

## Care of the Imminently Dying or Deceased Patient in the Perioperative Clinical Area

Issue Date	Review Date	Version
February 2019	February 2024	V1

### Purpose

This Standard Operating Procedure (SOP) identifies the correct procedure to be followed for End of Life Care, for patients who have either died in Theatre, or whose death is imminent, anticipated within the next 1-2 hours.

### Who should read this document?

All perioperative personnel within Plymouth Hospitals NHS Trust and including Tavistock Hospital

### Key Messages

This SOP will ensure that there is a system in place and a correct procedure to be adhered to, during the time immediately leading up to and following the death of a patient in the Perioperative Clinical area.

### Core accountabilities

<b>Owner</b>	Michelle-Jane Smith – Matron, Jenny Pitt – Clinical Quality Manager
<b>Review</b>	Theatre Policy and Standards Committee
<b>Ratification</b>	Somaiah Aroori HPB & Renal Transplant Consultant
<b>Dissemination</b>	Theatre Matrons
<b>Compliance</b>	Theatre Clinical Governance Committee

### Links to other policies and procedures

Hospital Bereavements APN  
 Care of Deceased Patients Policy  
 Resuscitation Policy  
 Handling of a Cadaver Policy

### Version History

<b>V 1</b>	February 2019	SOP for Care of Imminently Dying or Deceased Patient in Perioperative Clinical Area Review
------------	---------------	--

*The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.*

**An electronic version of this document is available on Trust Documents on StaffNET. Larger text, Braille and Audio versions can be made available upon request.**

Standard Operating Procedures are designed to promote consistency in delivery, to the required quality standards, across the Trust. They should be regarded as a key element of the training provision for staff to help them to deliver their roles and responsibilities.

<b>Section</b>	<b>Description</b>	<b>Page</b>
1	Introduction	3
2	Definitions	3
3	Regulatory Background	3
4	Key Duties	4
5	Procedure to Follow	5
6	Document Ratification Process	8
7	Dissemination and Implementation	8
8	Monitoring and Assurance	8
9	Reference Material	8
Appendix 1	Role of SNOD, early identification of potential organ donors _NICE clinical guideline 135.	9
Appendix 2	Early identification of potential organ donors - NICE clinical guideline 135	10

# Standard Operating Procedure (SOP)

## Care of the Imminently Dying or Deceased Patient in the Perioperative Clinical Area

### 1 Introduction

The purpose of this SOP is to address the issues encountered by Perioperative Clinical Staff when a patient dies, or is expected to die imminently in the perioperative clinical area.

This document will outline the general principles concerning care of the deceased or imminently dying patient ensuring consideration is given to different aspects of care, including organ donation and care of the body, end of life rituals and pastoral/spiritual care of patient, relatives and staff involved and that legal obligations are met.

The scope of this SOP is directed at staff immediately involved in managing the care of the patient and their relatives or significant others.

This SOP is restricted to staff working within the Perioperative Clinical setting.

### 2 Definitions

Donation following Circulatory Death (DCD) takes place when death has been established following irreversible cessation of the heart and confirmation of death. DoH (2009)

Donation following Brain stem Death (DBD) takes place when neurological death has been confirmed in ICU following brain stem testing.

SNOD / SPOD: Specialist Nurse/Practitioner in Organ Donation

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

### 3 Regulatory Background

CQC - Essential Standards of Quality and Safety

NICE - End of Life Care for Adults Quality Standard

NICE clinical guideline 135 2011 - Organ Donation for transplantation. Improving donor identification and consent rates for deceased organ donation

Academy of Medical Royal Colleges (2008) A code of practice for the diagnosis and confirmation of death

AAGBI (2005) Catastrophes in Anaesthetic practice- dealing with the aftermath. AAGBI, London 2005

**The Clinician (Surgeon/Anaesthetist):**

- Recognises and confirms imminent death or actual death of patient.

**Duty Floor Anaesthetist (DFA):**

- Confers with Clinician/Senior Team Leader
- Addresses organisational issues, allowing opportunity for dying/deceased patient's anaesthetist to attend relatives/significant others.

**Matron/Duty Senior/Team leader of the day:**

- Liaise with above to provide support as required
- Liaise with Bed Manager and ward
- Cardiac staff to liaise with allocated ward/CICU
- As required, liaise with contract portering staff to transfer the patient to the mortuary, within the hour.
- Delegate responsibility to designated person, who will implement SOP.

**Specialist Nurse in Organ Donation (SNOD)**

The SNOD will be involved for those patients' undergoing organ retrieval and will:

- Determines potential to donate organs in discussion with clinicians.
- Checks organ donor register to see if patient consented to organ donation.
- Discusses potential donation with next of kin and formal consent
- Contacts the coroner
- Organises all aspects of organ referral and retrieval in association with theatre and critical care staff.
- Assists in theatre with retrieval and last office, supports staff.

**Staff member:**

- Facilitates SOP, with another staff member, providing support as required

**Clinical Educator**

- Responsible for ensuring all new staff are familiarised with this SOP and process.

## 5 Procedure to Follow

A multidisciplinary approach is required in response to managing the circumstances surrounding the imminently dying/deceased patient in the Perioperative Clinical setting and implementation of this SOP for their care, in conjunction with due regard for any specific cultural, spiritual or religious beliefs, will ensure best practice.

All dying patients should be considered for organ donation and their wishes and that of their next of kin established before death occurs (NICE,2011; Appendix 1), however this is outside the scope of this SOP.

- In the event of a patient death or imminently dying, the clinician responsible for the patient's care will inform the Perioperative team leader of the situation and anticipated timescales of the patient's death.
- Surgeon/Anaesthetist should contact the patient's next of kin/significant others to advise of the patient's prognosis. This conversation should be undertaken face to face where ever possible. (SOP: Supporting the team following sudden death or catastrophic event, 2019)
- Dignity of the patient must be maintained and it is therefore essential that when it is anticipated that the patient's death will not be for some hours that they are transferred to an appropriate area where their care can be maintained and any family or loved ones can be with them.
- Patient's who have been transferred from the Emergency department – will not have an allocated ward bed – it is therefore essential that the Bed manager is informed and a ward bed is identified for patient transfer if appropriate at the earliest opportunity.
- **Where the patient is from an inpatient ward** – the team leader must inform the ward of the patients' change in circumstances and agree the plan for end of life care.
- **In circumstances where no bed is available** – the patient will be cared for within the Recovery unit. A designated nurse will be assigned to remain with the patient and to support the next of kin or significant others.
- **Imminent death:** in circumstances where there is no time to transfer the patient – they will be cared for in the recovery unit or if necessary within theatre.
- **Next of kin/significant others:** will be provided with access to Critical Cares relatives rooms. The Team leader must contact the Coordinator for critical care to check room availability.
- **Pastoral care:** Routinely consider the wishes and general preferences of the patient, taking into account their culture, religion and spiritual beliefs. Consider wider aspects of pastoral care for Next of Kin/Significant others and the multidisciplinary team. The on call duty chaplain can be paged day and night and can provide additional holistic support including reflect debrief support.

- It is strongly recommended that pastoral support is sought when the patient is a child.
- **Time out:** consider emotional welfare of the multidisciplinary team, allowing timely interruption of organisational flow (SOP: Supporting the team following sudden death or catastrophic event, 2019)
- **Debrief:** Debrief is undertaken routinely within UHP, however were an unexpected death or catastrophic event occurs it may be necessary to debrief on the specific case.
  - Clinician and senior team Leader on Duty to decide on level of debrief required, who should lead debrief and where and when it should take place.
  - Following debrief if not already discussed a decision should be made as to the ongoing running of the theatre lists
  - During debrief the Senior Team leader commits to contact all members of the team within 7 days to ascertain whether further support is necessary

## Care of Deceased Patient

### Clinician's responsibility:

- To discuss and gain agreement with the Theatre Team that patient has died.
- To certify death
- To contact the Next of Kin/Significant Others

### Team Leader responsibilities:

- Liaise with the Duty Floor Anaesthetist (DFA) to address organisational issues.
- Designate a member of staff as Patient Advocate, to provide patient care, following the "Care of the Deceased Patient Policy".
- Designate another member of staff to provide support for Patient Advocate.
- Consider paging the "On Call Duty Chaplain", whatever the time of day, for additional holistic support.

### If death occurs in the Perioperative Environment:

- All drains must be left in situ.
- Catheters and cannula should be closed with a spigot.
- Wounds should be covered with a dressing.
- Stomas treated as open wounds and covered with a dressing.
- A cadaver bag must be used
- Endotracheal or tracheostomy tubes can be removed when there is no suspicion that the positioning has been instrumental in the cause of death.
- **Ensure ALL** correct documentation has been completed in accordance with Check List for Last Offices "Care of the Deceased Patient Policy" – (See Appendix 2)
- Bariatric Cadaver bags are available for morbidly obese patients.
- See Appendix 1 for Check list for Last Offices

### Transferring the Patient to the Mortuary

- The Patient Advocate should remain with the patient until the deceased patient is taken to the mortuary.
- **Hospital Case Notes must** be tidied and sent to the Bereavement Office in hours/out of hours they are sent back to the ward from where the patient came from **NOT** sent to the Mortuary. Cardiac patients Hospital Case Notes sent to CICU
- If a patient is transferred to the mortuary before the Next of Kin/significant others have had chance to see them. The on call mortuary technician should be contacted to arrange an appropriate time to visit, escorted by a senior nurse

## **6 Document Ratification Process**

The design and process of review and revision of this policy will comply with The Development and Management of Formal Documents.

The review period for this document is set as default of five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be reviewed by the Theatre Policy and Standards Committee and ratified by the Director / Clinical Governance lead.

Non-significant amendments to this document may be made, under delegated authority from the Director / Clinical Governance lead, by the nominated owner. These must be ratified by the Director / Clinical Governance lead.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades who are directly affected by the proposed changes.

## **7 Dissemination and Implementation**

Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Formal Documents.

The document owner will be responsible for agreeing the training requirements associated with the newly ratified document with the named Director / Clinical Governance lead and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

## **8 Monitoring and Assurance**

Monitoring of adherence to this SOP will be via the review of working practices and monitoring of any incidents. This will be undertaken by the Matrons and any concerns raised via the Theatre Clinical Governance Group.

## **9 Reference Material**

AfPP (2011) Standards and Recommendations for Safe Perioperative Practice

NICE End of Life Care for Adults Quality Standard

NICE clinical guideline 135 (2011) - Organ Donation for transplantation. Improving donor identification and consent rates for deceased organ donation

Academy of Medical Royal Colleges (2008) A code of practice for the diagnosis and confirmation of death

**Early identification of potential organ donors - NICE clinical guideline 135****Specialist Nurse in Organ Donation (SNOD)**

- Determines potential to donate organs in discussion with clinicians.
- Checks organ donor register to see if patient consented to organ donation.
- Discusses potential donation with next of kin and formal consent
- Contacts the coroner
- Organises all aspects of organ referral and retrieval in association with theatre and critical care staff.
- Assists in theatre with retrieval and last office, supports staff.

**Prepare the body (for viewing)**

- Follow guidance in Handling Cadaver Policy
- Ensure dignity, respect and security of deceased at all times.
- Position body on back with support of one pillow.
- Close eyelids.
- Insert dentures and close mouth – record in patient's notes.
- Record any Implanted Cardiac Defibrillators in situ, to alert Mortuary staff.
- Leave cannulae, catheters, wound dressings etc. in situ, record in patient's notes, using body map if necessary.
- Ensure all tubes are spiggoted and wounds dressed to avoid leakage. Record in notes
- Wash skin, clean mouth and comb hair, unless specific religious preparation of the body is required.
- Dress deceased in a shroud.
- Any jewellery removed should be documented in the patient record and property book.
- Jewellery requested by family to be left in place must be recorded as jewellery left on the patient and secured with tape.
- Fit patient's ID bracelets to wrist and ankle.. If existing ID bracelet has become illegible, it should be replaced.
- Cover the patient with appropriate bedding.

**Prepare the deceased patient for transfer to the mortuary:**

- Once family have attended the deceased, prepare for transfer to the Mortuary.
- Wrap the deceased in a clean sheet and secure with tape.
- Place the deceased in a body bag if leakage of fluids is likely.
- Complete body identification form(s) and secure to the sheet or body bag in the chest area.
- Record all care given and any clinical devices remaining in the body – use body map if necessary.

**Prepare the Patient's Property – Check list B**

- List all the patient's property – checking contents with a second person.
- Record all valuables in Property Book, including jewellery removed from the deceased – to be logged with the Cashier for safe keeping.
- Valuables and/or property removed by the family should be recorded at the time.
- Place property in patient's bag or Hospital Property bag – carefully and tidily.
- Soiled clothing being returned to the next of kin, needs to be in an alginate bag and labelled appropriately.
- It is best practice to inform the Next of Kin/Significant other if there is soiled items within the patients' property and to offer to remove this and dispose of this so that they do not need to handle this. If soiled items are disposed the consent to do so and items should be listed in the patient record.

**Information to family/relatives/significant others – Check list C**

- Consider the need for Communication Support (e.g. signer/translator)
- Details of any Coroner or Hospital post-mortem needed – clinicians to discuss.
- Information regarding the opening hours of the Bereavement Office.
- Arrangements for viewing the body at a later stage in Sir Jules Thorn Viewing Suite, Level 4 – viewing arranged through Bereavement Office.
- Ascertain any known wishes regarding organ/tissue donation – check NHS Organ Donor Register (01179 757575) – refer to Donor Transplant Co-ordinator if registered, carried a Donor Card, or family agree.
- Information leaflet “What to do after Death”
- Information given and discussions held with family must be recorded in the Patient’s notes.