ITAPS Management of Intraoperative Death	University Hospitals of Leicester NHS NHS Trust Trust Reference C10/2023

Introduction

Death during a surgical procedure is fortunately a rare event. It is a catastrophic event for the family members of the deceased and the staff involved who may also feel a sense of personal responsibility for the events and the outcome, whether the event was a direct consequence of their actions or not.

These guidelines are for both elective and emergency surgeries. This guideline outlines the process to follow and the available support for staff involved in an intraoperative death or a catastrophic event.

Scope

The guideline is to be used across all 3 sites in conjunction with the Last Offices Care of the Deceased UHL Policy, present on Insite.

This guidance applies to those who work in the theatre suite. It includes ITAPS and Surgical teams. It applies to all areas where ITAPS provide anaesthesia and sedation.

(Anaesthetist, Surgeons, Theatre team leader, Theatre nurse, scrub nurse, Operating Theatre practitioner)

Guidelines, Standards and Procedures

Immediate measures

1.1 Initial debriefing

The initial team debriefing after the catastrophic event is important to destress the staff. It should be a focussed debrief soon after the event and allow everyone to share their experience.

The aims of this are to

- Allow individuals to process and make sense of the situation
- Identify the theatre team members who may be particularly affected by the event so that further follow-up can occur.
- For explanation provided to the team members about the next steps that are likely to follow
- A consultant (anaesthetist and/or surgeon) not directly involved in the incident can facilitate the initial debrief.

1.2 Documentation

- An accurate and contemporaneous record of the anaesthetics, operation and the event must be kept in the patient's note folder. These must be legible, timed, dated and signed.
- A critical incident ('Datix') form should be completed electronically after the event.
- The Team leader should document staff statements.
- Electronically stored monitoring records must be printed and filed in the notes. If stored monitoring records are unavailable, recordings must be made on the basis of recollection as accurately as possible and preferably corroborated by staff who were present at the time.
  - Original notes and charts must not be altered in any way at a later date.
  - Amendments and additions must be recorded separately, timed, dated and signed.

1.3 Equipment, drugs and theatre checks

- All equipment and kit should not be used until all appropriate checks have been done. If there is a suspicion of equipment failure or a hazard affecting the theatre, a decision may be made to take the theatre or anaesthetic machine out of commission until further notice.

- In the case of an anaesthesia related death, all anaesthetic equipment, drugs, syringes, and ampoules that are available should be kept and stored securely for investigation. An accurate record should be made of all the checks undertaken including time and date of inspection. Further investigation may be required by medical equipment maintenance personnel, manufacturers or toxicologists. Clinical engineering and pharmacy should be informed as appropriate as soon as possible after an incident so that necessary checks may be undertaken.

1.4 Initial staff support systems

- The clinical commitment of the anaesthetist/surgeon concerned must be reviewed immediately by the clinical director.
- A consultant anaesthetist/surgeon with coordinator/theatre manager should make a decision whether the trainee anaesthetist/surgeon should continue with his/ her list or shift.
- Affected staff members need to be relieved of their immediate clinical duties to allow sufficient time for this. This needs to be taken into account by theatre co-ordinators/managers when managing overall theatre workload after an intra-operative catastrophe.
- The team should have an early debriefing at a time to suit all staff and ideally within a few hours of the event. The structure and content of the debrief will be dictated by the circumstances of the event and guided by the experience of the facilitator.

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2. Communication with patient's relatives

- Provision should be made to have separate room for breaking bad news.
- A team approach should be adopted to breaking bad news with relatives and should include senior members of the surgical, anaesthetic and nursing team responsible for the patient
- Breaking bad news should not be done over the telephone. It will be necessary to invite the relatives to come into hospital informing them that some complication had occurred, but no details should be given over the phone.
- Find a suitable quiet and comfortable room free from interruption for the interview.

- The task of breaking bad news should not be carried out by a post graduate doctor in training or staff grade /associate specialist doctor without a consultant present.
- Explain the bad news first in a straightforward and honest way, followed by answering any questions which may arise.
- Usual post death process should be followed. Bereavement support nurses will be able to provide assistance to the family members and friends.

3. Subsequent effective staff support measures

- It is important that the staff involved in the incident get required support and a senior colleague or mentor should be assigned to this role.

- Staff members should be encouraged to recognise if they may have been adversely affected by a catastrophe in theatre to allow them to take personal responsibility to seek help (e.g., from their GP or through Workplace Health & Wellbeing).
- For medical staff members affected, follow-up of the incident should take the form of three-party discussion involving: the member of staff, assigned mentor/supervisor and relevant clinical director.
- Where there are serious concerns about the psychological state of a member of staff – the concerns must be escalated to the appropriate clinical lead and a referral to occupational health for support should be undertaken

- Clinicians are advised to be a member of a medical defence organisation.

- Sometimes, the media may try to approach staff at the hospital or home. A Trust manager trained with dealing with the media should be the only person communicating with them. All media enquiries should be directed to this manager.

- Useful links:

- **http://www.amica-counselling.uk**

- **http://insite.xuhl-tr.nhs.uk/homepage/health-and-wellbeing/trauma-risk-management-trim**

Monitoring Compliance

- Learning needs to disseminated to the wider team with safety alerts where appropriate, and any changes to practice discussed at unit meetings. There may need to be a Root Cause Analysis.

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Datix form completed for all deaths in operating theatre.	Datix incidents and audit	ITAPS Q&S Lead	All incidents	ITAPS Q&S Board

Case is discussed at departmental Mortality and Morbidity meeting within 6 weeks.	Clinical governance meeting minutes.	ITAPS Q&S Lead	All cases	ITAP Q&S board

Supporting References

RCOA guidelines 2.13 Management of death in the operating theatre

AAGBI Catastrophes in anaesthetic practice 2005 guidelines

GMC duty of candour

Last Offices Care of the Deceased UHL Policy

Key Words

Perioperative death, anaesthetic death, pastoral support after death

CONTACT AND REVIEW DETAILS	
Guideline author: **Dr Hina Lodhi**	**Executive Lead:** **ITAPS Q&S Lead**
Details of Changes made during review: New guidance	