Serious Injury or Death of a Patient during Anaesthesia, Surgery or in the Recovery Unit

Version	1.1
Designation of Policy Author(s)	Consultant Anaesthetist
Policy Development Contributor(s)	Anaesthetic Department, Theatre Matron, Theatre Managers
Designation of Sponsor	Medical Director
Responsible Committee	Anaesthetic Clinical Meeting, CSS Governance Committee
Date ratified	12/12/2024
Date issued	13/12/2024
Review date	15/11/2027
Coverage	Surgical Services

The Trust is committed to a duty of candour by ensuring that all interactions with patients, relatives, carers, the general public, commissioners, governors, staff and regulators are honest, open, transparent and appropriate and conducted in a timely manner. These interactions be they verbal, written or electronic will be conducted in line with the NPSA, 'Being Open' alert, (NPSA/2009/PSA003 available at www.nrls.npsa.nhs.uk/beingopen and other relevant regulatory standards and prevailing legislation and NHS constitution)

It is essential in communications with patients that when mistakes are made and/or patients have a poor experience that this is explained in a plain language manner making a clear apology for any harm or distress caused.

The Trust will monitor compliance with the principles of both the duty of candour and being open NPSA alert through analysis of claims, complaints and serious untoward incidents recorded within the Ulysses Risk Management System.

CONTENTS

Content Page

1 Executive Summary

1.1 Policy Scope

This policy describes the actions to be taken when death or serious injury occurs to a patient in the:

- Operating theatre trust wide
- Theatre recovery units trust wide

Examples of serious or critical events in theatre include anaphylaxis, major haemorrhage, inadvertent surgical damage, malignant hyperthermia, cardiac events. This list is not exhaustive.

The following group of staff should be familiar with this policy:

- All staff who work in theatres and have patient contact
- Staff on surgical wards
- Staff in Delivery Suite

2 Introduction

National Confidential Enquiries into Patient Outcome and Death (NECOPD) have demonstrated an overall perioperative mortality if 0.7% in approximately 500,000 operations. The State of UK Anaesthesia survey 2013 (the activity survey for NAP5) suggests a figure of about 0.04% for in theatre mortality.

In the majority of cases where a death occurs in theatre, the death is expected and the cause can be easily identified. However, in our practice at LWH, death or serious injury is usually unexpected. The experience can be traumatic for staff present.

Serious or critical events in theatre are more common.

After any such event the Trust has a responsibility, as part of clinical and corporate governance and risk management, to provide support to the staff according to their individual needs. In addition, the trust has a responsibility to other patients and staff to ensure that they come to no harm.

3 Policy Objectives

The aim of this policy is to provide support and guidance to staff who have been involved in a serious or critical incident, including the death of a patient, in the theatre environment.

The aim of this policy is to ensure that all staff follow general principals in the care of the seriously injured or deceased patient; in order to ensure that the patient is treated with dignity and respect in relation to the patient's own cultural values.

4 Duties / Responsibilities

4.1 Chief Executive

In line with the requirements of Governance, the Chief Executive, as Accountable Officer, carries ultimate responsibility for assuring the quality of the services provided by the Trust that is included within this procedural document.

4.2 Chief Executive Nurse

The Chief Nurse has Executive accountability for Clinical Governance within the Trust and ensuring that the framework to deliver this policy is in place within the Trust.

4.3 Heads of Department, Matron, Theatre Managers

Managers are responsible for all staff in their department. They have a responsibility to provide immediate and ongoing support to staff following a serious or critical incident, or death in theatre. They also have a responsibility to ensure the processes detailed in this policy are followed.

4.4 Bleep-holder/Consultant on call

In instances where the staff members manager/clinical director/equivalent is not available then the bleep holder or consultant on call as appropriate should facilitate debrief of staff and ensure the processes detailed in this policy are followed.

They should also ensure staff members provide a factual statement for all serious or critical events as soon as possible after the incident and submit it to their manager/head of department.

4.5 All Employees

All employees to whom this policy applies should read and understand this policy

5 Main Body of Policy

Overview

This policy should be used in conjunction with the Trusts Care After Death Policy which can be located on the intranet.

The bereavement team can provide support to staff and relatives. They can be contacted in hours vis Switchboard.

Immediate Management in any serious event / unexpected death in theatre

- Notify the theatre manager (daytime) / senior practitioner in charge (OOH) who will inform the site manager
- Notify the ward
- Medical staff should inform the Consultant in charge
- Medical staff should arrange for next of kin to attend the hospital
- Allocate time for the team to make contemporaneous records
- Complete an incident report
- The surgeon in charge of the case is responsible for documenting and verification of death and notification of the coroner

Caring for the next of kin (NOK)

Usually, the NOK should **NOT** be informed of the death over the telephone, unless they specifically ask to be informed. The senior surgeon and anaesthetist should arrange to talk to the next of kin in a private area. A nurse, preferably the named nurse for the patient, should also be present. At least one consultant and a nurse should be present. All discussions should be documented in the patients notes. If there is only a single relative, they should be encouraged to bring a friend with them. Trainee surgeons and anaesthetists should not meet with relatives without the presence of a consultant colleague. Before the meeting decide who will be the main spokesperson. Break bad news in a clear and honest way, do not use euphemisms. Explain the circumstances in lay language rather than medical terms and attune your language to your assessment of their level of understanding. Answer any questions honestly. Wherever possible leave all bleeps and mobile phones with someone outside the room so as to not cause interruptions.

The relatives should be allowed space for privacy and be supported without any unnecessary interruptions.

The recovery nurse/ODP will contact the ward to ascertain if a side room is available to transfer the patient back to.

If there is no ward side room available, the relatives should be given the opportunity to pay their last respects in the theatre suite. Alternatively, arrangements for viewing in the mortuary can be made.
Should the relatives wish to attend the theatre suite, the following locations are suggested:

- **In hours**: Any vacant theatre or recovery in a bay as far as practically possible from the other patients, this may mean a delay to patients entering recovery at the end of their procedure.
- **Out of hours**: Recovery or the forward waiting area as appropriate (gynaecology theatres)

If relatives are attending the theatre suite, they should be accompanied at all times by theatre staff when walking through the department. Attempts should be made to shield the relatives from any clinical work that is on-going. And they should be warned that some equipment/devices may need to be left in place.

The relatives should be offered assistance to contact any other support as required, including support from their chosen religious representative if they so wish. If preferred by the relatives, the hospital chaplain can be contacted via switchboard.

The only medical equipment that should be removed from the body is the endotracheal tube, assuming that it is certain it was correctly placed in the trachea. If there is any uncertainty then the endotracheal tube should be left in situ.

Remember – it is ok to apologise: this does not imply fault.
Remember – always Inform the relatives of next steps – e.g. bereavement office, coroner's office, including providing contact details and that a post mortem may be required.

For patients/ relatives who are non-english speaking, language line/ interpreters are available and can be used where required.

Post death care will be given in the recovery room where possible
The religious beliefs of the deceased should be ascertained from the notes, and care should take these into account. If there are religious beliefs and staff are unsure, then the hospital chaplaincy should be contacted, or the patient's relatives should be respectfully asked.

Theatre staff should be made aware of specific requests from the relatives for personal and cultural requests such as jewellery remaining on the patient. In this case the nurse should document and record all articles.

The ward has all relevant documentation and shroud available to perform last offices, which are performed as soon as possible after the time of death. The shift senior practitioner will organise the use of the above and may request the attendance of a ward nurse to assist with the delivery.

The patient should be washed and dried in a dignified manner.
A clean theatre gown should be used.
In the event of an unexpected death:

- Drain tubes should be left in position and capped.
- Catheters and cannulas should be capped / spigot.
- Endotracheal tubes / tracheostomy must be kept insitu.

A dressing should cover wounds
The patient should then be transferred to the bed.

For further information on care after death refer to the 'care after death policy'. This policy details the requirements for any cultural or religious practices which may need to take place on the same day.

Ongoing management of the theatre list

The impact of severe/critical event or unexpected death in theatre will clearly vary with the individual circumstances.
After such event there should be time for the theatre team to have a break.
It is a joint decision between the surgeon / anaesthetist / theatre team leader and theatre manager as to whether the list can continue. Following an unexpected death in theatre, where possible the remaining patients should either be cancelled or moved onto another theatre list. All team members should be allowed to make an individual decision regarding whether they feel happy to continue the list or not. All team members should be given time to debrief and reflect and should not feel under any pressure to continue with the list.
Any staff members affected should be supported by senior colleagues and mentors with occupational health support offered to any individuals who feel they may benefit from it.

If there is suspicion of any equipment failure or hazard a consultant not involved in the incident should check the patient and equipment, and make a decision to take any equipment, including the anaesthetic machine or the entire theatre, out of action.

In the case of an anaesthesia related incident or unexpected death, all anaesthetic equipment, syringes, drugs and ampoules 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.

Equipment and Records

If the serious or critical event or death occurs in the theatre or anaesthetic room then the area should not be used immediately following the event. This allows time for all relevant disposables and equipment to be examined and recorded – ideally this should mean the area is out of use for no longer than an hour. If the event occurs in recovery then only that recovery bay should be temporarily out of use.

All equipment should be left in place and all surgical instruments should be checked for completeness and/or damage by 2 qualified members of staff before being removed from theatre. Any equipment including trays, found to contain missing, incomplete or damaged items should be retained to allow ongoing investigations.

The theatre manager should appoint a senior ODP and senior theatre nurse ~~to~~ who have not been involved to:

- Record the serial numbers of all equipment used
- Where possible ensure all ampoules, syringes, infusion sets etc, used are identified and retained
- Record the batch numbers and expiry dates of drugs used
- Any drugs retained in syringes should not be immediately discarded but retained in case required for ongoing investigation. A written record of this must be kept.
- Identify and record the batch numbers of all disposable equipment used.

Any checks made should be documented, and pharmacy and medical equipment should be informed so that further checks can be carried out as necessary.

There will be alternatives to most equipment that might need to be out of service for a period of time. If there is a circumstance where a piece of equipment is required for use in an emergency and no alternative is available, it may be re-used as long as the equipment was not considered to have played a role in the event. This decision must be documented in the notes of the patient it has been used on. Prior to use the equipment should be fully decontaminated and tested in accordance with the manufacturers instructions and confirmed to be in full working order.

Team Debrief

A “hot debrief” of the team should occur at a time to suit all staff and ideally within a few hours of the event. The aims of this initial debrief are:

- To provide and record necessary information
- To give feedback whilst details are still fresh
- To identify individuals who are particularly affected by events and may require further support
- To identify any organisational or team factors that could be improved upon for future practice
- To explain to team members the likely next steps

The debrief should be structed, for example following the four questions in an ‘After Action Review’ (AAR ; see Appendix 1 for template).

- What was supposed to happen?
- What actually happened?
- Why was there a difference?

- What can we learn from this?

Individual team member debrief.

It is vital that members of the team are supported. Each staff member should be assigned a mentor, usually a senior colleague. Staff members should be encouraged to recognise if they may have been adversely affected by an event in theatre to allow them to seek help. Mentors can direct to help from the following sources:

- Staff members GP
- Occupational health and wellbeing team
- Educational Supervisors or College Tutor for trainee medical staff
- Workplace mentors for nursing and non-medical staff

Senior leadership teams should be informed. For medical staff affected, follow-up of the incident should form a 3 party discussion involving the member of staff involved, an assigned or nominated mentor/supervisor and the relevant clinical lead.

In some cases, the media may get involved. There should be a trust manager trained in dealing with the media and all communication should go through them.

Staff members responsibilities

Caring for the bereaved or being involved in a serious or critical event can be stressful. Take time to care for yourself – ask for support from a mentor, supervisor or senior colleague if necessary.

6 Key Reference

i. Ian Clegg, MB ChB FRCA, Ralph MacKinnon, BSc (Hons) MB ChB FRCA; Strategies for handling the aftermath of intraoperative death, Continuing Education in Anaesthesia Critical Care & Pain, Volume 14, Issue 4, 1 August 2014, Pages 159–162, https://doi.org/10.1093/bjaceaccp/mkt050

ii. Catastrophes in Anaesthetic Practice – dealing with the aftermath, The Association of Anaesthetists of Great Britain and Ireland 2005 http://dx.doi.org/10.21466/g.CIAP.2005

iii. Special circumstances Guidelines | Resuscitation Council UK

7 Associated Documents

i. Supporting staff following a work related traumatic event or serious incident policy

8 Training

i. All anaesthetists train in the management of critical incidents and achieve competence in this to achieve their CCT. However, this does not usually include how to debrief or manage staff after the event. This guideline provides guidance for managing this process and a links to the AAGBI guideline on this topic. It is advisable that all member of the theatre team undergo simulation training at least annually in the management of critical incidents. Staff should also be encouraged to attend events/courses/training on debriefing, staff welfare and supporting colleagues in difficulty. Mindfulness and staff wellbeing is an important part of being a resilient healthcare worker and all staff should be encouraged to learn and think about this as part of their CPD.

9 Policy Administration

9.1 Consultation, Communication and Implementation

Consultation Required	Authorised By	Date Authorised	Comments
Impact Assessment			
GDPR			
Have the relevant details of the 2010 Bribery Act been considered in the drafting of this policy to minimise as far as reasonably practicable the potential for bribery?	Yes (TICK)		No (TICK)
External Stakeholders			
Trust Staff Consultation via Intranet	Start date:		End Date:

Describe the Implementation Plan for the Policy (and guideline if impacts upon policy) (Considerations include; launch event, awareness sessions, communication / training via CBU's and other management structures, etc)	By Whom will this be Delivered?
Policy will be launched via communication with Heads of department and safety lead for anaesthetics. It will be discussed at relevant meetings and signature of all relevant staff taken to ensure awareness is documented	Theatre managers Safety lead for anaesthetics

Version History

Date	Version	Author Name and Designation	Summary of Main Changes
5/09/23	1.0	Carol Kenyon Consultant Anaesthetist	New policy
6/12/2024	1.1	D Molyneaux Theatre Matron	Review, no changes required

9.2 Monitoring Compliance with the Policy

Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
All serious injury or Death incidents reported onto trust incident recording system	100%	Ulysses reports	CSS Governance	Monthly	Governance Manager
Formal Debrief process undertaken for all serious injury or Death incidents	100%	Serious incident investigation report recommendations	CSS Governance	Monthly	Governance Manager

9.3 Performance Management of the Policy

Who is Responsible for Producing Action Plans if KPIs are Not Met?	Which Committee Will Monitor These Action Plans?	Frequency of Review (To be agreed by Committee)
Clinical director, Anaesthetic safety lead, Theatre Matron	CSS Governance	

Initial Equality Impact Assessment Screening Tool

Name of policy/ business or strategic plans/CIP programme:	**Details of policy/service/business or strategic plan/CIP programme, etc:**	
SERIOUS INJURY OR DEATH OF A PATIENT DURING ANAESTHEISA, SURGERY OR IN THE RECOVERY UNI	Policy details how to deal with a serious incident in the operating theatre or in recovery and support the staff thereafter	
Does the policy/service/CIP/strategic plan etc affect (please tick)	**Patients** ☐ **Staff** ☐ **Both** x	
Does the proposal, service or document affect one group more or less favourable than another on the basis of:	**Yes/No**	**Justification/evidence and data source**
Age	No	The policy does not discriminate against any of the listed protected characteristics and all patients/ relatives who have been involved in a serious incident or death in theatres or in the recovery unit would be treated equally. The policy has taken into consideration the need to offer non-english speaking patients/ relatives an interpreter to ensure we fulfil our duty of care to the patient. The policy also refers to an associated policy 'care after death' and acknowledges there may be requirements for certain religions for staff to consider if necessary on the same day and also references that the chaplain can be called if requested.
Disability: including learning disability, physical, sensory or mental impairment.	No	
Gender reassignment	No	
Marriage or civil partnership	No	
Pregnancy or maternity	No	
Race	No	
Religion or belief	No	
Sex	No	
Sexual orientation	No	
Human Rights – are there any issues which might affect a person's human rights?		**Justification/evidence and data source**
Right to life	No	
Right to freedom from degrading or humiliating treatment	No	
Right to privacy or family life	No	
Any other of the human rights?	No	
EIA carried out by: David Molyneux Quality assured by: Sarah Thomson (04/10/23)		

Appendix 1 – After Action Review

Liverpool Women's NHS Foundation Trust

After Action Review

What is an After Action Review?

A four-step process, centred on these questions:

1. What was expected? Review what was supposed to occur.
2. What happened? What occurred?
3. What went well and why? Determine what was right or wrong with what happened.
4. What can be improved and how? Determine how things should be done differently next time.

An After Action Review features:

- An open and honest professional discussion.
- Participation by everyone on the team.
- A focus on results of an event or project.
- Identification of ways to sustain what was done well.
- Development of recommendations on ways to overcome obstacles.

Date: *Todays*	**Incident no:**	**Division:**
Name:	*Insert rows below to record names of people involved in AAR*	*Job title*
Date of Incident		
Description: ***What happened? What Occurred?***		
NHSE Guidance for AAR: *What you need?* *A Lead* *Safe place to discuss the event.* *Sticky notes and paper*		

What was expected? Review of what was supposed to occur?
What went well and why? Determine what was right or wrong with what happened.
What can be improved and how? Determine how things should be done differently next time
Immediate learning identified.

FINDINGS

Contributory factors The following are a guide of possible contributory factors, please tick those that are applicable:
Lessons learnt
Recommendations
Arrangements for shared learning

Action Plan

Recommendation	Action Description	Operational Lead	Management Lead	RAG Status	Target Date/ Completion Date	Progress Update	Evidence	Risk Register?/ Ref No.