Worcestershire Acute Hospitals NHS Trust

Care of the Deceased Patient in Theatre

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

This guidance aims to guide practitioners through managing a death in theatre. It should be utilised as a reference for this unusual but tragic event.

Nursing Care should not stop when the patient dies. Last offices, sometimes referred to as 'laying out', is the term for the nursing care given to the deceased patient which demonstrates continued respect for the patient as an individual (Dougherty and Lister, 2008).

This guideline is for use by the following staff groups :

- Perioperative practitioners
- Anaesthetists
- Surgeons
- Health care assistants
- Porter staff
- Bereavement office staff

Lead Clinician(s)

James Hutchinson	Consultant Anaesthetist
Approved by Theatre, Anaesthetics Governance meeting on:	17th May 2023
Review Date: This is the most current document and should be used until a revised version is in place	17th May 2026

Key amendments to this guideline

Date	Amendment	Approved by:
May 2023	New document approved	Theatre, Anaesthetics Governance
December 24	Minor change to wording for cannula and drainage devices on page 3	Dr Hutchinson

Care of the deceased patient in theatre

Introduction

The majority of theatre staff will unfortunately be involved with a sudden patient death in theatre. This is an unusual but tragic event and this guidance aims to give guidance on steps required.

The objectives of this guidance include:
- Describing the immediate measures which happen after a patient death in theatre
- Describe care of the relatives and standards of disclosure
- Advice on effective support for staff involved

Definitions

'Last Offices' is the care given to a deceased patient which demonstrates our respect for the dead and is focused on maintaining dignity and fulfilling religious and cultural beliefs.

'First Victim' Patient or relative affected by sudden death in theatre.

'Second victim' Healthcare providers involved in an unanticipated adverse event who are traumatised by the event and may feel personally responsible for the outcome. Many feel as though they have failed the patient, doubting their clinical skills and knowledge base.

Immediate Actions

Please see Appendix 3 for these actions in checklist format.

Ensure there are accurate and contemporaneous records
- Legible accurate and timed records of the event should be kept. If notes cannot be made immediately then a full retrospective account must be made as soon as possible.

Complete an Incident report form
- All deaths should have an incident form completing as close to the event as possible.

Death should be formally certified and documented according to local guidelines
- This is the responsibility of the medical team involved

Ensure the death has been communicated
- Senior anaesthetic and surgical clinicians should be informed (if not present)
- The ward must be informed
- The patients GP should be informed by telephone or email by the clinician responsible for the patient
- The Coroner should be informed (see section on Coroner referral below)
- Relatives must be informed (see section on Care of Relatives below)

Medical Equipment
- In the event of a death related to anaesthesia: keep all anaesthetic equipment, drugs, syringes and ampoules.
- Where there is suspected equipment failure then that piece of equipment should be isolated until a formal examination can happen

- If there is a potential hazard affecting the theatre the theatre or anaesthetic machine may be taken out of commission until further notice
- All lines, tubes and other equipment connected to the patient must be left in place. If there is concern about the placement of the endotracheal tube its position should be confirmed by an independent anaesthetist

Bereavement Office Support

- The Bereavement Office at WRH and the Alexandra Hospital are open Monday to Friday from 0900-16:00.
- Within office hours they should be telephoned to inform them of the death.
- The Bereavement Office will:
  - Be able to support the relatives and advise regarding the next steps
  - Ensure the relevant Bereavement booklet provided
- Outside of Office Hours the bereavement office should be telephoned and a voicemail left informing them of the death. The relatives must be advised to contact the bereavement office for further support in hours. The bereavement office will not automatically make contact with the relatives.

Offer Pastoral Support

- Check if the relatives would like the support of a Chaplain or other faith representative
- There is Chaplaincy support provided 24 hours a day, 7 days a week. A Roman Catholic Chaplain is also available at each site.
- The Chaplain can be contacted via the switchboard.
- For other faiths please contact the Chaplain on call and they can advise on links with a representative from another faith.

Prepare the body for viewing

- See appendix 1 for list of equipment that may be required.
- The act of 'Last Offices' for a body should be carried out within 4 hours of death. The aim is to show respect and prepare the body for viewing by the relatives.
- Follow infection control and good hygiene throughout all stages
- Wash skin, clean mouth and comb hair (unless specific religious preparation of the body is required)
- All lines, tubes and other equipment connected to the patient must be left in place.
- Wounds should be covered by a dressing
- Petroleum should be applied to lips. Oropharynx should be suctioned if patient is intubated.
- Name bands should be applied to the wrist and ankle
- Close eyelids
- Ensure cannula and drainage devices are spigoted to avoid leakage. Catheters should remain connected to a drainage bag which should be emptied.
- Dress the body in a shroud/cadaver bag
- Cover patients body with appropriate bedding
- Make a note of any pacemakers or implanted devices to alert mortuary staff

Care of relatives

- The relatives must be informed by the most senior team members present
- Bad news should not be given over the telephone. Relatives should be told there has been a complication and invited into the hospital.
- The relatives should be supported, either by family members or healthcare staff where needed.
- Communication with the relatives should happen in a quiet and comfortable room.
- Avoid private conversations in communal areas (i.e. corridors)

- There should be a team approach to breaking bad news with senior members of the anaesthetic, surgical and nursing team responsible for the patient.
- Apologising is not an admission of guilt
- A second meeting may be necessary to enable questions after the news has sunk in
- The relatives should be offered a chance to view the patients body
- The Bereavement Booklet should be provided to the relatives. To ensure the most up to date booklet is provided the Bereavement Office should be asked to provide a booklet. Out of hours please inform the relatives that the Bereavement Office will post a booklet out as soon as possible. Out of hours it is important to leave a message (i.e. voicemail) with the Bereavement Office informing them of the death.

Offer the relatives a chance to pay their respects to the body

- Relatives should be allowed to view the body in a private and uninterrupted area. Please ensure the relatives are given sufficient time to spend with the patient.
- An anaesthetic room or curtained off area of recovery may be appropriate depending on the time of day
- The relatives should be directed to use a private waiting area close to the theatre complex. The critical care relatives area could be utilised.
- If the patient's body is transferred to the mortuary before the relatives have had a chance to see them in theatre then a viewing can be arranged in the chapel of rest.
- Within normal hours please contact the mortuary to arrange this.
- Out-of-hours chapel of rest viewings are in exceptional circumstances only and must be agreed by the senior nurse on duty. The senior nurse will liaise with porter teams to arrange for a suitable time. Please consult local guidance on the procedure.
- Please consult local guidelines for details. At the time of writing the senior nurse for each site (Alex or WRH) should be contacted to arrange a viewing in the mortuary.

Consider if organ donation is suitable

- There is a 24 hour contact number 0300 020 3040 which will connect to advice from a regional organ donation specialist nurse
- Patient may be a candidate but this needs discussion with the specialist nurse
- Generally it is advised that donation should not be initially discussed with the relatives, this will be undertaken by the specialist teams in the event of donation
- The specialist donation team will need to ensure permission for donation is granted by the coroner.

Arrange for transfer of the patient's body to the mortuary

- After the relatives have viewed the body the patient should be transferred to the mortuary
- The porter service should be contacted to transfer the body to the mortuary
- The hospital case notes should be sent to the Bereavement Office. Out of hours the notes should be kept in theatre and then transferred to the Bereavement Office.

Arrange for patient's property to be brought to the relatives in theatre

- Patients property may still be on the ward
- This property should be brought to the relatives
- Relatives must not be asked to retrieve this property themselves as this is distressing

Coroner Referral Process

Deaths due to a person undergoing any treatment of procedure of a medical or similar nature must be reported to the local Coroner.

This is the responsibility of the patient's consultant.

Relatives should be advised that a referral to the coroner will be made. Further details about the Coroner process will be provided by the Bereavement Office.

Staff support

The unexpected death or harm to a patient will have an effect on the team. Team members may be stressed and traumatised. As well as the first victim, consideration must be given to the second victims, i.e. those staff members involved.

In an unexpected and sudden death, the team involved will be traumatised and stressed. Ideally team members will be able to leave work for rest and recuperation. Further cases should be reallocated or postponed to another day. It is recognised that in emergency lists this may not be possible, staff should be given long enough to feel safe to continue working.

The following steps may be useful and should occur. Full details are in Appendix 2. Some useful points for staff support are also included. Appendix 4 is a useful staff information leaflet.

1. **Immediate debrief.** An informal session which happens within hours of the incident. The aim is to provide immediate support. Ground rules must be respected (no hierarchy / it is fine to just listen / no blame / immediate debrief is confidential but lessons learned will be shared).

   The team should be thanked for their involvement. An open discussion about what has happened and a check on how team members are feeling.

   The team should be checked to see if they are safe to return to work. Team members names and contact details should be taken and passed onto the clinical lead. The clinical lead may designate another consultant to ensure team members are contacted and offered the chance for a further debrief.

2. **Post event follow up.** This is another group discussion in the 48 to 72 hours after the incident. The aim is to update the team and check on the psychological mood and to provide ongoing support. Any issues should be raised. Liaise with the clinical psychology service to organise for further follow up. Staff can access free counselling. For confidential support contact the occupational health department via switchboard or email wah-tr.OccupationalHealth@nhs.net.

3. **After Action Review Meeting.** A third meeting should be organised within 1-4 weeks of the incident. This meeting is to to update the team, provide learning and ongoing support. Ideally this will be facilitated by a person who was not involved in the incident. Again ground rules must be respected (respect each other, there should be clarity in learning, link lessons to future actions, be honest).

   During this debrief issues can be raised. Things that worked well and that didn't work well can be discussed. Would anything be done differently? What were the strengths of the team? Issues raised should be recorded. Consider where this learning needs to be shared. Liaise with clinical psychology if team members need further support

   In some incidents (i.e. where there is significant ongoing distress) a different type of meeting may be needed called an 'Critical Incident Stress Debrief'. This is facilitate by clinical psychology.

4. **Counselling services –** Staff can access free counselling. For confidential support contact the occupational health department (via switchboard) or email wah-tr.OccupationalHealth@nhs.net. Staff who are already receiving psychological therapy via their GP or other provider cannot be taken on by the Occupational Health Counselling Service.

In an unexpected and sudden death the team involved will be traumatised and stressed. Ideally team members will be able to leave work for rest and recuperation. Further cases should be reallocated or postponed to another day.

Kidderminster Treatment Centre

A death at the KTC is recognised to be a very rare event. The principles of the above SOP can be followed.

There is no mortuary at the KTC which means the body will need to be transferred to the mortuary at WRH or the Alexandra Hospital.

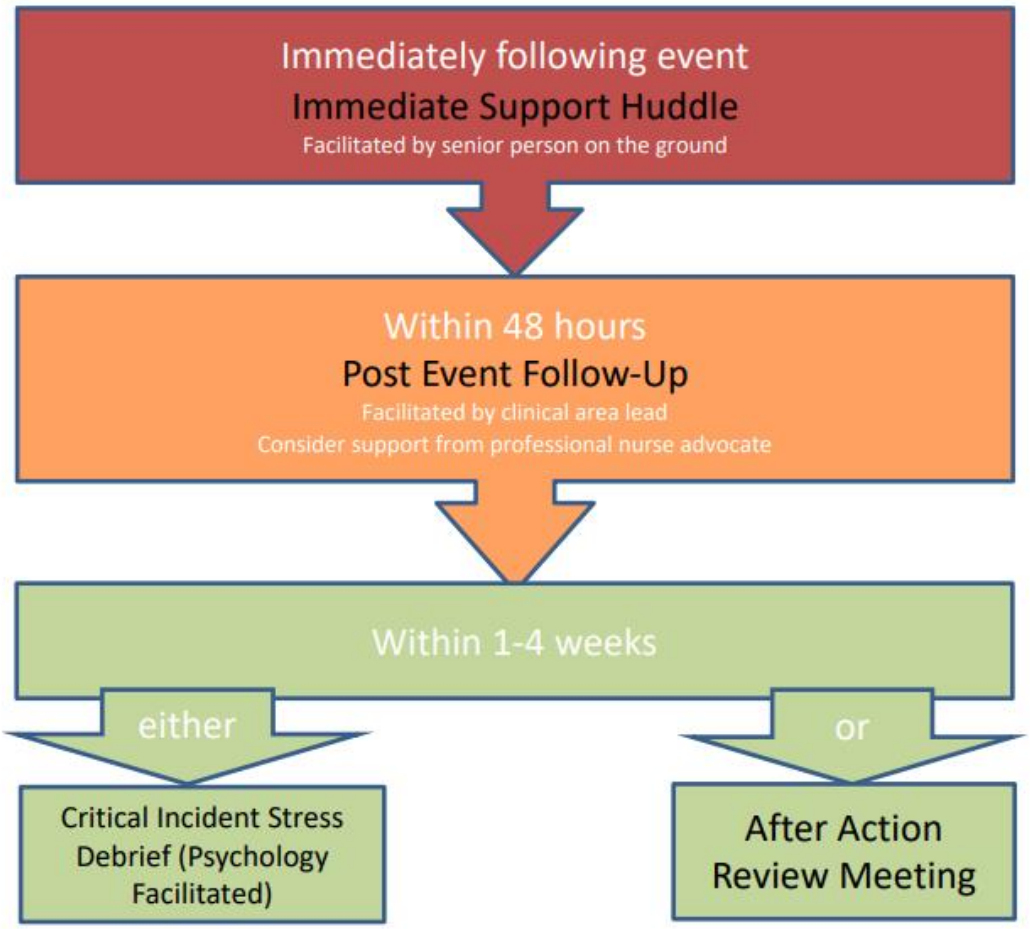
Useful telephone contacts (correct at time of publication)

Bereavement Office Worcestershire Royal Hospital: via switchboard: 01905 763 333
Bereavement Office Alexandra Hospital: via Alex switchboard: 01527 503 030
Coroner
Mortuary Alex: 42083
Mortuary WRH: 39352
Occupational Health: Worcestershire Royal Hospital - 01905 760693

Appendix 1. Equipment list for 'Last Offices'

- Personal Protective Equipment (disposable gloves, aprons, goggles relative to the risk of body fluid exposure.)
- Gauze, waterproof tape, dressings and bandages if wounds or intravenous arterial lines and cannula are present
- Bowl of warm water, soap, disposable wash cloths and two towels.
- Receiver for collecting urine if appropriate.
- Plastic bags for clinical (yellow), household waste (black), laundry (red)
- Equipment for mouth care including equipment for cleaning dentures
- Identification labels x 2
- Record book for property and valuables
- Bags for the patient's personal possessions
- Clean sheet
- Shroud or patient's personal clothing if previously requested by patient, or clothes that comply with family or cultural wishes
- Body bag and labels for the body bag including labels that identify any known infection/disease

Appendix 2. Flow chart summarising debrief requirements after a traumatic event



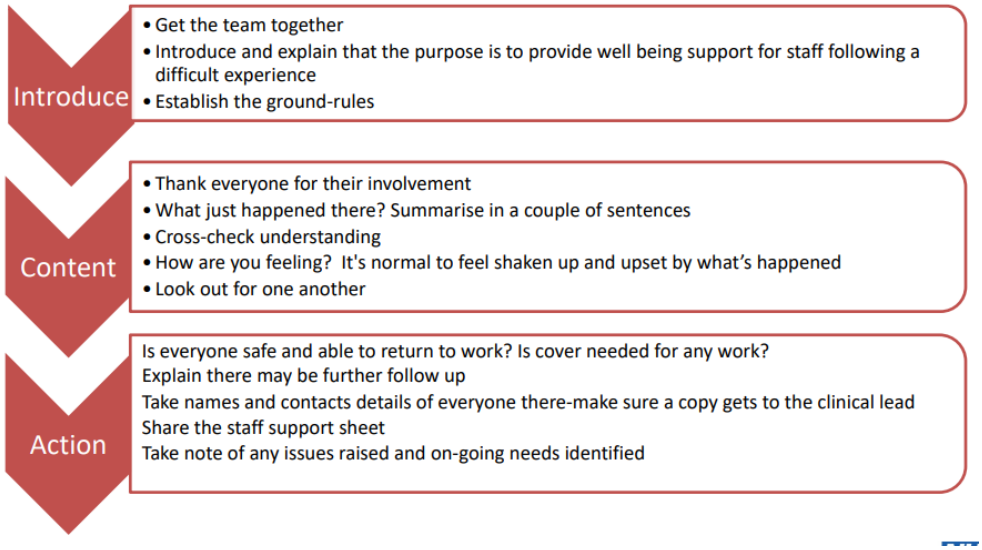
Which of these is indicated will be decided by the clinical area checking in with staff. Pervasive and continuing distress is an indication for psychology facilitated stress debrief

Appendix 2. Points to remember when supporting staff.

Staff Support after a difficult event

Appendix 2.
Immediate debrief guidance

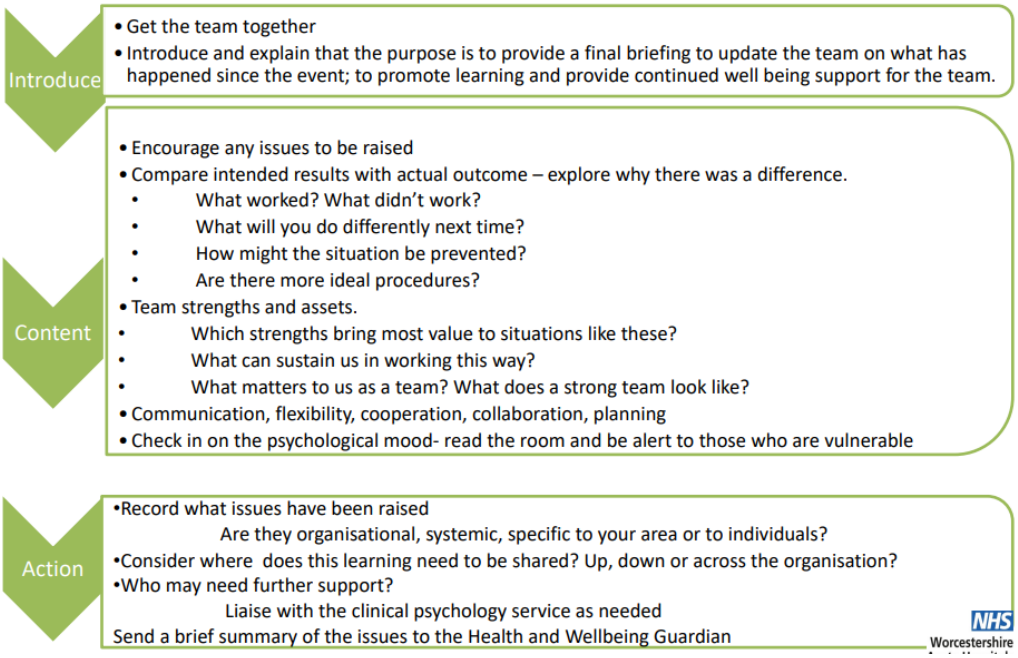
Immediate Support Huddle Facilitator Guidance (Debrief)



Ground Rules for facilitating the Immediate Support Huddle (Debrief)

Appendix 2.

After Action Review Facilitator Guidance



Ground Rules for facilitating the After Action Review

An After Action Review is about learning and cohesion – 'forward thinking accountability'.
Active participation, involvement, openness, and honesty are core components.

For the AAR process to be successful the team needs to discover for itself the lessons provided by the experience with a focus on team strengths.
The focus on improving a team's own learning and, as a result, its own performance. It is about team performance and not individual performance and learning is specific to, and about the team.
There is clarity in learning. Any lessons learnt are clearly understood and link to future actions.
Team trust is essential.
The more open and honest the discussion, the better.
It's OK to disagree. Blame and judgements are not a part of the discussion.
The review presents a final opportunity to 'check in' with regard to how team members have been affected by this incident and provide specific support as needed.

- You might be asked to write a statement.
- You might be asked to attend a 'round table' meeting to discuss the incident.
- Incidents can take weeks to investigate so don't expect a quick report.
- The findings should be shared with you – if you haven't heard anything and want to know then the SCSD governance team can help.

coroner – this is a factual account of your involvement in the patients care. Have a read of the guidance on the Anaesthetics Intranet page.

- It is possible that you might be called to give evidence at an inquest.
- Information about attending the Coroners court is on the Anaesthetics intranet page. You can also discuss this with any of the Anaesthetic or ICU Consultants.
- **Bear in mind: Requests for statements or attendance at court can happen many months after the event.**

Where can I find help?

- Inform your team leader / mentor / educational supervisor – they can signpost you to additional resources for help and support you if you need to write a statement or attend an inquest.
- Anaesthetic and Intensive Care Consultants, ICU band 7 nursing team and Theatre management team can provide advice and support.
- Anaesthetic Intranet page: you will find guides on writing statements and the Coroner's court process here, as well as some fantastic wellbeing resources.
- The Trust psychology service can provide individual and group support.
- Trust document WAHT-HR-002 'Supporting staff' is on the intranet and contains further generic trust-wide information.

Appendix 3. Checklist for actions in event of sudden death in theatre.

Ensure documentation is complete	
Complete Incident Report form	
Ensure death is certified by medical practitioner	
Communicate death to senior clinician in charge / ward / GP	
Relatives care - Ask relatives to attend for news about the patient - Use a private side room - Team approach to breaking bad news - Patients property should be collected and given to relatives	
Bereavement Office If death is in hours involve the Bereavement Office. For out of hours death, telephone Bereavement Office and leave a message. Ensure relatives are told to contact the Bereavement Office in office hours.	
Medical Equipment Ensure connected devices are left untouched Quarantine any equipment which could be faulty	
Contact organ donation nurse	
Body prepared as per the Last Office guidance	
Relatives are given opportunity to view body If body has moved to mortuary: In hours: contact mortuary to arrange viewing in Chapel of Rest. Out of hours – contact site bleep holder.	
Pastoral Support Should be offered. Chaplains can be contacted via switchboard	
Staff support Initial debrief with staff details recorded Clinical Lead to be contacted about further follow up of team members (may delegate to another staff member) Clinical psychology contacted Ensure staff know how to get support in the initial few days (GP, local counselling services, occupational health) Ensure staff are given 'Supporting Staff After a Critical Incident' leaflet (Appendix 4)	

Appendix 4. Leaflet for staff support in event of unexpected death.

Supporting Staff after a Critical Incident

Worcestershire NHS
Acute Hospitals NHS Trust
Anaesthetics, Theatres & Intensive Care

You have been given this leaflet because you have been involved in a potentially traumatic event – different people react in different ways to stressful events. The information below provides some information about processes that might happen next and where you can find support and further help if needed.

Immediately after the event:

- 'Support huddle' – led by most senior person available.
- A chance to discuss the event and clarify uncertainties.
- Provide support for staff and signpost to additional help if required.
- Arrange short term arrangements for work responsibilities.
- Arrange a formal debriefing session if required.

Some days later- Debriefing:

- Ideally occurs within a week of the event.
- Supported by the Trust psychology service.
- Explores issues including: Sequence of events, experiences, reactions and methods to manage emotional responses.
- **It's not compulsory!** – some might not find it a useful process.

What might happen next?

Not all clinical incidents lead to further investigations, but if a traumatic and unexpected event has occurred, an investigation might be undertaken. If the patient died then the Coroner might be involved.

It's a good idea to write a statement of events as you remember them while they are fresh in your mind.

Serious Incident Investigations

- Fact finding exercise to work out what happened and if there was anything that could have done differently.
- Aim is to learn and improve rather than blame.
- You might be asked to write a statement.
- You might be asked to attend a 'round table' meeting to discuss the incident.
- Incidents can take weeks to investigate so don't expect a quick report.
- The findings should be shared with you – if you haven't heard anything and want to know then the SCSD governance team can help.

Coroner's Inquest

- An inquest is not a trial – it is an enquiry into who died, when and where they died and how they came about their death.
- You might be asked to write a statement for the coroner – this is a factual account of your involvement in the patients care. Have a read of the guidance on the Anaesthetics Intranet page.
- It is possible that you might be called to give evidence at an inquest.
- Information about attending the Coroners court is on the Anaesthetics intranet page. You can also discuss this with any of the Anaesthetic or ICU Consultants.
- **Bear in mind: Requests for statements or attendance at court can happen many months after the event.**

Where can I find help?

- Inform your team leader / mentor / educational supervisor – they can signpost you to additional resources for help and support you if you need to write a statement or attend an inquest.
- Anaesthetic and Intensive Care Consultants, ICU band 7 nursing team and Theatre management team can provide advice and support.
- Anaesthetic Intranet page: you will find guides on writing statements and the Coroner's court process here, as well as some fantastic wellbeing resources.
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Monitoring Tool

This should include realistic goals, timeframes and measurable outcomes.

How will monitoring be carried out?

Who will monitor compliance with the guideline?

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.	What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.)	Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'.	Who is responsible for the check? Is it listed in the 'duties' section of the policy? Is it in the job description?	Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference.	Use terms such as '10 times a year' instead of 'monthly'.
		Datix forms completed for deaths in theatre	12 monthly			12 monthly
		Initial debriefs happen	After events			

References

Catastrophes in Anaesthetic Practice – dealing with the aftermath 2005. Published by Association of Anaesthetists of Great Britain and Ireland.

Mortuary Assistance (Out of Hours) WAHT PAT 002 Worcestershire Acute Hospitals NHS Trust Pathway

Strategies for handling the aftermate of intraoperative death. Clegg et al. Continuing Education in Anaesthesia, Critical Care and Pain. Published August 2013

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Victoria Ker – Specialist Nurse in Organ Donation
Elaine Stratford – Bereavement Office Manager
Band 7 Theatre staff: Mark Butwell, Andy Fryer, Mark Southall
Theatre Matron – Kim Simpson
Sheryl Thomas – mortuary manager
Rob Glasson – Clinical Director Anaesthesia and Theatres
Toni Brunning – Departmental Wellbeing Officer and College Tutor
Sue Aston – Quality Governance Manager Surgery

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	NA	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	NA	
7.	**Can we reduce the impact by taking different action?**	NA	

If you have identified a potential discriminatory impact of this key document, please refer it to Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval