

MOR Patient Death Debrief

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Intraoperative Mortality



Approximately 40-50 million major surgeries are performed each year in the US

Intraoperative mortality: 0.333% (3.3 per 10,000 cases)



Introduction

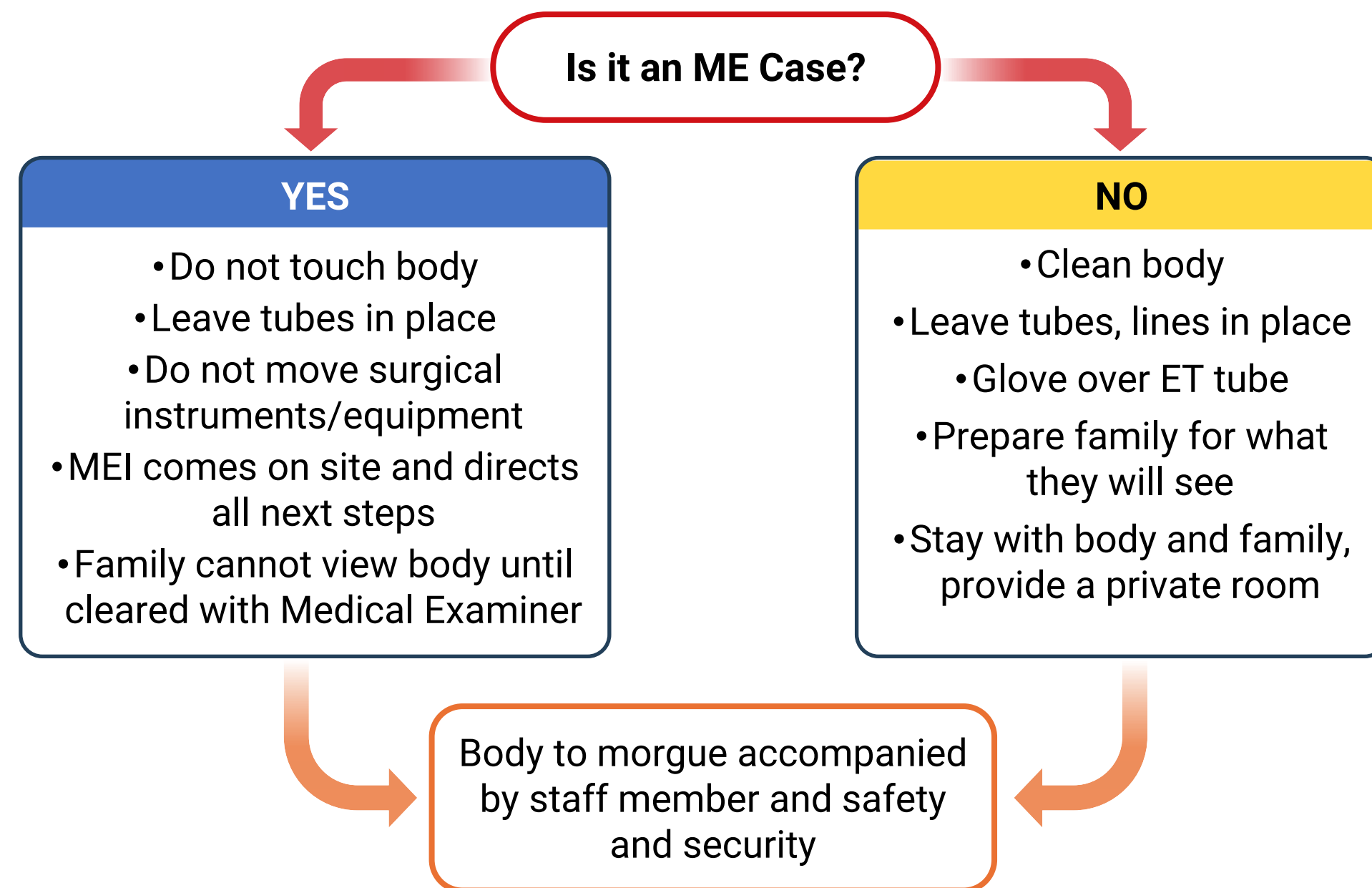
- Family was informed they could view the decedent; however, the case was later designated a Medical Examiner (ME) case, making viewing prohibited
- There was confusion regarding the appropriate location for family viewing of the decedent, resulting in an Incident Report
- Deaths in the OR are infrequent: surgeons, residents and RNs are unfamiliar with the process
- Insufficient communication regarding unexpected intraoperative deaths can create significant stress for the Operating Room team, the patient's family, and the Decedent Care Center

Methods

- Assembled key stakeholders to develop a communication tool for unexpected intraoperative deaths
- Stakeholders evaluated multiple scenarios to determine the most effective workflow and clarify each team member's role and involvement
- Stakeholders: Nursing, Social Workers, Clerks, Safety and Security, Decedent Care Center, Medical Examiner Office, Admission and Transfer Center (ATC), IT, Chaplain

Death Debrief

- Circulating Nurse Role** – Calls Charge RN, ATC, and Decedent Care Center
- Surgeon Role** – Talks with family, discusses autopsy, no offer to view body, calls OR to let team know family aware
- Charge RN** contacts Nursing Leadership and completes an incident report
- DCC Role** – Gathers information, scans medical record, calls ME if needed, calls circulator with ME determination
- ATC Role** – Calls DCC for review of death, calls donor network



Goals

- Develop and provide clear workflow instructions within the EPIC Intraoperative Navigator outlining the appropriate steps to follow in the event of an unexpected intraoperative patient death
- Enhance communication between multidisciplinary team members and patient's family
- Provide support for staff

Implications for Perioperative Nursing

- Workflow developed to guide staff in responding appropriately to an unexpected death in the operating room
- Death Debrief Workflow added to EPIC Intraoperative Navigator
- Annual review of death debrief procedures conducted with all staff by the Perioperative Educators
- Provided support to staff from COPE Team or Chaplain following the intraoperative death
- Charge nurses now have an established workflow to support consistent practice

2025 Results

- 5 unexpected intraoperative deaths occurred
- 5 postoperative Death Debriefs lead by COPE team
- No Incident Reports have been filed regarding family concerns about communication surrounding the decedent's death
- Ongoing updates to Death Debrief workflow