Department of Anesthesiology

PATIENT *SAFETY */ PAUSE

May 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:

Noise Pollution

Click here to watch a discussion on safety issues related to noise pollution. It is inspired by *OK to Proceed,* Chapter 19.

OK To Proceed?

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

Chapter 18: Overlapping Procedures

Chapter 19: Noise and Distractions

Chapter 20: Social Determinants of Health

Chapter 21: Overtreatment

Recent Patient Safety Events

April - May 2021

1. **Case cancellation intraoperatively**: A morbidly obese patient was scheduled for a posterior craniectomy in the prone position. The case was cancelled intraoperatively due to inability to position this patient safely.
2. **Cannot ventilate / Difficult intubation / Cardiac arrest**: A patient with a pre-existing tracheostomy was induced with general anesthesia. The trach was removed and replaced with an endotracheal tube. The patient was difficult to ventilate, so the trach was replaced but still with difficulty ventilating. The patient became hypoxic and asystolic. Transoral intubation was performed with improvement of oxygenation and ROSC was achieved.
3. **Aspiration / Unplanned intubation:** A patient was undergoing a procedure in EP with MAC sedation when the patient suddenly vomited. The patient was intubated and remained hemodynamically stable.
4. **Cardiac arrest / Intraoperative death:** A patient with complicated medical history was undergoing a VATS pleurodesis for a loculated pleural effusion. The patient became profoundly hypotensive during the procedure deteriorating into PEA arrest and ultimately death.

Figure 1: Marked eye edema after being in prone position.

5. **Unplanned reintubation:** Patient was flipped supine after undergoing a thoracic laminectomy. Severe eye edema was noted (see *Figure 1*) raising concern for airway edema. Additionally, ETCO2 was elevated. However, a cuff leak was present, and the patient was following commands. The patient was extubated in the OR but had increased work of breathing and was able to express fatigue with breathing. The patient was re-intubated successfully with a Glidescope, which showed moderate airway edema. A PaCO2 sent right before reintubation returned with a critical value of 64.
6. **Transfusion reaction**: A patient received a unit of prbc while simultaneously receiving sugammadex prior to extubation and became profoundly hypotensive, which was responsive to a small dose of epinephrine. The patient then received a unit of FFP in the PACU and had marked facial edema, which was medically managed. Tryptase was negative. The transfusion medicine team diagnosed this as an allergic transfusion reaction.
7. **Unplanned reintubation / Hypoxia**: A patient with an unremarkable nasal intubation was extubated in the OR. The patient developed frank bleeding from the nare and began to desaturate. The patient was reintubated and the ETT was suctioned for 50-100c of blood.

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

Clinical skills **safety drills**

Perioperative patient **lactation** awareness and education

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!