BOSTON MEDICAL CENTER
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Department of Anesthesiology

PATIENT *SAFETY* / PAUSE

March 2021 Newsletter

In each installment of our newsletter, we will share safety events from the prior month that have occurred in the Department of Anesthesiology at Boston Medical Center. By **raising awareness and providing education**, we strive to minimize these events and enhance the safety of our patients and staff.

Each month, we will introduce a new pertinent patient safety topic and feature an accompanying video presentation. These presentations will be created and hosted by Dr. Karolina Brook.

Safety Topic of the Month:

Fatigue

Click here to watch a discussion on safety issues related to medication administration. It is inspired by *OK to Proceed,* Chapters 10 and 11.

OK To Proceed?

Missed a week? Click on these links to review this month's topics:

Chapter 9: Workforce Planning
Chapter 10: Fatigue and Sleep Deprivation
Chapter 11: Physician Burnout
Chapter 12: The Impaired Practitioner

BONUS WEEK! Chapter 13: Time of the Day

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Recent Patient Safety Events

Feb - March 2021

1. **Line placement complication:** During central line placement, arterial puncture occurred. Pressure was held and decision was made to postpone procedure.
   Equipment issue: During the rescheduled procedure, TOF monitor was placed to assess for degree of muscle paralysis. At some point, it was noted that the BIS number increased to 98; additional medications (propofol, midazolam) were administered to prevent awareness. Once the TOF was disconnected from the patient, the BIS number went back down to 6. It was suspected that the BIS monitor had shown interference from the TOF monitor.

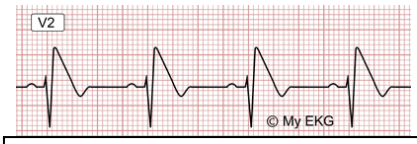
2. **Case cancelled preoperatively:** A case was canceled as the patient had held their diuretics but had continued to take their anticoagulant until day of surgery.

3. **Line placement error:** A patient with difficult IV access had an ultrasound-guided IV placed which worked well during preoperative nerve block. The patient was induced in the OR at which point the IV was found to be infiltrated. Since the patient had received propofol and appeared partially anesthetized, sevoflurane was administered via face mask. Ultrasound was used to attempt new IV placement; first attempt of a non-pulsatile structure yielded an inadvertent arterial line, which was promptly removed and pressure held. A second attempt under ultrasound yielded an adequate IV.

4. **Neuraxial complication:** A patient had a spinal placed in the sitting position using hyperbaric local anesthetic. At incision, patient was endorsing pain, thus decision was made to convert to general anesthesia.

5. **Neuraxial complication:** Decision was made to remove and replace an existing epidural on a laboring patient. The first attempt at replacement yielded concern for intravascular placement after two “test” 5cc doses of lidocaine with epinephrine, prompting removal and replacement. After successful placement, aspiration was negative, and “test” 5cc dose of lidocaine with epinephrine was administered, which resulted in a total spinal. The patient ultimately required Caesarean section.

6. **Case cancelled preoperatively:** A patient was seen in preop clinic and an EKG ordered, which showed Brugada pattern. No further followup was done. The patient was cancelled when this was reviewed on day of surgery, and the patient was referred to see cardiology.



Source: https://en.my-ekg.com/diseases/brugada-syndrome.html

7. **Skin/Soft tissue injury:** A patient was placed supine after several hours in the prone position. It was discovered that a BIS monitor had been placed on the forehead by the original care team at the start of the case. The patient had marks and indentations on the forehead related to pressure on the monitor.

8. **Near miss:** A patient was positioned with the usual precautions for a robotic procedure. Soon after positioning in steep Trendelenburg, it was noted the patient was sliding cephalad. The patient was repositioned on foam padding, and the surgeon made the decision to convert from a robotic to open procedure.

Ongoing QI Projects:

Improving intraoperative handoffs amongst providers

Assessing **transfusion requirements** on L&D

Emergency manual use during OR crises

Increasing the frequency of **on-time first case starts**

Decreasing turnover times in all operating rooms

Reducing perioperative **IV acetaminophen use**

Malignant hyperthermia **safety drills**

Questions, concerns, comments?

Are you interested in learning more about
patient safety in the Department of Anesthesiology?

Do you have **ideas** for future editions of this newsletter?

Contact Dr. Karolina Brook and share your thoughts!