Catastrophes in Operating Theatres - Dealing with the Aftermath Standard Operating Procedure (SOP)

Reference no.: CG-SURGEN/2023/004

1. Introduction

When a catastrophic event occurs in the operating theatre it is imperative there are guidelines available to support the Medical and Theatre Team managing the situation in order to provide;

- Patient care respectfully and with dignity
- Appropriate support of relatives
- Appropriate support of colleagues
- Management of equipment that may have contributed to the event

2. Aim and Purpose

Strategies for handling the aftermath of intraoperative death

3. Related guidelines

- This SOP should be read in conjunction with care of the Deceased Patient in the Operating Department
- Appendix 1 - Medical devices involved in critical incidents

4. Standard Operating Procedure

Step	Key Points	Explanation
Record keeping	Keep accurate and contemporaneous records which are legible, timed, dated and signed	All notes should be made contemporaneously where possible and any retrospective entries identified as such. Where practical, it is advisable during attempted resuscitation for one member of the team to scribe on the Resuscitation Document Form (WPH1577) Or the Paediatric Resuscitation Document Form (WPH1544). The Resuscitation Team Leader is responsible for completion of the form. These forms are kept on the resuscitation trolley. Amendments and additions must be recorded separately, timed, dated and signed.
The clinician involved	If a non-consultant grade clinician is involved, then the responsible consultant should attend in person. A decision will need to be made whether the clinician should continue with his/her list or on-call Follow trust policy towards serious incidents. Contact college tutor if trainee is witnessed/ involved in the incident. Use of TRiM practitioners (see paragraph below)	Many clinicians' may feel their ability to deliver safe anaesthesia/surgical expertise compromised after an intraoperative death, with feelings of guilt and anxiety being common. The decision is best made after assessing the situation between the anaesthetist/surgeon involved, a senior colleague and the clinical director
The Staff involved	Staff should be supported and consideration should be made if the list should continue or if staff involved can be given down time and the chance to debrief	The stress and anxiety of the situation can compromise the theatre practitioners practice and response should be to the needs of the clinician.

Patient Management	The consultant anaesthetist involved in the incident (or consultant surgeon if no consultant anaesthetist present) will inform the coroner and complete an incident form (Datix / IR1). The patient's General practitioner need to be informed as soon as possible by the responsible Consultant Surgeon/Anaesthetist. In event of death, all lines, tubes and other equipment connected to the patient must left in place. If there is any cause of concern regarding the placement of endotracheal tube, its position should be confirmed and recorded by an independent anaesthetist. The notes need to be sent to Medical Examiners (ME) office for review.	There may be a post-mortem or inquest depending on the outcome of the coroner's referral (if appropriate).
Support for relatives and interview with family	Breaking bad news should be done in person. Speak to the family as a team. Identify a spokesperson. A senior colleague should accompany trainees and SAS doctors for support. A team approach is vital, with a senior member of the anaesthetic, surgical and nursing team responsible for the patient present.	Breaking bad news should not be done over the telephone. It will be necessary to invite the relatives to come to hospital informing them that some complication occurred, but no details should be given. Explain the 'bad news' first in a straightforward and honest way, followed by answering any questions which may arise. If no cause has been identified, do not speculate or offer an opinion. Use an interpreter in cases where understanding of English is limited. Give the family the time to take in the bad news and do not give them too much information initially.

		Giving an apology does not imply fault.
Equipment and Drugs	The clinical director or a consultant not involved should take responsibility for checking the patient and equipment.	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. See Appendix 1. The person in charge of the Theatre will be responsible in removing and quarantining any equipment and devices that have been involved in the incident. All anaesthetic equipment, drug syringes and ampoules should be kept and moved to a secure room for investigation. An accurate record should be made of all the checks undertaken including time date and inspection. All disposable equipment including syringes and ampoules, airway devices etc. should be kept in a secure box. Further investigation may be required by medical equipment maintenance personnel, manufacturers or toxologists. (See Appendix 1)
Team De Brief	Team Debrief at a time to suit all staff and preferably within a few hours of the catastrophe. Use of TRiM practitioners (see paragraph below).	Several surveys have highlighted that clinical staff feel debriefing would be useful and should occur. The aim is to provide and record information, and to gain feedback while details are still fresh. It is also useful to allay anxieties or misconceptions experienced by members of the theatre team.
Dealing with media	A trust manager trained with dealing with media should be the only person communicating with them	The media may try to approach staff at the hospital or at home. All media enquiries should be directed to the trust manager.

Trauma Risk Incident Management (TRiM) Practitioners

TRiM is a peer support approach that aims to help people who have experienced traumatic or potentially traumatic events. The TRiM session is designed to provide individuals with a safe and confidential space to process their experiences and have the impact of the experience assessed. TRiM is not a replacement for traditional counselling or therapy but focuses on the immediate aftermath of a traumatic event. It is intended to provide individuals with support they need to begin the healing process and likelihood of developing long term mental health issues.

If it is deemed a TRiM assessment is necessary / beneficial or if you would like to know more, please contact 01332 787703 or email UHDB.support@nhs.net.

5. Documentation Controls

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6. Appendices

Appendix 1

Medical devices involved in critical incidents