If your mortuary (not an individual) would like to be reimbursed for the cost of donation, please send your invoice to the above address.

Yours sincerely

[redacted] Brain Bank Administrator

What went well?

I followed the instructions given by [redacted] Brain Bank entirely and successfully retrieved everything they requested by the timescale given. I ensured I maintained accurate records of what I had done and when as was requested by [redacted] Brain Bank, and I took duplicate back-up copies so I had evidence supporting what I had done if the original was to be misplaced.

What would I do differently next time?

Next time I like to see the whole process through to completion as unfortunately the courier arrived to collect when I was out of the department.

What have I learned?

I have learnt how to sample CSF confidently from my learning of anatomy and physiology and that I am able to carry out a successful brain donation unassisted.

Mentor/management comments if applicable:

[redacted] completed this brain donation in a very organised and timely manner. Her preparation for the retrieval was well thought out as she ensured everything was at hand, and successfully retrieved a large amount of CSF without contaminating it. [redacted] both confidently and competently regularly completes brain donations to a good high standard.

Candidate Signature: [redacted]	*Date:* **05.12.23**
Mentor Signature: [redacted]	*Date:* 20.01.2024

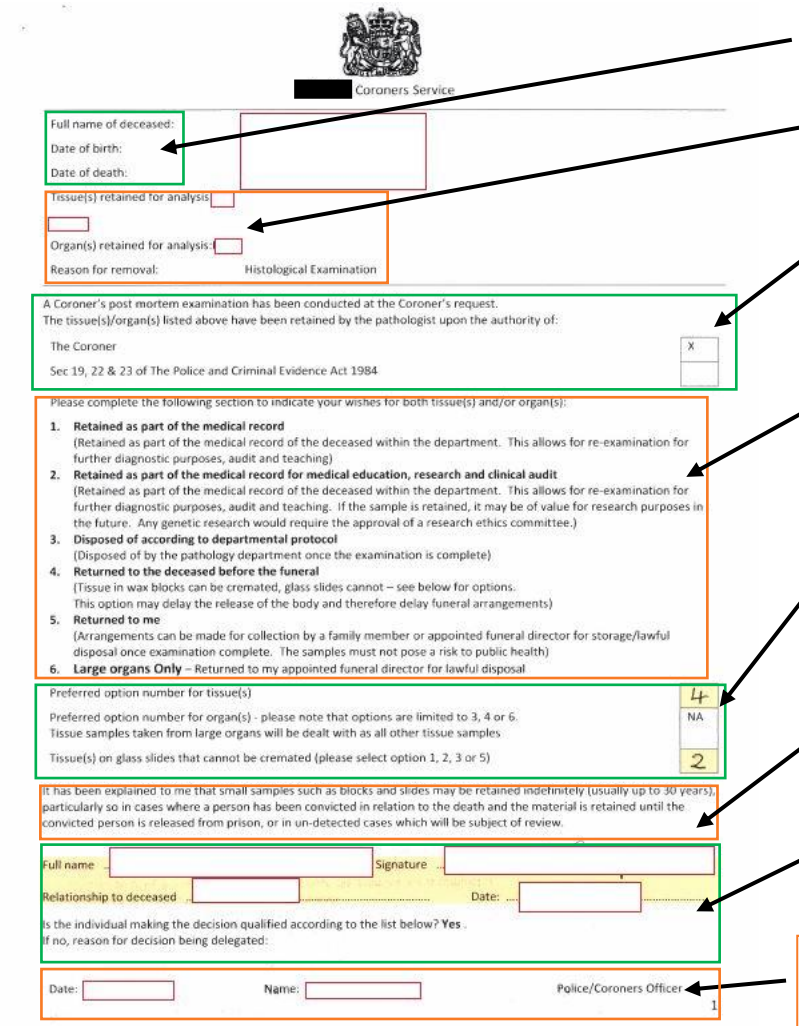
Work Based Objective Evidence

Name: [redacted]	*RSPH candidate number:* [redacted]
Unit number: **3.8**	*Evidence number:* **9**
Activity date: [redacted]	*Evidence type:* **Documents and screenshots**
Department: **Mortuary**	*Hospital:* [redacted]

Evidence Title:

Coroner Consent Form for Tissue Retention and Disposal

The evidence below is a document (anonymised) provided to us by the Coroner's office, it is provided after a deceased patient has had histology samples taken at post mortem and consent for tissue retention and/or disposal has been obtained from the person of Highest Qualifying Relationship (HQR) to the deceased. Person of HQR was formally known as Next of Kin (NOK), this was changed recently by the HTA (Human Tissue Authority). This document and the screenshots proceeding is evidence that I can maintain accurate records of tissue retained for analysis and I am able to comply with local tissue retention and disposal standard operating procedures.



[redacted] Coroners Service

Full name of deceased:
Date of birth:
Date of death:

Tissue(s) retained for analysis
Organ(s) retained for analysis:
Reason for removal: Histological Examination

A Coroner's post mortem examination has been conducted at the Coroner's request.
The tissue(s)/organ(s) listed above have been retained by the pathologist upon the authority of:

The Coroner — X
Sec 19, 22 & 23 of The Police and Criminal Evidence Act 1984

Please complete the following section to indicate your wishes for both tissue(s) and/or organ(s):

1. **Retained as part of the medical record**
(Retained as part of the medical record of the deceased within the department. This allows for re-examination for further diagnostic purposes, audit and teaching)
2. **Retained as part of the medical record for medical education, research and clinical audit**
(Retained as part of the medical record of the deceased within the department. This allows for re-examination for further diagnostic purposes, audit and teaching. If the sample is retained, it may be of value for research purposes in the future. Any genetic research would require the approval of a research ethics committee.)
3. **Disposed of according to departmental protocol**
(Disposed of by the pathology department once the examination is complete)
4. **Returned to the deceased before the funeral**
(Tissue in wax blocks can be cremated, glass slides cannot – see below for options.
This option may delay the release of the body and therefore delay funeral arrangements)
5. **Returned to me**
(Arrangements can be made for collection by a family member or appointed funeral director for storage/lawful disposal once examination complete. The samples must not pose a risk to public health)
6. **Large organs Only** – Returned to my appointed funeral director for lawful disposal

Preferred option number for tissue(s) — 4
Preferred option number for organ(s) - please note that options are limited to 3, 4 or 6. Tissue samples taken from large organs will be dealt with as all other tissue samples — NA
Tissue(s) on glass slides that cannot be cremated (please select option 1, 2, 3 or 5) — 2

It has been explained to me that small samples such as blocks and slides may be retained indefinitely (usually up to 30 years), particularly so in cases where a person has been convicted in relation to the death and the material is retained until the convicted person is released from prison, or in un-detected cases which will be subject of review.

Full name ... Signature ...
Relationship to deceased ... Date: ...
Is the individual making the decision qualified according to the list below? **Yes** .
If no, reason for decision being delegated:

Date: Name: Police/Coroners Officer

Deceased patient's full name, date of birth and date of death

Specimen details – number of tissues retained, number of organs retained, what organs were retained and reason for specimen removal

Statement of why specimens have been removed from the deceased patient and who gave the permission for this to happen

Information on the options of retention and disposal for tissue samples and whole organs for the person of HQR to consider

Specimen types broken down into three categories with the limitations of options for each written plainly next to each category – individual boxes for recording the options chosen

Statement for person of HQR - confirming they have had circumstances of prolonged sample retention explained to them

Person of HQR confirmation – name, signature, relationship to deceased and date

Name and date of coroner's officer who facilitated the completion of form

RSPH Diploma in APT – Level 3
Portfolio – Objective evidence

This document is issued to us once the Coroner's office has received the deceased patient's post mortem report from the pathologist. Detailed in the report is what histology samples were taken and how many, this also includes whole organs. This document is given to the person of HQR to the deceased by the Coroner's officer and once they have made their decisions it is passed back to the Coroners who then email a copy to us.

This document tells us what we must do with the deceased patient and the outstanding samples **before we can release the deceased from our care**. This is a HTA requirement, releasing a deceased patient without complying with the wishes of the person of HQR constitutes a HTARI (Human Tissue Authority Reportable Incident) which would subsequently need to be investigated. By following the information on the document I am complying with the local tissue retention and disposal, following this document is also written into my mortuary's departmental standard operating procedures (SOP) 'SOP MORT 031 – Post Mortem Specimen Guidelines'. Below are a series of screen shots of our SOP regarding this document and how it applies to our practices in the mortuary.

DATABASE AND CLEARANCE

The APT / Mortuary Office Assistant must promptly annotate on the Eden database the appropriate details from the Post Mortem Schedule or Paediatric Care Plan of any whole organ(s), tissue(s), microbiology sample(s) and/or toxicology which have been retained for further analysis.
With regards to microbiology and toxicology samples, there is as a rule no residual material left after the testing procedure(s), so no consent is required for the retention/disposal of these samples. If however samples larger than required are received by the toxicology lab there may be residual tissues left after examination has taken place. The lead toxicologist will contact the mortuary if residual tissue remains and consent will be sought in the usual fashion.
With regards to whole organs/tissue samples, a signed HTA consent form is raised by the Coroner or her officers, and the wishes of the person of highest qualifying relationship or nominated representative to the deceased with regards to the samples **MUST** be completed before the deceased patient can be released to the Funeral Directors.

[redacted] CELLULAR PATHOLOGY NETWORK
Post Mortem Specimens Guidelines
[redacted]

HTA CONSENT (CORONERS CASES)
Once the pathologist has informed the Coroner/Coroners Officer that samples have been taken from the deceased patient, the designated person of highest qualifying relationship or nominated representative to the deceased will be informed that tissue(s) and/or organ(s) have been retained for further analysis to ascertain the cause of death.
After the tissues/organs have been used to fulfil their scheduled purpose, the person of highest qualifying relationship or nominated representative to the deceased have the following choices for when organ(s) or tissue(s) are retained:

Tissue
- Retain as part of the medical record
- Retain as part of the medical record and use of tissues in research
- Disposed of according to departmental protocol
- Returned to the deceased patient before the funeral
- To be returned to them

Whole Organs
Organs cannot be stored as part of the medical record in the same way that blocks and slides can be, therefore the options for the person of highest qualifying relationship or nominated representative to the deceased are:
- The organ(s) to be disposed of
- To be returned to the deceased patient before the funeral

The Coroner's Office will usually sign the HTA consent form on the person of highest qualifying relationship or nominated representative to the deceased behalf to avoid potential delay in the release of the deceased patient, and a signed copy from the person of highest qualifying relationship or nominated representative to the deceased will follow within 2-3 days
Once a fully completed, signed consent form is received, the NOD form should be annotated in green with the HTA consent wishes and the HTA consent form stored with the NOD form (please see MORT SOP 068 for further information). Then 1 of the 2 following options is followed, depending on the person of highest qualifying relationship or nominated representative to the deceased wishes:

1. If HTA consent chooses retention (both options), disposal, or return of tissues to the family at a later date, or disposal of organs:
- The Eden database will be updated with the HTA consent option. The above options will not restrict release of the deceased patient.
- The pathologist pertaining to the case will also be sent a copy of the HTA consent form to inform them of the person of highest qualifying relationship or nominated representative to the deceased choice, and the instructions for what is to be done with the tissues/organs at the Cotman Centre.

[redacted] CELLULAR PATHOLOGY NETWORK
Post Mortem Specimens Guidelines
[redacted]

- Once the Coroner's office has sent clearance, the deceased patient may then be released in the usual fashion to the Funeral Directors.

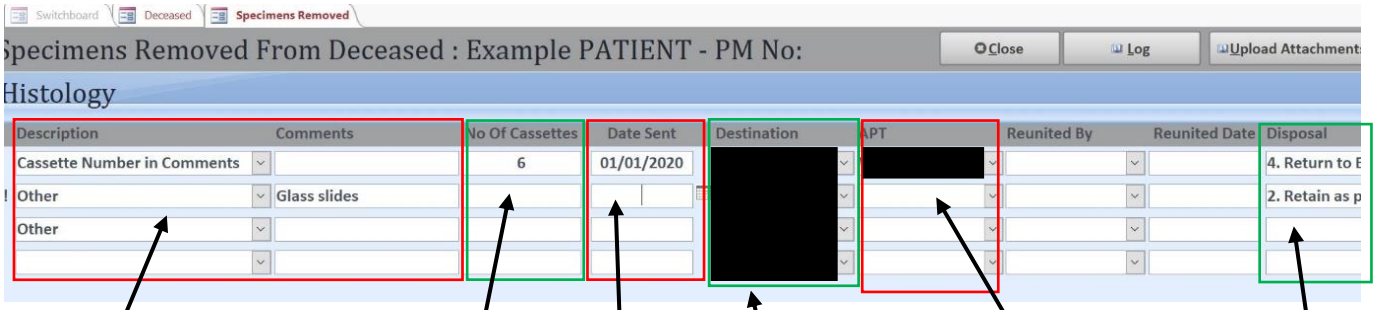
Should person of highest qualifying relationship or nominated representative to the deceased choose for the samples to be returned to them at a later date (applies to tissue samples only), they will be informed they must collect them within 28 days of when the samples are receipted back into the Mortuary. They may appoint their Funeral Director to collect them on their behalf; they may collect the tissues themselves (please note they must read and sign the form found under O:\Mortuary\Administration Documentation (HTA Return To Me - Information Sheet)); or they may have them sent to them as long as they cover the cost of postage.
The Histopathology Department has the responsibility for the sensitive clinical disposal of the aforementioned tissues/organs etc. according to the Coroner's or the person of highest qualifying relationship or nominated representative to the deceased wishes, in accordance with the rules and regulations created by the Human Tissue Act/Authority 2004.

2. If HTA consent requires that the tissues/organs are to be returned to the deceased patient:
- The Eden database will be updated with this HTA consent option as well. The pathologist pertaining to the case will also be sent a copy of the HTA consent form to inform them that the tissues/organs will need to be processed and sent back to the Mortuary in good time so as not to delay the funeral unnecessarily.
- Once the tissues/organs have been returned to the Mortuary, TWO APTs must ensure they are returned to the correct deceased patient, the form accompanying the samples should be checked, against the number of samples returned by means of counting and the assigned PM numbers should be checked to correspond. Once both APTs are happy that they match, the form can be annotated and signed by the relevant APTs. The NOD form and relevant paperwork should also be checked and the database updated The NOD form should then be annotated with the name of the APT and date the samples were returned.
- The form accompanying the samples should be scanned onto Eden under the relevant patient and then sent back to the Cotman centre
- Once the Coroner's Office has sent clearance, the deceased patient may then be released in the usual fashion to the Funeral Directors. **Note the electronic database will not allow a clearance to be entered unless it has been ticked that the samples have been returned.**

The GREEN tag should remain on the deceased patient to remind APT staff to check the HTA consent option upon release. This ensures the deceased patient is not released to the Funeral Directors before the retention/disposal wishes on the HTA consent form have been adhered to.

Within the Coroner's document I have anonymised all patient, coroner and person of HQR detail's, but have left the numbers of the decisions they made. The document shows that for all tissues taken (but not those on glass slides) they chose option four – **returned to the deceased before the funeral**. The option for whole organs is – **N/A**, this is due to no whole organs being taken from the deceased patient at post mortem. Lastly, the option chosen for tissues on glass slides was two – **retained as part of the medical record for medical education, research and clinical audit**. This information tells me that I cannot release the deceased patient until all tissue blocks have been returned and placed with the patient, apart from glass slides which will be kept.

When this document is received I update the patient's records on our electronic database EDEN as per our SOP. See below an example of how I would update the information, this screenshot is evidence that I maintain accurate records of tissue retained for analysis.



Description of specimen taken and additional comments

Number of the specimen type taken

Date the specimen was sent/left the mortuary

Destination specimen was sent to

APT that potted the specimen sample

Disposal – information taken from the Coroner consent form for tissue retention and disposal that the person of HQR has signed

I would also transcribe the information from the coroner consent form onto the patient's NOD form (Notification of Death) so the information is in a third location and the APTs releasing the patient have a further reminder to check the tissue retention and disposal requirements before releasing the patient.

Candidate Signature: [redacted]	*Date:* **13.12.23**
Mentor Signature: [redacted]	*Date: 20.01.2024*

Candidate Number: [redacted]

Candidate Assessment Summary Form

Level 3 Diploma in Anatomical Pathology Technology

Unit APT3.9 Viewing of the deceased

Learning Outcome/Assessment Criteria	Evidence for Achievement[1]	Assessor Decision[2]
Be able to prepare a deceased person for viewing		
Confirm the identity of the deceased person for viewing	**Evidence 3 – Witness Statement** **Evidence 4 – Reflective Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 7 – Objective Evidence** **Evidence 8 – Objective Evidence**	
Check that there are no restrictions on the viewing of the body by relatives, friends and carers, to include restrictions due to disfigurement and risk of infection	**Evidence 4 – Reflective Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement**	
Follow standard operating procedures in preparing the deceased for viewing	**Evidence 4 – Reflective Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 7 – Objective Evidence** **Evidence 9 – Objective Evidence**	
Take account of any religious and/or cultural requirements when preparing the deceased for	**Evidence 4 – Reflective Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement**	

1. Use this column to signpost the relevant evidence in the portfolio.
2. The assessor should tick this box if he/she believes the assessment criterion / learning outcome has been met.

viewing	**Evidence 9 – Objective Evidence**	
Take appropriate protective measures when preparing the deceased for viewing	**Evidence 3 – Witness Statement** **Evidence 4 – Reflective Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement**	
Be able to provide support to relatives, friends and carers when viewing the deceased		
Confirm the identity of relatives, friends and carers prior to allowing the viewing to take place	**Evidence 3 – Witness Statement** **Evidence 4 – Reflective Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 8 – Objective Evidence**	
Communicate appropriate information in a sensitive manner	**Evidence 1 – Witness Statement** **Evidence 2 – Witness Statement** **Evidence 3 – Witness Statement** **Evidence 4 – Reflective Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 8 – Objective Evidence**	
Follow standard operating procedures when conducting the viewing of the deceased	**Evidence 4 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 7 – Objective Evidence** **Evidence 9 – Objective Evidence**	
Advise relatives, friends and carers appropriately with regard to after death procedures	**Evidence 3 – Witness Statement** **Evidence 4 – Reflective Statement**	

1. Use this column to signpost the relevant evidence in the portfolio.
2. The assessor should tick this box if he/she believes the assessment criterion / learning outcome has been met.

Candidate Number: [redacted]

	Evidence 6 – Reflective Statement **Evidence 7 – Objective Evidence** **Evidence 10 – Objective Evidence**	
Refer relatives, friends and carers to additional sources of support and guidance as required	**Evidence 3 – Witness Statement** **Evidence 4 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 7 – Objective Evidence** **Evidence 10 – Objective Evidence**	
Understand why rigorous procedures have been developed for viewing of the deceased		
Explain why it is important to check the identity of the deceased, relatives, friends and carers prior to the viewing of a body	**Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 8 – Objective Evidence**	
Outline why it is important to take account of any religious or cultural considerations when preparing a body for viewing	**Evidence 3 – Witness Statement** **Evidence 4 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 9 – Objective Evidence**	
Explain the rationale of any protective measures taken during the preparation of a body for viewing	**Evidence 6 – Reflective Statement**	

Award of unit / qualification recommended:

1. Use this column to signpost the relevant evidence in the portfolio.
2. The assessor should tick this box if he/she believes the assessment criterion / learning outcome has been met.

Candidate Number: [redacted]

	YES / NO	Name	Signature	Date
Assessor				
Internal Verifier				

1. Use this column to signpost the relevant evidence in the portfolio.
2. The assessor should tick this box if he/she believes the assessment criterion / learning outcome has been met.

Personal Reflective Learning Statement

Name: [redacted]	*RSPH candidate number:* [redacted]
Unit number: **3.9**	*Evidence number:* **5**
Activity date: [redacted]	*Evidence type:* **Full Reflection**

Activity Title/ Description you are reflecting on:

Setting up a viewing with numerous property additions

What I did:

First viewing

I checked the mortuary diary and Eden (electronic data base) to confirm the date and time of the viewing. I then matched the name and retrieved the patient's NOD (notification of death) form from the mortuary office. I checked if there were any restrictions over the viewing and for any religious or cultural requirements and then if there were any infectious hazards/risks I should be aware of before setting up the patient. There were no restrictions or requirements that I needed to enact to accommodate this viewing.

I donned the required standard PPE (personal protective equipment) for handling a deceased patient: nitril gloves, disposable apron and theatre mask, and then retrieved the patient from their fridge space as per their NOD form. Before transferring them to the viewing suit I checked their wrist ID band against their NOD form for three points of ID, this was to ensure I had the correct patient in case we had another with the same name. When I was satisfied this was the correct patient, I moved them to the suit. This viewing was a straightforward set up following the departmental SOP (standard operating procedures), the patient was presented on the viewing bier with the duvet and pillow and the overhead lighting dimmed down to a soft low level.

We received a call from the West Atrium reception to inform us that the family had arrived for the appointment and had been placed in our Pod area. I went to speak to the family and took our visitor viewing form with me for the family to sign when they had provided identification that matches the information we had. It is important I checked with the family who they were expecting to view before we went to the mortuary as this allowed another check to ensure we had the correct patient set up for viewing/ or had the correct family in cases of multiple viewing on the same day.

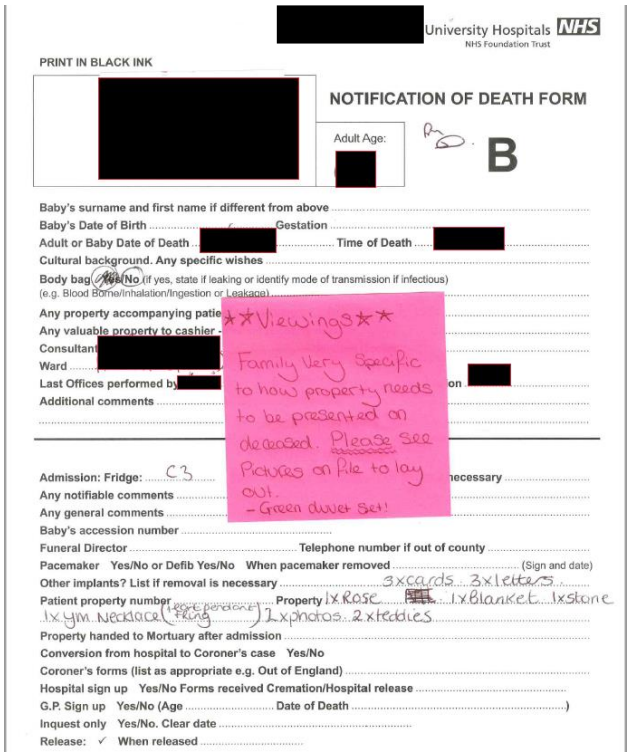
While in the Pod the family had many questions and had received mixed information from different agencies within the hospital, so they were unsure of the process ahead and were not aware that their loved one was being kept in the mortuary and believed they were going to our Chaplaincy. I listened to all their concerns and sensitively answered their questions and corrected any misconceptions they had.

I walked them down to our mortuary and lead them into our private seating area, where I explained how their loved one was presented and how to use the call bell to call for me.

They requested if they could add some property to be kept with their loved one to which I agreed. During the viewing they called me back through and requested I retrieve three specifically coloured flowers from chaplaincy as they had be told they could have these. I said I needed to make some calls and look into this. Chaplaincy confirmed that they do not offer this service but were able to source a single flower on this one occasion.

Once the viewing had come to a close, they disclosed that their loved one may be with us for a while, and they would like to book multiple viewings. I advised that due to the time of year (December) multiple viewing would be dependent on availability, we booked one for the following week. The family said they were very insistent the property was to be left in the exact position that they had put it in for their next viewing, I wanted to oblige but to manage their expectations I explained that when their loved one was moved back into temperature controlled storage the items where likely to move so I would do my very best to log the property and its position, I then saw the family out. On our way back to the West Atrium we met the Chaplin who had a red rose that was for the family's loved one as promised. The family directed the Chaplin exactly where to place the flower when we returned to the mortuary.

With the families wishes regarding property, I diligently logged what they had added to the patients NOD form and Eden and decided to respectfully take pictures of the positions and upload them to the deceased Eden as there was more than I had thought and if another colleague was to facilitate the next viewing, they needed to be sure on what items went where. I have included below a picture of the NOD form with the added property and the two photos that would aid the next viewing set up.



[redacted] University Hospitals NHS
NHS Foundation Trust

PRINT IN BLACK INK

[redacted]

NOTIFICATION OF DEATH FORM

Adult Age: [redacted]

B

Baby's surname and first name if different from above
Baby's Date of Birth ..... Gestation .....
Adult or Baby Date of Death [redacted] Time of Death [redacted]
Cultural background. Any specific wishes .....
Body bag Yes/No (if yes, state if leaking or identify mode of transmission if infectious)
(e.g. Blood Borne/Inhalation/Ingestion or Leakage) .....
Any property accompanying patie
Any valuable property to cashier
Consultant [redacted]
Ward .....
Last Offices performed by [redacted] on [redacted]
Additional comments .....

Viewings
Family Very Specific to how property needs to be presented on deceased. Please see Pictures on file to lay out.
- Green duvet set!

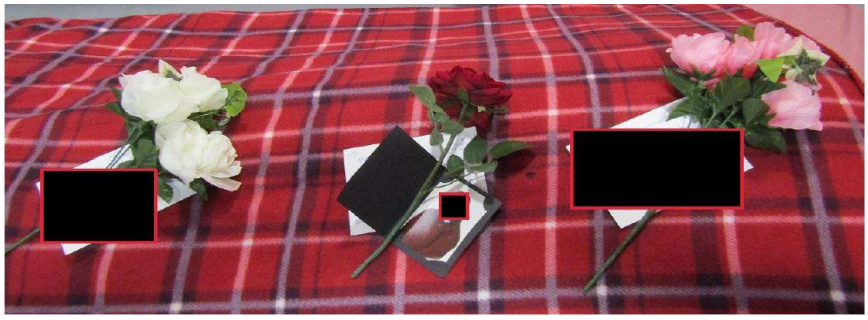
Admission: Fridge: C3 ..... necessary .....
Any notifiable comments .....
Any general comments .....
Baby's accession number .....
Funeral Director ..... Telephone number if out of county .....
Pacemaker Yes/No or Defib Yes/No When pacemaker removed ..... (Sign and date)
Other implants? List if removal is necessary 3xcards 3xletters
Patient property number ..... Property 1xRose [redacted] 1xBlanket 1xstone
1xgm Necklace (1xpearl bracelet) 1xRing 2xphotos 2xteddies
Property handed to Mortuary after admission .....
Conversion from hospital to Coroner's case Yes/No
Coroner's forms (list as appropriate e.g. Out of England) .....
Hospital sign up Yes/No Forms received Cremation/Hospital release .....
G.P. Sign up Yes/No (Age ..... Date of Death .....)
Inquest only Yes/No. Clear date .....
Release: ✓ When released .....

Second viewing

I volunteered to set up and conduct the second viewing to help maintain consistency. I repeated as the first time with retrieving the patient and checking their ID with their NOD form. I ensured I started this set up earlier than usual as I knew there was a lot of property to place. I copied the pictures from the first viewing exactly and was satisfied that the family's wishes had been met.

The family arrived 40 minutes early and had brought additional property they wanted to add to their loved one. I again asked them to sign the visitor viewing sheet and checked their ID before leading them to our viewing suit and allowing them to view their loved one. When closing the viewing they questioned why the duvet was different as their items would have had to been moved. I carefully explained that their loved one did not stay in the viewing suit and delicately why the duvet could not go into the temperature-controlled storage with them. They accepted this but expressed their displeasure that the property was not in the correct place. I apologised for this and stated we had made diligent notes about placement, but that I was sorry something had gone wrong. I then saw the family out.

On breaking down the viewing set up I made additional notes to the added property. I transcribed these onto the patient's NOD form and Eden and respectfully, took additional pictures to include the new items and the new positions of the original items. I was saddened that despite my best efforts the family felt I had set up the items incorrectly. I made sure to check the photos I had previously taken to see what was wrong, but these photos served as evidence that I had followed them exactly and that the family had misremembered the placement and therefore there was not anything more I could have done. Below I have included the last photo I took after the second viewing with additional property in case a third was arranged.



What did I do well?

I listened to the family's wishes and completed them to the best of my ability by going beyond noting down property but by taking photos and writing additional notes for my colleagues if they needed it and liaising multiple times with chaplaincy to arrange the flower and communication mix ups. I also ensured that I volunteered to conduct the second viewing so I could take charge of the setting up of the property as per the family's request.

What would I do differently next time?

After speaking with my mentor and arranging a second viewing, I should have said to the family that at this time of year especially (December) we can only facilitate one viewing per patient and that if they wish to view their loved one further this can be arranged at their chosen funeral directors.

What have I learned?

I have learnt how to manage a complicated viewing arrangement and how to better communicate with my team as I made time to speak to them about the complexity of the set up and why it was important it was done in case they were to conduct a further viewing.

Mentor/management comments if applicable:

I have observed [redacted] conducting many viewings and her kindness, knowledge and ability to empathise professionally make her an excellent APT. [redacted] attention to detail in this case was exceptional and she ensured the patient was presented in the same way continuously throughout each viewing. She showed great leadership skills and took on the responsibility for preparing and viewing this patient each time and the family appreciated her help.

[redacted] has gained a lot of experience with preparing patients of a variety of different cultures and religions during her training. She has referred to the departments religion and culture file many of times to double check any requirements and now has the confidence and knowledge to adapt viewings accordingly.

Candidate Signature: [redacted]	*Date:* **23.11.2023**
Mentor Signature: [redacted]	*Date:* **30.11.2023**

Work Based Objective Evidence

Name: [redacted]	*RSPH candidate number:* [redacted]
Unit number: **3.9**	*Evidence number:* **7**
Activity date: [redacted]	*Evidence type:* **SOP and photographs**
Department: **Mortuary**	*Hospital:* [redacted]
Evidence Title: **Setting up a baby viewing**	

The evidence I am presenting are a series of photos of a baby viewing set up and ready for the parents. This demonstrates I am able to prepare a deceased for viewing in accordance to our Standard Operating Procedures.

Standard Operating Procedures (SOP) for viewing procedures

SOP 'Viewing Procedures' Front sheet and relevant pages from in the SOP for the setting up of a neonate viewing which in the pictures below it is seen I followed

[redacted]

Viewing Procedures

DEPT. SOP NO.: SOP-MORT-005 (CP-SHLT.1001b) | EDITION: 14
AUTHORISED BY: [redacted]
AUTHOR: [redacted] | DATE OF ISSUE: 20/03/2023

Mortuary Non Examination Procedure

Viewing Procedures

DATE OF ISSUE	20/03/2023
EDITION No	14
REVIEW INTERVAL	Biennial
AUTHORISED BY	[redacted]
AUTHOR	[redacted]
RELATED STANDARDS	CPA Standard A2.4c, ISO 15189:2012 Standard 4.1.2.2
COPY	1 Of 3
LOCATION OF COPIES	1. Master Copy on Q Pulse 2. Mortuary Office 3. Pathology Shared Drive

Groups of staff to be aware of and responsible to perform this procedure
(Italics equals Partial Group)

CLINICAL DIRECTOR	MORTUARY MANAGER & DEPUTY
SERVICE MANAGER	MORTUARY SENIORS & APT
HISTO/CYTO MANAGER	TRAINEE APT (UNDER SUPERVISION)
HTA DESIGNATED INDIVIDUALS	MORTUARY ASSISTANT (UNDER SUPERVISION)
ALL MEDICAL STAFF	
CLINICAL DIRECTOR	

DOCUMENT REVIEW HISTORY

REVIEW DATE	REVIEWED BY	SIGNATURE
07/12/2015	[redacted]	[redacted]
15/03/2018		
30/10/2018		
28/06/2020		
01/03/2021		
09/06/2022		
20/03/2023		
18/10/2023		

[redacted]

Viewing Procedures

DEPT. SOP NO.: SOP-MORT-005 (CP-SHLT.1001b) | EDITION: 14
AUTHORISED BY: [redacted]
AUTHOR: [redacted] | DATE OF ISSUE: 20/03/2023

GUIDELINES FOR SET UP OF THE VIEWING ROOM

- Raise or lower the lighting levels to an appropriate setting as required. It is advisable to lower the main overhead lights to their lowest setting (press and hold the wall switch to achieve this) and adjust the uplighter set to the appropriate level.
- Pull the net curtains across the closed double doors leading to the fridge room.
- Check that the viewing suite and waiting areas are clean, tidy and smell fresh as well as featuring an adequate supply of tissues etc.
- Before the APT leaves the department to collect the family and conduct the viewing; the 'Viewing' signs should be placed in their appropriate places so that they may be seen by all users of the Mortuary. These locations are above the hearse bay call bell, above the double doors between the access corridor and fridge room, above the double doors leading to the fridge room, and above the door in the corridor leading to the fridge room from the office.

PREPARATION GUIDELINES FOR NEONATAL VIEWING
Following is the procedure for the correct presentation of the deceased neonate so that any stress associated with family members attending may be kept to a minimum.

GUIDELINES FOR THE PRESENTATION OF THE DECEASED NEONATE
Families viewing their deceased neonate in the viewing suite will have certain expectations. These will be that

- They look peaceful
- They are clean and tidy
- Their eyes and mouth are closed
- They may wish for them to be dressed in clothes provided
- They may have property that the family wish to see or take away
- They may wish for extra photographs or locks of hair to take away

Families may also have expectations that cannot be achieved or maintained, these requests will require careful and tactful information to be given to them by the attending APT. Some of these expectations may be as follows-

- **The deceased neonate should be 'warm'** (some time at room temperature prior to the viewing taking place may assist in 'warming' the deceased neonate). However, be mindful that repeated room temperature warming and subsequent refrigerated cooling will in almost every circumstance create advanced and/or accelerated decomposition.
- **The deceased neonate should not 'look' dead** (often they may have been deceased 'in utero' for some time prior to delivery, tactful description of events should be given, common sense prevails)
- **They don't want to see incision marks-cuts-stitches** (clothing and adhesive dressings can be used to hide such marks, but as families often wish to hold the

DEPARTMENT OF CELLULAR PATHOLOGY
Page 9 of 14

Guidelines for set up of the viewing room:

- Raise or lower the lighting levels to an appropriate level
- Pull the net curtains across the **closed** double doors
- The viewing suite and waiting area are clean, tidy and smell fresh and have tissues
- 'Viewing' signs in appropriate places

Specific expectations for presentation of deceased neonate:

- Peaceful
- Clean and tidy
- Eyes and mouth closed
- Dressed in specific clothes
- Property with them for family to see
- Extra photos and keepsake opportunities

Exceptional family expectations for the deceased neonate that are unattainable to meet but need to be considered when setting up a neonatal viewing:

- They should be warm
- They should not look 'dead'
- The family do not want to see incision marks-cuts-stitches

[redacted]

Viewing Procedures

DEPT. SOP NO.: SOP MORT 035 (CP.SH.T.1001b)	EDITION: 14
AUTHO[redacted]	
AUTHO[redacted]	DATE OF ISSUE: 20/03/2023

deceased neonate, if they look hard enough or attempt to undress the deceased, they may see marks associated with any invasive examination. Again tactful explanation of the examination procedure or the realistic achievement of the above expectations should be given, omitting any information that may be deemed 'too sensitive', see senior APT for advice).

Common sense is of more use than procedural advice in many cases of deceased neonate viewings, and as with many aspects of Mortuary related work, the technique will improve with practice and the support of experienced colleagues. APTs presenting a deceased neonate for viewing should take into account all of the same checks for those relating to adult viewings. These checks are –

- The deceased neonate should be identified by means of thorough checks of the identification tags being checked against the NOD form.
- Packing materials must not be visible to the observer
- Eyes must be closed using an approved closure method (small pieces of cotton wool placed under the eyelid should be sufficient)
- Mouth must be closed using an approved closure method. Kalip should be sufficient
- The body must be washed clean and dried after any invasive procedures
- Incisions and/or sutures must be covered to prevent cross contamination – a plaster or other adhesive dressing is useful for this
- Clothing must be clean and appropriately sized
- The deceased neonate should be wrapped in a blanket and presented in a natural and peaceful manner in a Moses basket or other suitable alternative.

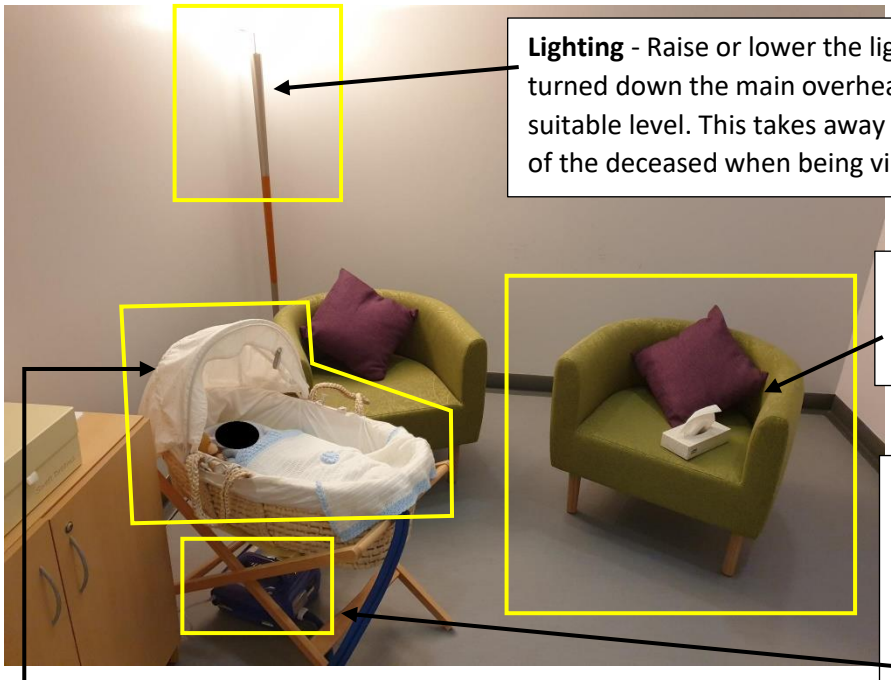
GUIDELINES FOR SET UP OF THE VIEWING ROOM
Due to its size, the viewing bier is not always suitable for the presentation of a deceased neonate or some paediatric viewings. Therefore, it is considered best practice to use the waiting room to conduct the viewing. Use your judgement if you feel the viewing suite would be suitable or not.

Checks for presenting and setting up a deceased adult and/or neonate:

- Thorough checks of identification tags against the patient's NOD form
- Packing materials must not be visible
- Eyes to be closed
- Mouth to be closed
- Body is washed and dried after PM procedures
- Incisions/sutures must be covered
- Clothing to be clean and appropriate
- Specifically for a neonate, they should be wrapped in a blanket and presented in a natural and peaceful way either in a Moses basket or other suitable alternative

The use of the viewing room is up to the APT's discretion when setting up a neonate viewing, ordinarily the waiting room is best suited for an imitate setting. Below my photo evidence shows that due to the use of a cuddle cot the viewing room was most suitable as more space was needed, this was also the case because the cuddle cot requires electricity to operate and our waiting room does not have plug sockets.

Below - Neonate viewing set up in viewing suite



Lighting - Raise or lower the lighting levels to an appropriate level, I turned down the main overhead lighting and turned the side lamp to a suitable level. This takes away the harsher light and soften the features of the deceased when being viewed

The viewing suite and waiting area are clean, tidy and smell fresh and have tissues

Cuddle cot refrigeration system, tucked carefully under the Moses basket. Those viewing were made aware of the system under the basket, why it was there and the noise it makes

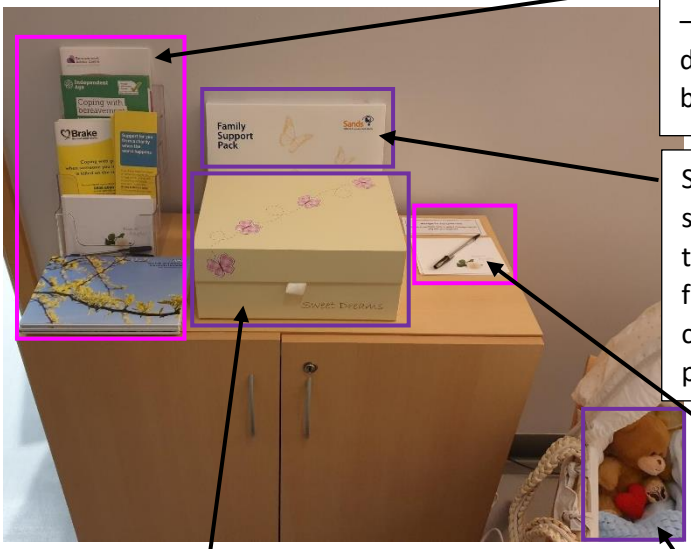
RSPH Diploma in APT Level 3
Portfolio – Objective Evidence

The set-up of the deceased neonate:

- Wrapped in a blanket
- In Moses basket or other suitable alternative
- Peaceful
- Clean and tidy
- Eyes and mouth closed
- Dressed in specific clothes
- Property with them for family to see
- Extra photos and keepsake opportunities

For patient privacy and confidentiality I have covered the face of the neonate, if the face was visible it would be seen that they were clean, eyes and mouth closed and incision marks/cuts were tactfully covered and property the neonate came to us with was placed with them. Photos below show clearer evidence of personal property with the patient.

Bereavement literature next to the neonate



Bereavement literature, generalised literature non-specific to neonatal loss: Bereavement advice guide – coping with bereavement, Brake – coping with a death on the road, Samaritans and our hospital bereavement booklet pack

Sands 'Family Support Pack' – I placed this out specifically as this contains information provided by the charity SANDS (Stillbirth and Neonatal Death) for families going through the process. In most cases this pack is given out on the ward but we provide a pack in case they need another

Card and pen left out for those viewing to write messages that can be left with the deceased and stay with them

The yellow box I placed on the cabinet is a SANDS initiative that we keep in stock. It is a memory box containing items such as to take hair locks, plaster casts of hand and foot prints, keepsakes for both neonate and family, teddy bears, books etc. By placing this box out for the family to take and use it helps provide the unattainable expectations they may have from earlier

Personal property of the neonates – I placed these on prominent display next to the neonate so the family could be sure these had not been lost or misplaced and were kept with the neonate as per their wishes – this is an important part of our SOP for both adult and neonatal deceased patients

Waiting room before those viewing enter the viewing suite

Our viewing suite, we are still in the process of refurbishment and so currently the suite is unfinished and lacking in artwork and updated finishing's such as thick curtain for sound proofing and cushions

The net curtain we currently have to obscure the double doors from sight and look more homely like drawn window curtains

Waiting room is kept clean, tidy with a supply of tissues on hand

---

Literature and side area of the waiting room

Additional literature, the same as those in the viewing suite with a few additions such as Nelson's Journey and Macmillan

Disposable medical grade masks, since Covid some people still prefer to wear masks in enclosed spaces. We also provide masks if the deceased patient has a respiratory infection, although we will not disclose the infection we can let the viewers know that there is an inhalation infection present and there are masks available if they wish to wear them

Fish tank provided for distraction and comfort for a home like and non-clinical feeling to the viewing

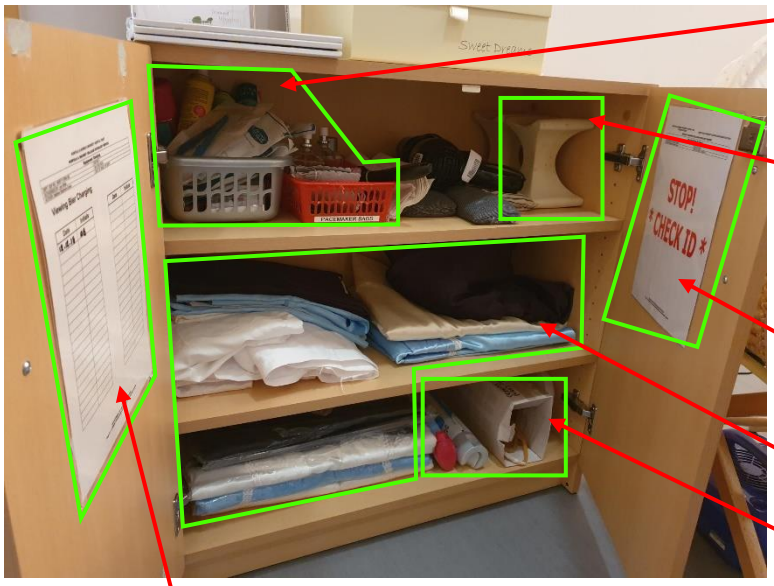
---

Additional facilities provided in the waiting area

Drinking facilities and toilet area provided that is separate and private from the rest of the hospital and the mortuary for the privacy and dignity of the relatives viewing their deceased

RSPH Diploma in APT Level 3
Portfolio – Objective Evidence

Reconstruction and viewing equipment kept in our viewing suite



Reconstruction and presentation tools: Hairbrush, disposable forceps, dry shampoo, cotton wool and perfumes

Head blocks for raising head to aid in closing the mouth with no invasive procedures

Notice – to remind the APT to check the patients ID before continuing

Silk shrouds – laid over the adult deceased patient and under the duvet

Air fresheners and neck brace (to aid in holding the mouth closed)

Viewing bier charging log – used for keeping track of last charge and units needing charging

---

Viewing signs as described in the SOP

Viewing room signs that let funeral directors, colleagues and other visitors to the mortuary know that there is a viewing being held and they need to be quiet

Candidate Signature: [redacted]	*Date:* **07.01.24**
Mentor Signature [redacted]	*Date:* **09.01.2024**

Candidate Number: [redacted]

Candidate Assessment Summary Form

Level 3 Diploma in Anatomical Pathology Technology

Unit APT3.10 Team working

Learning Outcome/Assessment Criteria	Evidence for Achievement[1]	Assessor Decision[2]
Be able to participate in planning the work of a team		
Describe the roles and contributions of team members to the work of the team	**Evidence 1 – Witness Statement** **Evidence 6 – Reflective Statement** **Evidence 7 – Reflective Statement**	
Identify the aims and objectives of the team	**Evidence 1 – Witness Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 7 – Reflective Statement**	
Plan activities with the team in order to meet the aims and objectives	**Evidence 1 – Witness Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 7 – Reflective Statement**	
Agree timescales for completion of activities	**Evidence 1 – Witness Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 7 – Reflective Statement**	

1. Use this column to signpost the relevant evidence in the portfolio.
2. The assessor should tick this box if he/she believes the assessment criterion / learning outcome has been met.

Candidate Number: [redacted]

Be able to carry out own role as part of a team		
Organise own work in order to meet agreed aims and objectives on time	**Evidence 1 – Witness Statement** **Evidence 2 – Witness Statement** **Evidence 3 – Witness Statement** **Evidence 4 – Witness Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 7 – Reflective Statement** **Evidence 8 – Objective Evidence** **Evidence 9 – Objective Evidence** **Evidence 10 – Objective Evidence**	
Monitor own progress towards meeting aims and objectives	**Evidence 1 – Witness Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 8 – Objective Evidence** **Evidence 9 – Objective Evidence** **Evidence 10 – Objective Evidence** **Evidence 11 – Objective Evidence**	
Take appropriate action if aims and objectives are unlikely to be met within agreed timescales	**Evidence 1 – Witness Statement** **Evidence 2 – Witness Statement** **Evidence 4 – Witness Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 8 – Objective Evidence**	
Evaluate own contribution to the work of the team	**Evidence 1 – Witness Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement**	

1. Use this column to signpost the relevant evidence in the portfolio.
2. The assessor should tick this box if he/she believes the assessment criterion / learning outcome has been met.

	Evidence 7 – Reflective Statement **Evidence 8 – Objective Evidence**	
Be able to communicate effectively with other team members		
Clarify own role and the role of others in meeting the team's aims and objectives	**Evidence 1 – Witness Statement** **Evidence 7 – Reflective Statement**	
Inform other team members of own progress towards aims and objectives	**Evidence 1 – Witness Statement** **Evidence 2 – Witness Statement** **Evidence 5 – Reflective Statement** **Evidence 6 – Reflective Statement** **Evidence 11 – Objective Evidence**	
Give advice to team members if requested to enable them to meet their aims and objectives	**Evidence 1 – Witness Statement** **Evidence 7 – Reflective Statement** **Evidence 10 – Objective Evidence** **Evidence 11 – Objective Evidence**	
Understand the importance of team work and communication		
Explain why team work is important in an organisation	**Evidence 1 – Witness Statement** **Evidence 7 – Reflective Statement** **Evidence 10 – Objective Evidence**	
Explain how effective communication aids the work of a team Explain how effective communication aids the	**Evidence 1 – Witness Statement** **Evidence 5 – Reflective Statement**	

1. Use this column to signpost the relevant evidence in the portfolio.
2. The assessor should tick this box if he/she believes the assessment criterion / learning outcome has been met.

Candidate Number: [redacted]

work of a team	**Evidence 6 – Reflective Statement** **Evidence 10 – Objective Evidence**	

Award of unit / qualification recommended:

	YES / NO	Name	Signature	Date
Assessor				
Internal Verifier				

1. Use this column to signpost the relevant evidence in the portfolio.
2. The assessor should tick this box if he/she believes the assessment criterion / learning outcome has been met.

Personal Reflective Learning Statement

Name: [redacted]	*RSPH candidate number:* [redacted]
Unit number: **3.10**	*Evidence number:* **7**
Activity date: [redacted]	*Evidence type:* **Full Reflection**

Activity Title/ Description you are reflecting on:

Organising and taking handprint keepsakes from an adult patient

What I did:

The family of a deceased patient called the mortuary and requested we take handprints and eleven locks of hair from their loved one for them to collect by the end of the day. Before starting, I retrieved the patient's NOD (Notification of Death) form from our mortuary office, I checked if there were any infection risks I needed to be aware of before proceeding; there were not. I donned the correct PPE (Personal Protective Equipment): disposable apron and nitril gloves, I located the patient's fridge space from the NOD form and proceeded to remove the patient on their tray from the fridge using a TST trolley. Once the patient was at a safe working height I checked their ID wrist band for three points of ID that correlated with their NOD form, when I was happy that this was the correct patient I drove the trolley out of the main fridge room into a more private area that also afforded more space for me to work with.

I asked two members of staff (an APT and Mortuary Porter) to assist me with the task as I was mindful of the short time constraint I had to complete the task. Before starting the task I spoke to both team members about how I had planned to take the hand prints and hair locks and how I would require their help, I said that I wanted the prints to be as clear as possible and so we may be taking a few and that also the hair locks needed to be clean and presented well. We then had a short discussion about dividing the tasks and who should do what as we were mindful that not only did we need to get handprints, but they needed to try in time for collection.

I retrieved the following items to take the keepsakes: scissors, small pouch bags, fine string, alcohol gel, paper towels, paint, paint brush, paper, clipboard, towels, comb and shroud. I took charge of taking the handprints, first lifted the patients arm and placed towels under and around the arm to help stop paint transfer to other areas. I cleaned the hand with alcohol gel and gently massaged the fingers so they would be easier to manipulate and position, I then dried the hand thoroughly with paper towels. I asked my colleague to hold the patient's hand up so I could apply the paint carefully, on first attempt of taking the print it was of poor quality with digits missing and a half a palm print. I discussed briefly with my colleague that this print is not suitable, and advised we needed to change how we were taking the print.

We tried a number of times to which during the process I spoke to my colleague and asked if they were happy with the quality of the prints and if they had any ideas on how we could

improve. Listening to their suggestions we came up with a strategy on how to move the paper and patients fingers together with one of us taking the hand and holding the fingers up and the other the paper, when the hand was on the paper my colleague pressed one of their hands on top of the patient's hand and their other hand they placed at the back of the clip board to push together. I then pushed each finger down gently at their base in order to get a full fingerprint. We both understood our separate roles and how working together they created a good print. When we had a number of acceptable prints from the hand we cleaned it with alcohol gel and dried it and then repeated the process on the other hand. Once we were finished, we put a clean shroud on the patient as despite our best efforts we got some paint on the cuffs. Below I have included pictures of the hand prints we took and the equipment needed.

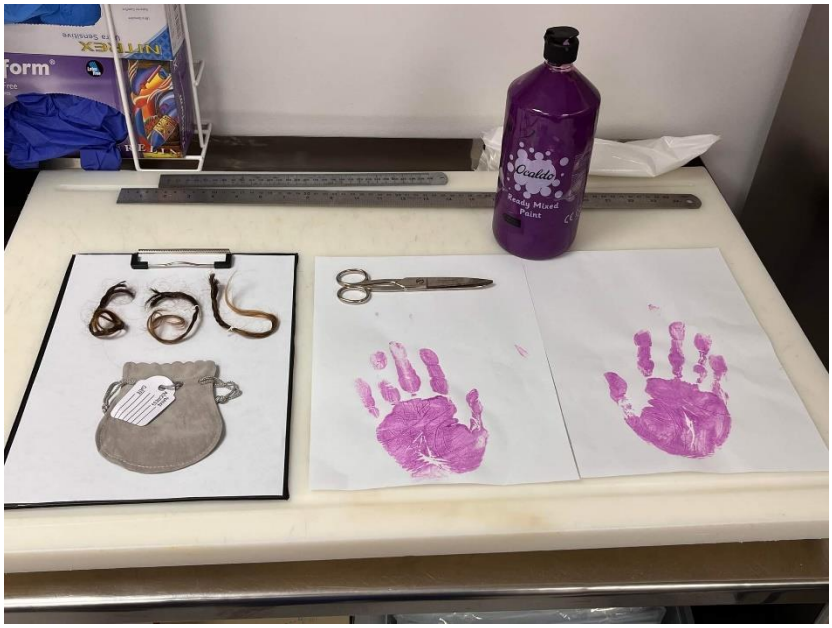
1. The paint equipment used

2. Our first attempt at a handprint where we discussed a new strategy as it was not acceptable

3. A selection of handprints we took after getting the technique correct

Next, we took the eleven hair locks, fortunately the patient had a good full amount of mid length hair. This meant that we were able to take the hair discretely from the sides and back of the head, therefore not interfering with the appearance of the front of the face if they were to have any future viewings. We gently moved the patients head to the side and carefully combed their hair; we left the top section intact meaning it would cover the gaps where we were taking the hair. The hair was parted into small locks, plated to keep it together, tied with string and cut. The APT assisting me advised that best practice was to try and keep all the locks of hair at a similar length and thickness if possible. Before putting the patient back into the fridge space, we both individually counted the locks to ensure that we had taken eleven. These locks were then placed in individual small velvet pouch bags for the family.

An image of some of the hair locks, the pouch bags we provide, and a handprint set that were taken.



What did I do well?

I volunteered to take charge of the task; I created a plan, delegated tasks to my colleagues, advised what they needed to change and listened to their suggestions and acted on them during the task which ultimately allowed us to fulfil a family's wishes in a short time frame to a standard I was happy with.

What would I do differently next time?

I discussed with the APT who assisted me with the hair locks that I was not thrilled by the way the hair looked in the locks although they were neat and uniform. I was advised that if we had all of the equipment available and importantly more time in order to take the

keepsakes, our best practice would have been to wash the hair in the products the patient used to use and dry the hair. The hair would have then been tied with hair bands or ribbons for better presentation, and finally the hair could have been styled with a flat iron hair tool to give the hair a smooth finessed finish with a slight curl.

In the future if I am not able to wash the hair, I will make sure to dry shampoo the hair beforehand as this helps to clean it and gives it a pleasant smell. After this incidence we made sure to order ribbons so that all future hair keepsakes would be tied with ribbon instead of string.

What have I learned?

By requesting assistance from my colleagues, I found that team work was the most important factor in getting the task completed within the timescale. If I had done the prints by myself they would not have been as clear as they were with two of us participating, which ultimately is what is in the best interest of the patient's family; to have well defined clear prints. With my team helping I was able to stick to the agreed timescale and complete the keepsakes.

Mentor/management comments if applicable:

[redacted] completed this task well she took the lead in the process and instructed her colleague of how things would be done and worked really well as a team. [redacted] requested to senior staff the option of having different coloured paints other than the purple and red the department had to create a softer image, which is a good idea and has since been implemented in the department.

Candidate Signature: [redacted]	*Date:* **27.11.2023**
Mentor Signature: [redacted]	*Date:20.01.2024*

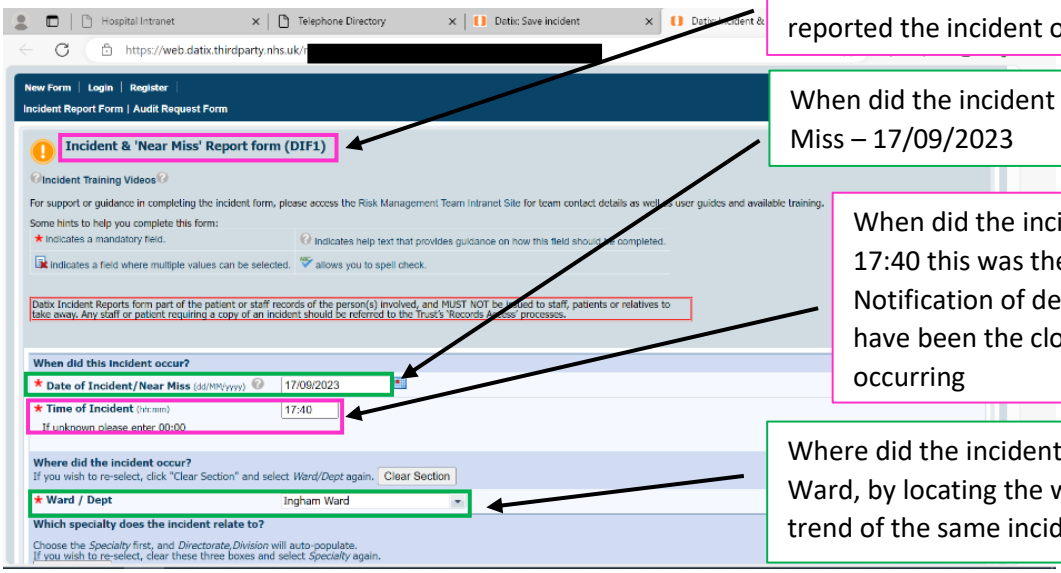
Work Based Objective Evidence

Name: [redacted]	*RSPH candidate number:* [redacted]
Unit number: **3.10**	*Evidence number:* **10**
Activity date: [redacted]	*Evidence type:* **Screen shots and email trail for DATIX incident**
Department: **Mortuary**	*Hospital:* [redacted]
Evidence Title: **Completing a DATIX**	

The evidence I am presenting below is a series of screenshots for reporting a DATIX incident, the resolution email and the email I sent to the individual involved with their reply. The DATIX incident involved the undignified transfer of a hospital patient who was left naked from ward to the mortuary; they were wrapped in a sheet and covered for the transportation but on booking the patient in when the sheets were opened the patient was fully exposed to the team present and the CCTV camera that looks over the area. This being a great lack of dignity and patient privacy and a direct violation of care after death procedures meant I was able to DATIX the incident to be able to seek a resolution.

This evidence demonstrates that I can agree time scales for completion of activities, monitor progress of the task I have created in way of email updates created by the DATIX system, I can give advice in a positive and supportive manner to help colleagues meet objectives. It shows I offer help and support constructively and from this evidence I believe going forward the HCA (Heath Care Assistant) involved will ensure this incident does not occur again and they will pass this on to others they work with meaning there is increased effectiveness of the team as they will know what they are doing and not to forget to dress a deceased patient again in accordance to our care after death procedures.

Screen shots – reporting incident on DATIX



Incident and 'Near Miss' Report form (DIF1) – the form I reported the incident on

When did the incident occur – Date of Incident/Near Miss – 17/09/2023

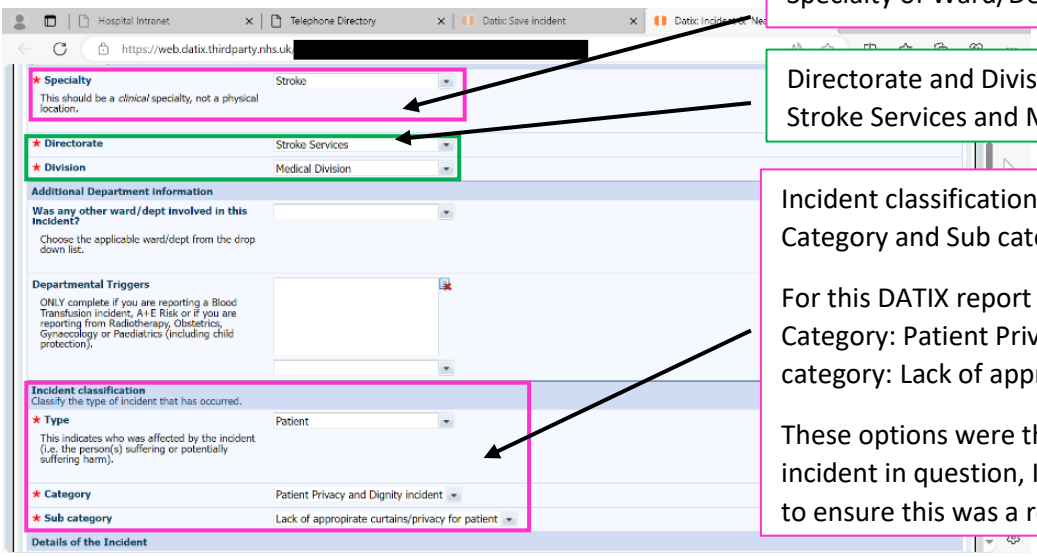
When did the incident occur – Time of Incident – 17:40 this was the time of death on the patients Notification of death form, so using this would have been the closest time to the incident occurring

Where did the incident occur – Ward/Dept – Ingham Ward, by locating the ward helps to see if there is a trend of the same incident happening at the same place

RSPH Diploma in APT Level 3
Portfolio – Objective Evidence

Specialty of Ward/Dept - Stroke

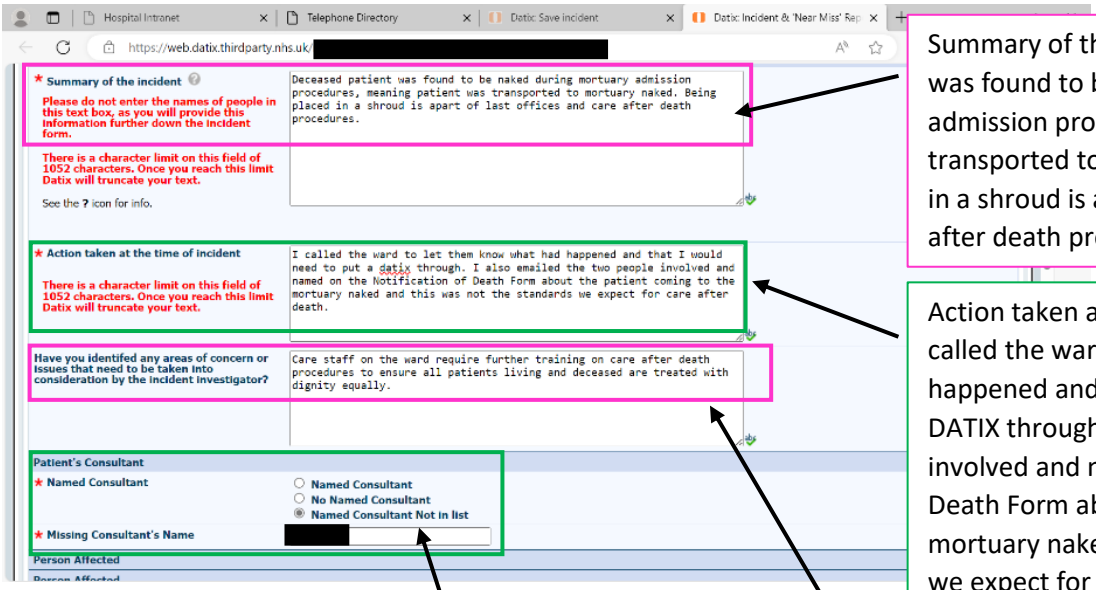
Directorate and Division (of the ward incident occurred) – Stroke Services and Medical Division



Incident classification – this includes three headings: Type, Category and Sub category.

For this DATIX report these were – Type: Patient, Category: Patient Privacy and Dignity incident and Sub category: Lack of appropriate curtains/privacy for patient

These options were the closest in relevance to the incident in question, I checked with my mentor at the time to ensure this was a reasonable and appropriate summery



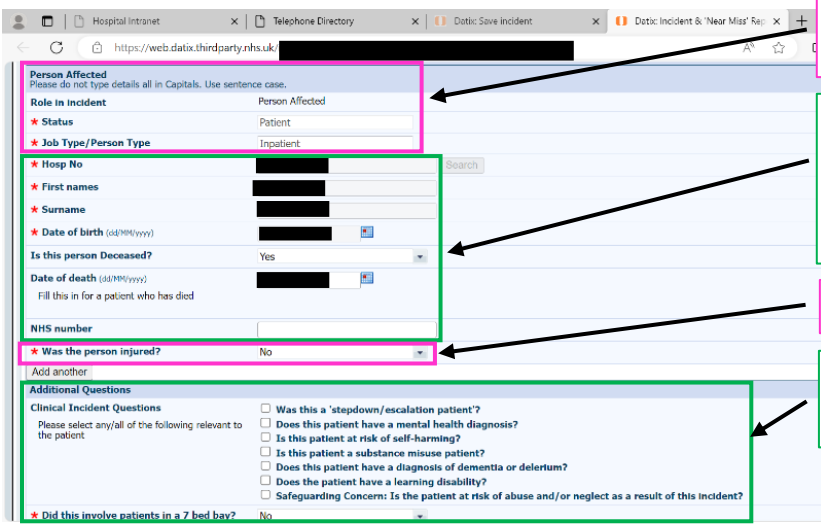
Summary of the incident - "Deceased patient was found to be naked during mortuary admission procedures, meaning patient was transported to mortuary naked. Being placed in a shroud is a part of last offices and care after death procedures."

Action taken at the time of the incident – "I called the ward to let them know what had happened and that I would need to put a DATIX through. I also emailed the two people involved and named on the Notification of Death Form about the patient coming to the mortuary naked and this was not the standards we expect for care after death."

Patient's Consultant, Named Consultant and Missing Consultant's Name – I wrote in the Consultant's name in the text box, I found this information from the patient's Notification of Death Form

Have you identified any areas of concern or issues that need to be taken into consideration by the incident investigator? – "Care staff on the ward require further training on care after death procedures to ensure all patients living and deceased are treated with dignity and equality."

RSPH Diploma in APT Level 3
Portfolio – Objective Evidence

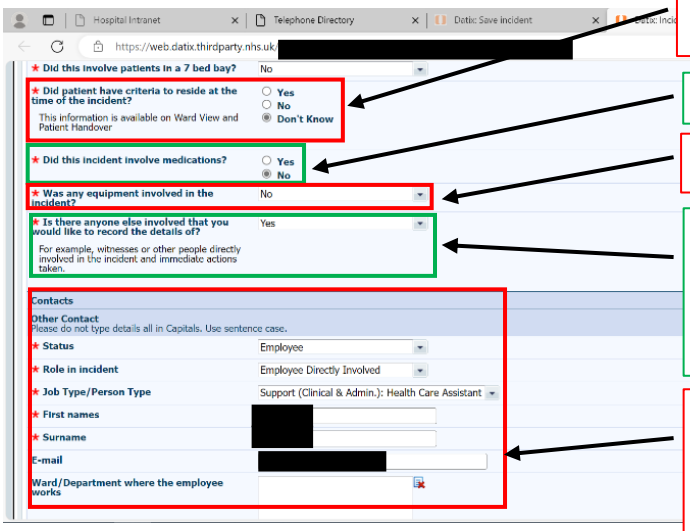


Person Affected / Role in incident – Status: Patient, Job Type/Person Type: Inpatient

Person Affected identification details – Hospital number: BLANK, First names: BLANK, Surname: BLANK, Date of Birth: BLANK, Is the patient deceased?: yes, Date of death: BLANK and NHS number: unknown

Was the person injured? - No

Additional Questions – not required for this incident as these are in relation to a living patient



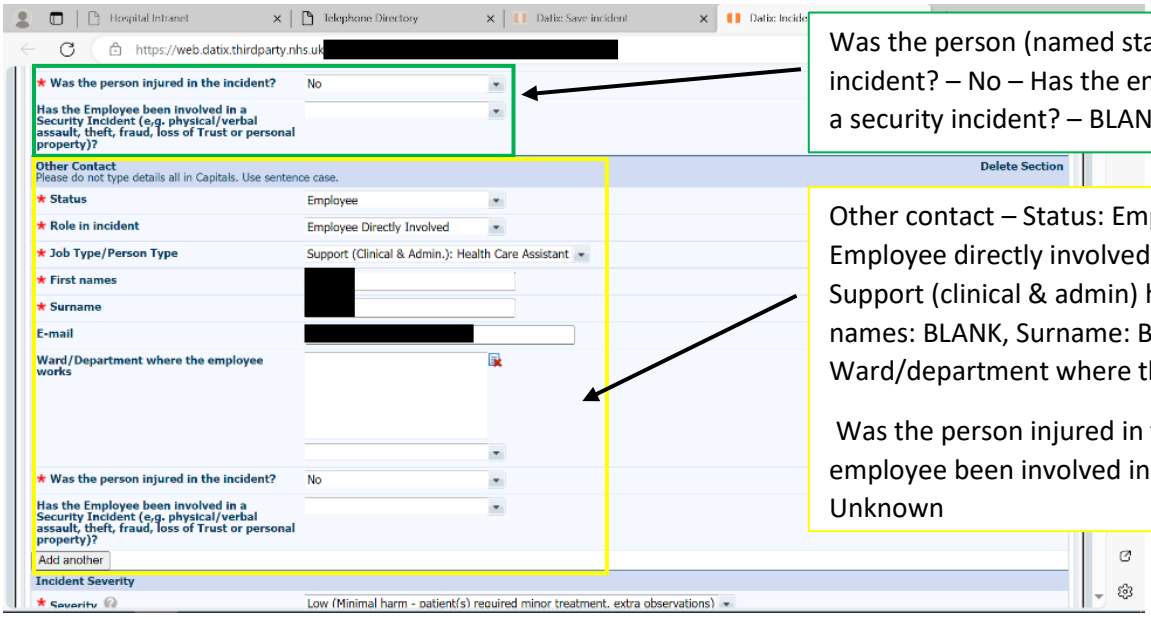
Does this patient have criteria to reside at the time of the incident? – Don't Know, this information is not available to the mortuary

Did this incident involve medications? - No

Was any equipment involved in the incident? - No

Is there anyone else involved that you would like to record the details of? – Yes, the patients Notification of Death Form had the names of two staff members who performed the last offices/care after death so I used these names

Contacts – Status: Employee, Role in incident: employee directly involved, Job Type/Person Type: Support (clinical & admin): health care assistant, First names: BLANK, Surname: BLANK, Email: BLANK and Ward/Department where employee works

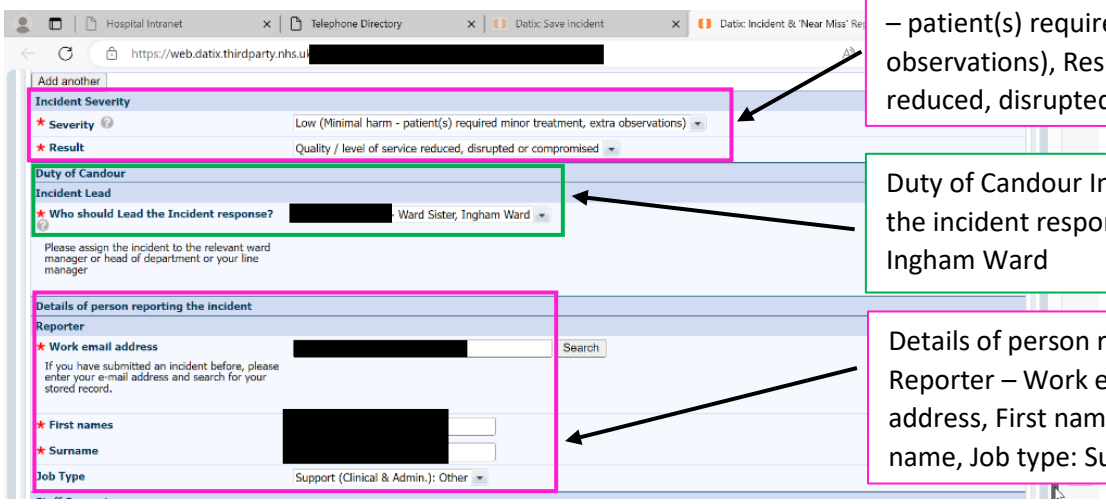


Was the person (named staff member) injured in the incident? – No – Has the employee been involved in a security incident? – BLANK as unknown

Other contact – Status: Employee, Role in incident: Employee directly involved, Job type/Person type: Support (clinical & admin) health care assistant, First names: BLANK, Surname: BLANK, Email: BLANK, Ward/department where the employee works: Unknown

Was the person injured in the incident: No, Has the employee been involved in a security incident?: Unknown

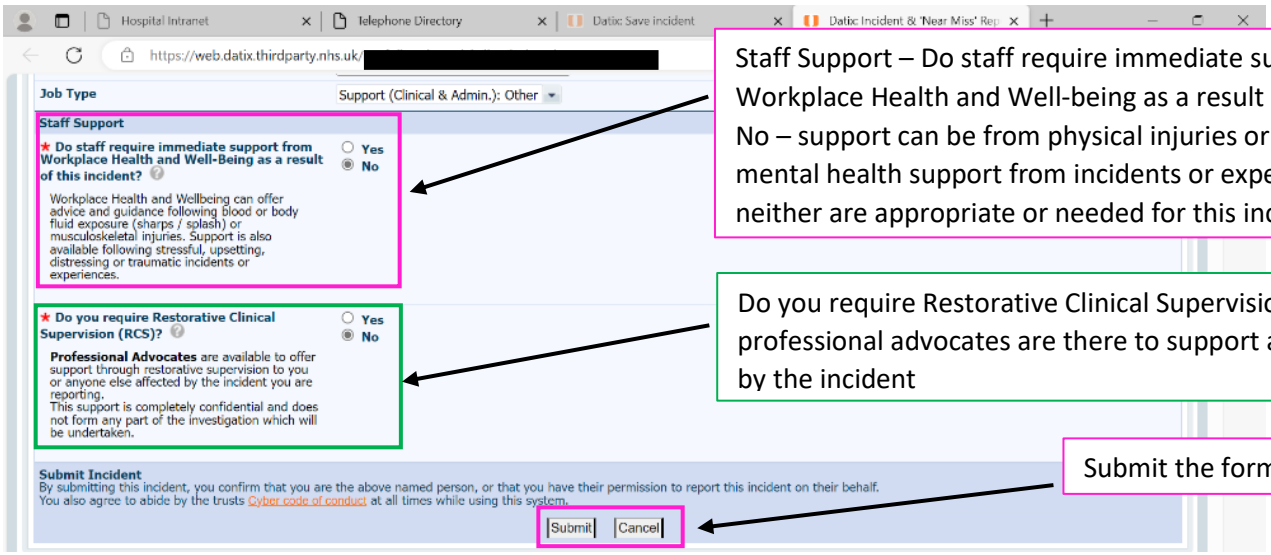
RSPH Diploma in APT Level 3
Portfolio – Objective Evidence



Incident Severity – Severity: Low (minimal harm – patient(s) required minor treatment, extra observations), Result: Quality/level of service reduced, disrupted or compromised

Duty of Candour Incident Lead Who should lead the incident response?: BLANK Ward Sister Ingham Ward

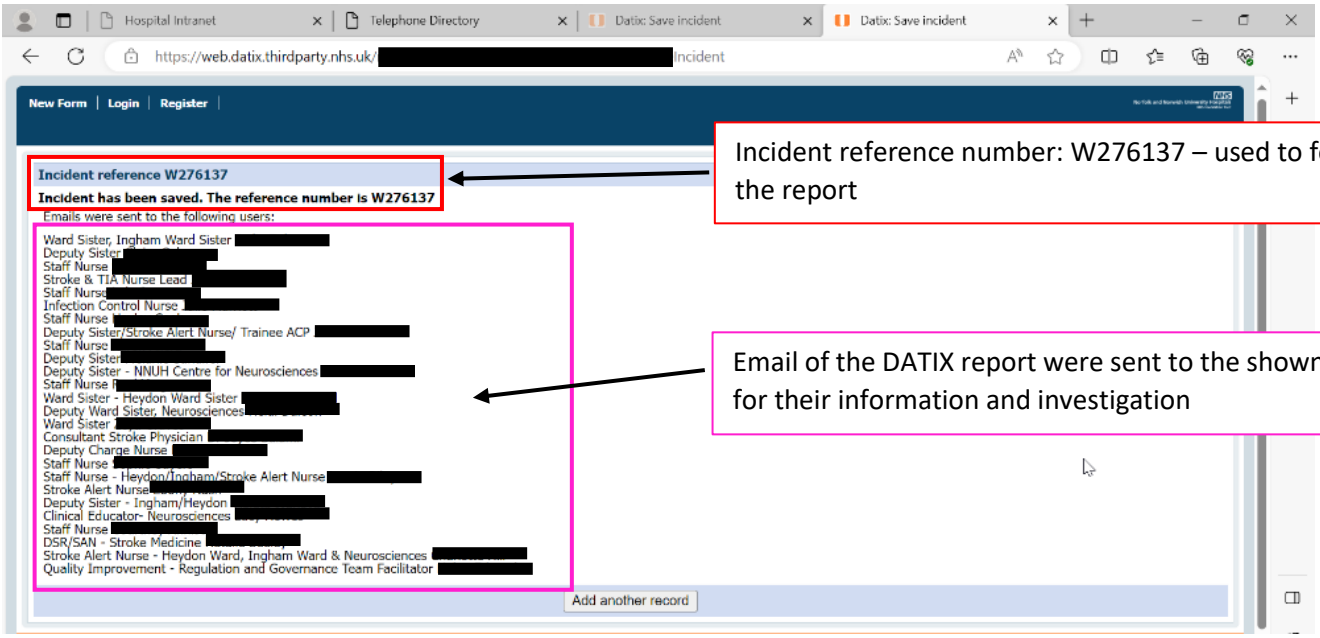
Details of person reporting the incident Reporter – Work email address: My work email address, First name: My name, Surname: My name, Job type: Support (clinical & admin) other



Staff Support – Do staff require immediate support from Workplace Health and Well-being as a result of this incident?: No – support can be from physical injuries or exposure or mental health support from incidents or experiences at work, neither are appropriate or needed for this incident

Do you require Restorative Clinical Supervision (RCS)?: No, professional advocates are there to support anyone affected by the incident

Submit the form once completed

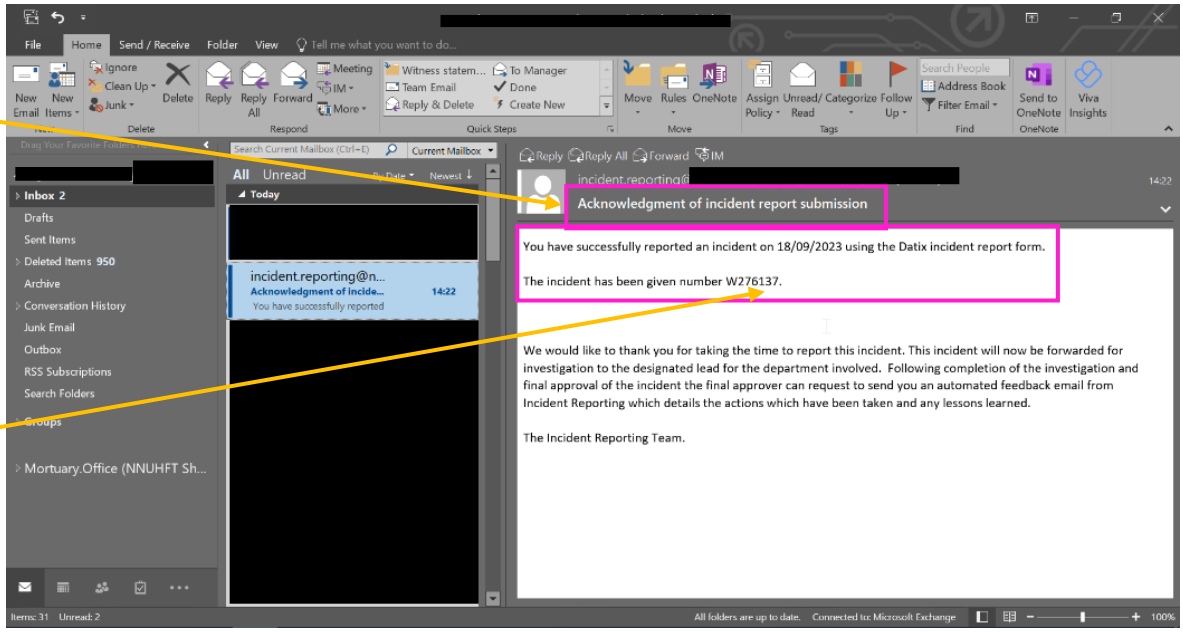


Incident reference number: W276137 – used to follow up on the report

Email of the DATIX report were sent to the shown list of staff for their information and investigation

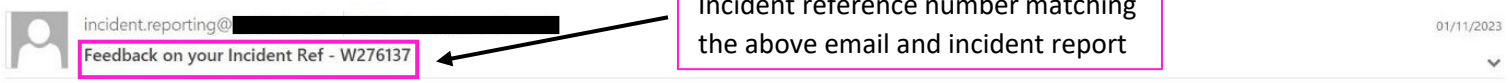
RSPH Diploma in APT Level 3
Portfolio – Objective Evidence

Email I received from Incident Reporting acknowledging my submission of the DATIX incident – the incident number given on the email matches the one on the DATIX form above: W276137



The following image is the email concluding and sumerising the investigation that took place in regard to the DATIX incident I raised

Incident reference number matching the above email and incident report



The following is an automated message from the Datix system following closure by the investigator. If you have any queries regarding the response, please contact the incident lead:
Incident Lead: [redacted] Ward Sister, Ingham Ward

Thank you,

The incident you reported on 18/09/2023 has been finally approved.

The details of the incident are -

Sub-Category: Lack of appropirate curtains/privacy for patient
Ward/Department: Ingham Ward
Incident Summary: Deceased patient was found to be naked during mortuary admission procedures, meaning patient was transported to mortuary naked. Being placed in a shroud is apart of last offices and care after death procedures.

The feedback from the investigator is as follows -

The findings/action taken: protocol not followed for the after care of a deceased patient
The lessons learned: 2 members of staff have been informed of the incident, no shroud available so they were unaware a gown or night wear could be placed on the patient.

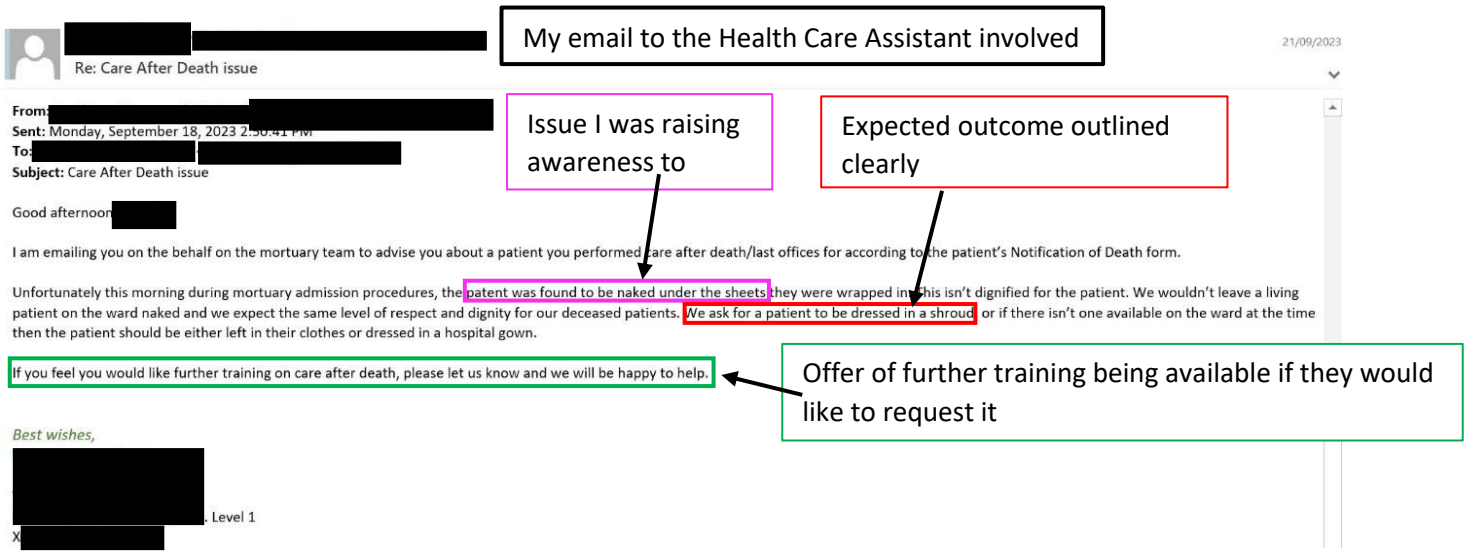
members of staff now aware of what to do when appropriate equipment is not available.

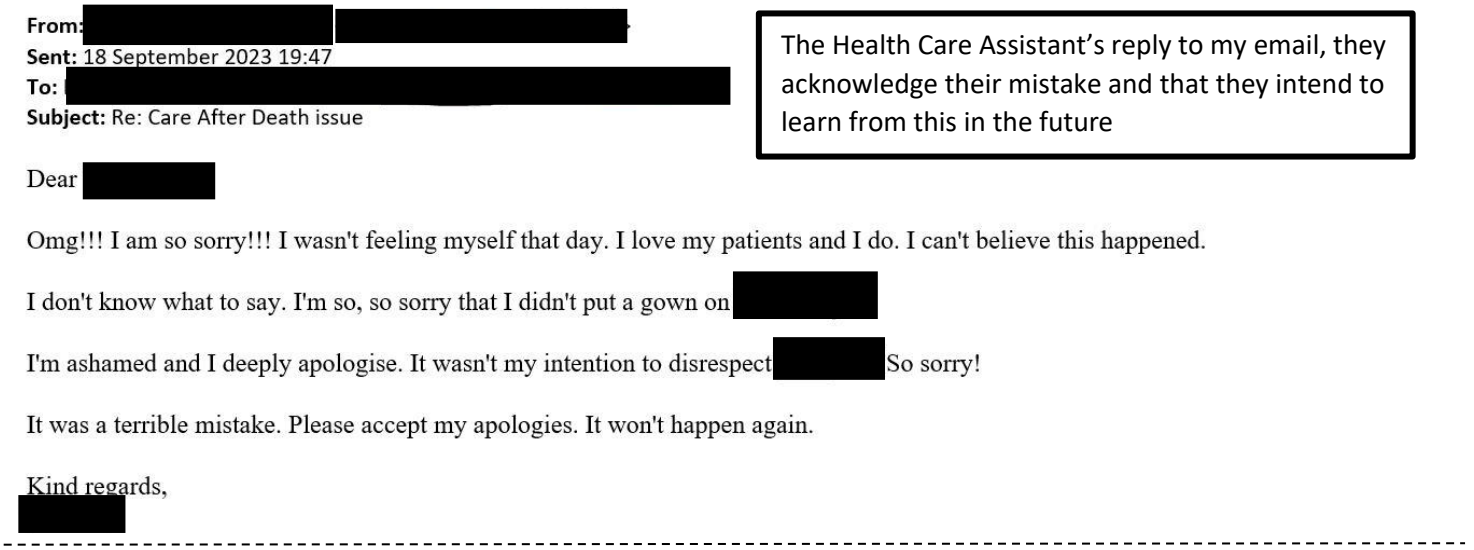
Details I submitted of the incident – Sub-category, Ward/Department

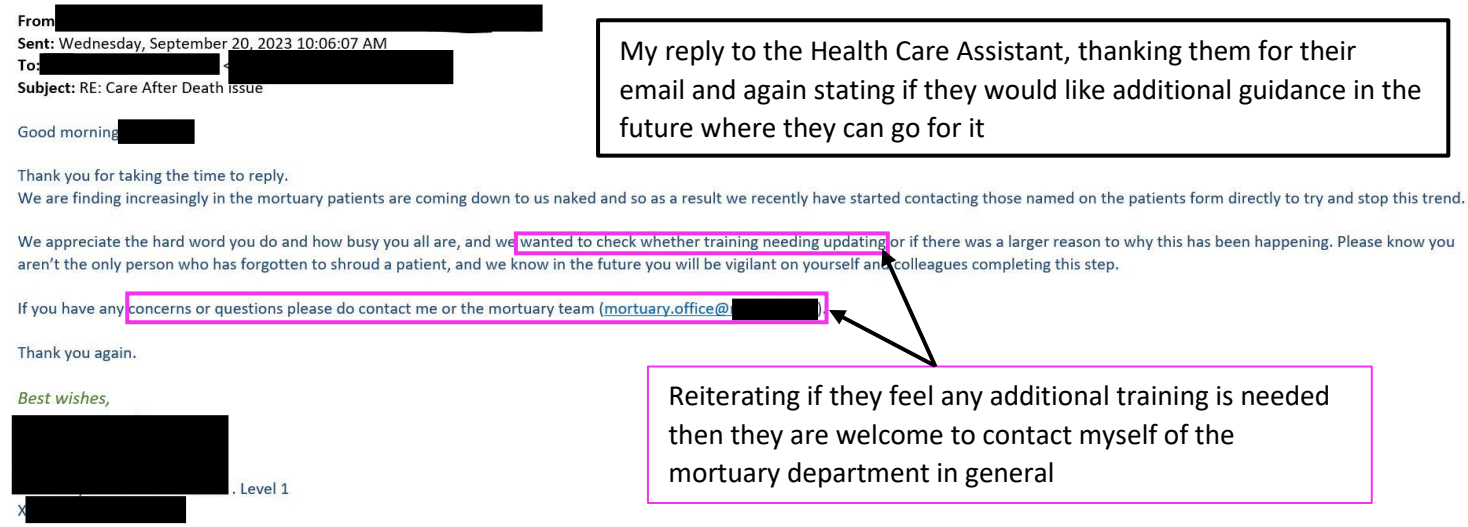
Feedback from the investigator – Findings/action taken: protocol not followed for the after care of a deceased patient, and Lessons Learned: 2 members of staff have been informed of the incident, no shroud available so they were unaware a gown or night wear could be placed on the patient. Members of staff now aware of what to do when appropriate equipment is not available

RSPH Diploma in APT Level 3
Portfolio – Objective Evidence

The last three images are the email trail I sent to one of the HCAs involved in the incident – I sent these emails in order to provide guidance and offer support to the staff member if they felt they required additional training to stop this incident from occurring again.







Candidate Signature: [redacted]	*Date:* **31.12.23**
Mentor Signature: [redacted]	*Date:* **11.01.2024**