ACECC
Anaesthesia Continuing Education Coordinating Committee

Review Resource Document 11 (2011)

WELFARE OF ANAESTHETISTS SPECIAL INTEREST GROUP

AFTER A MAJOR ANAESTHETIC MISHAP

INTRODUCTION

A Major Mishap or Critical Incident is defined as "an incident which may have (a "Near Miss"), or has, potential to produce harm to a patient".

Following such an incident, there should be processes in place to address needs in four different areas:

- The patient and/or relatives: Breaking the Bad News (Resource Document, RD 10)
- The anaesthetic and its environment: After a Major Mishap (RD 11)
- The team involved in the incident, and the "second victim" – the person directly concerned in the incident: Critical Incident Support (RD 05)
- Root cause analysis – to determine the various contributing factors leading up to the incident

It is the responsibility of all departments, private practitioners, private anaesthesia groups and staff in anaesthesia workplaces to establish a process for dealing with the aftermath of a major mishap, "critical incidents" or other distressing incidents.

This should include the encouragement of a formal or informal mentor system (see RD 08 Mentoring and Peer Support Programs) and peer support networks.

THE ANAESTHETIC AND ITS ENVIRONMENT, THE THEATRE, THE LIST

The other/duty anaesthetist should arrange for the surgical equipment, procedural equipment, and anaesthesia delivery systems, drugs, and equipment to be isolated, if applicable, for later careful examination.

The other/duty anaesthetist should arrange for a relief anaesthetist to carry on with immediate other duties, if applicable. Consideration should be given to relieving all involved staff from immediate other duties.

The other/duty anaesthetist should inform ward staff, hospital administration and referring doctors.

Where there is an adverse incident which may lead to a medico-legal process, it is important that appropriate hospital protocols be followed to notify hospital management and relevant insurers, and that legal advice be obtained at the earliest practical opportunity.

An account of the FACTS of the mishap (not opinions), as known at the time of writing, should be drafted, edited and written, as soon as possible after the event, for hospital records, the personal records of the individual involved, his/her medical defence organisation, and possibly the coroner. The written account should NOT include speculation on the causes of the mishap.

This account is of particular importance if medico-legal action is anticipated.

The account should be discussed in its draft form with the individual's mentor, and his or her medical defence organisation if medico-legal action is a possibility.

DO NOT ALTER ANY EXISTING NOTES MADE DURING THE CASE.

Personal copies of all relevant documents should be kept by the individual(s) involved.

THE PATIENT/RELATIVES

(see RD 10 Breaking Bad News)

The other/duty anaesthetist should arrange for the next of kin of the patient to come to the hospital, if applicable.

A structured team interview should be arranged. (Both proceduralist and anaesthetist should be present. A more senior anaesthetist may be best placed for this task, if the anaesthetist involved is junior).

Training for staff conducting such interviews should be undertaken on a regular basis

Contact with next of kin should be maintained, if applicable, particularly if the patient is still alive and/or critically ill.

THE TEAM AND THE SECOND VICTIM – THE PERSON DIRECTLY CONCERNED IN THE INCIDENT

(see RD 05 Critical Incident Support).

Immediately after the event, there may be a need for informal defusing of emotions; this may include all staff involved in the incident. The potential for distress must be acknowledged.

Counselling should be offered in a timely fashion to all staff directly involved. Some staff will be able to deal with the stress of the mishap by themselves, or with the help of family and friends. Others will need professional support. An "open door" policy should be instituted for any who initially refuse support.

Individuals and organisations providing professional support to individuals after a "critical incident" or other distressing situation may include the individual's general practitioner, and other individuals or organisations as listed below*. Professional support resources in each area or region should be identified in advance by a designated person (or persons) in each department or group.

Contact a friend or senior colleague (mentor) as soon as possible for advice and support, and inform another anaesthetist, such as the duty anaesthetist.

It is important to recognise the second victim's potential for significant on-going personal stress following a major mishap, "critical incident", or other distressing situation. This stress may be magnified if there is the potential for medico-legal action. Individuals should be encouraged to maintain on-going contact with their general practitioner, mentor(s) and support personnel.

ROOT CAUSE ANALYSIS (RCA)

An inquiry into causal factors culminating in the adverse incident (root cause analysis) should be conducted by the appropriate reviewing body in the health care facility or institution. Lessons learned from RCA will improve subsequent patient care.

WHO CAN YOU CALL ON?

Trusted colleague and/or peer
Mentor (s)
General Practitioner
Supervisor of Training or College Tutor
Employee Assistance Program in your hospital
Doctors Health Advisory Service (DHAS) Australia and New Zealand
BMA Counselling and Doctor Advice Service (UK 08459 200 169)
Departmental/divisional support person
Psychologist
Psychiatrist
WOA SIG representative
Medical Board/Council
Lifeline (Samaritans UK)

Further Reading

ANZCA College Professional Document
PS49 *Guidelines on the Health of Specialists and Trainees*

Australian Council for Safety and Quality in Health Care
July 2003. Open Disclosure Standard: A National Standard for Open Communication in Public and Private Hospitals, (www.safetyandquality.org/articles/Action/opendisclfact.pdf)

Bacon AK, Morris RW, Runciman WB, Currie M.
2005. Crisis management during anaesthesia:recovering from a crisis. Qual Saf Health Care e25.

Cyna A, Andrew M, Tan SGM, Smith A.(eds)
2010 Handbook of Communication in Anaesthesia and Critical Care. A Practical Guide to Exploring the Art. ISBN 978-0-19-957728-6

Manser T, Staender S.
2005 Aftermath of an adverse event; supporting health care professionals to meet patient expectations through open disclosure. Acta Anaesthesiol Scand.

Mitchell AM, Sakraida TJ, Kameg K.
2003 Critical Incident Stress Debriefing: Implications for Best Practice. Disaster Management Response 1: 46-51.

Tan H. 2005 Debriefing after critical incidents for anaesthetic trainees. Anaesth Intensive Care 33: 768-72.

Todesco J, Fasic NF, Capstick J.
2010. The effect of unanticipated perioperative death on anaesthesiologists. Canadian Journal of Anesthesiology 361-367.

Wessely S, Rose S, Bisson J.

2000. Brief psychological interventions ("debriefing") for trauma-related symptoms and the prevention of post traumatic stress disorder. Cochrane Database Syst CD000560.

White SM. 2003 Death on the table. Anaesthesia 58: 515-8

Welfare of Anaesthetists SIG Resource Documents
RD 05 Critical Incident Support
RD 08 Mentoring and Peer Support Programs
RD 10 Breaking Bad News

Older references which may be useful

Bacon AK. 1989. Death on the table. Anaesthesia; vol 44:245-248

Buckman R. 1992 How to break bad news; Papermac

Davies JM & Bacon AK.
1990. When things go wrong part II. Anesth Rev XVII:50-3

Fisher M. June 1993. The Anaesthetic Crisis. Clinical Anesthesiology

McNab F
1983. When disaster strikes. The critical incident debriefing process. J Emerg Med Services :36-9

Mitchell JT.
1988. After the catastrophe. Australasian Anaesthesia.

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ACECC is a joint initiative of the Australian and New Zealand College of Anaesthetists, the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists.

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