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Department of Anesthesiology

PATIENT *SAFETY* / PAUSE

April 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:

Infection Control

Click here to watch a discussion on safety issues related to infection control. It is inspired by *OK to Proceed,* Chapter 16.

OK To Proceed?

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

Chapter 14: Procedural Sedation
Chapter 15: Trainees and Procedures
Chapter 16: Breaches in Infection Control
Chapter 17: The Proceduralist

Recent Patient Safety Events

March - April 2021

1. **Airway event/Aspiration**: A patient with recurrent pyogenic cholangitis and chronic indwelling biliary drain was undergoing spyglass choledocoscopy and lithotripsy for multiple intrahepatic biliary stones via the biliary drain. During emergence but prior to endotracheal tube removal, the patient vomited copious clear liquid which was suctioned. It was then discussed that 2L of irrigation fluid likely drained into the duodenum. An orogastric tube was passed and drained an additional 800mL of fluid. The patient was extubated with no clinical sequelae.

2. **Regional complication:** Patient with ESRD had an epidural placed for pain postoperatively from BKA. Platelets and coagulation values were appropriate, and the subcutaneous heparin dose had been appropriately held prior to epidural placement. Two hours after epidural placement, bleeding was noted to be excessive under the Tegaderm which did not abate despite the application of pressure. The decision was made to remove the epidural.

3. **Consent issue:** Patient with history of dementia was scheduled for suspension microlaryngoscopy with vocal cord biopsies. There were multiple issues obtaining anesthesia consent for the procedure, which was deemed necessary. After several hours, a health care proxy was identified, and consent obtained. Shortly after induction, the patient went into a narrow-complex tachycardia with pulse which resolved with intravenous magnesium, after which the patient developed profound hypotension. The procedure was deferred, and the patient was extubated and kept overnight for observation.

4. **Neuraxial complication:** A laboring patient requesting an epidural had a wet tap on first attempt. Two subsequent attempts (#2 and #3) at epidural placement yielded good loss of resistance (as well as confirmatory CSF via dural puncture technique in #2, and with low dose bupivacaine administered during #3 via combined spinal-epidural technique), but showed continuous CSF upon aspiration of the epidural catheter. These were thus assumed to be intrathecal catheters; however the patient was still uncomfortable despite administration of small doses of bupivacaine. Attempt #4 yielded adequate epidural catheter placement with no CSF on aspiration of the epidural catheter, and after dosing of the epidural catheter, patient was able to achieve adequate pain control.

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!