Department of Anesthesiology

PATIENT *SAFETY* / PAUSE

February 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:

Medication errors

Click here to watch a discussion on safety issues related to medication administration. It is inspired by *OK to Proceed,* Chapter 8.

OK To Proceed?

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

Chapter 5: The OK to Proceed Model

Chapter 6: Fixation Errors

Chapter 7: Communication Breakdown

Chapter 8: Medication Errors

Recent Patient Safety Events

Jan - Feb 2021

1. **Unplanned dural puncture:** A laboring patient with a reported history of difficult/unsuccessful epidural placement requested an epidural. Epidural was placed with negative aspiration to CSF prior to administration of test dose (3cc 1.5% lidocaine with epinephrine 1:200 000). Patient developed motor and sensory numbness to approximately C5, which wore off approximately two hours later. The patient delivered without further issues. She developed a mild headache which did not require an epidural blood patch, and some hip discomfort attributed to patient positioning while patient had a motor block.

2. **Cardiac arrest**: Patient with history of pneumonia, several reintubations, and PEA arrest during the hospitalization was brought from the SICU to the OR for a wound closure and drain placement of a previously debrided chest wall hematoma. This was performed under MAC anesthesia. Direct return to SICU was refused, and patient became bradycardic and went into PEA arrest in the PACU. CPR was initiated, patient was reintubated and was transported to the SICU after ROSC was achieved.

3. **Case cancelled preoperatively:** A patient with significant cardiac history on aspirin and warfarin was bridged with lovenox five days prior to the procedure, but also stopped aspirin therapy at that time. Patient had not been contacted and evaluated by the PAT clinic.

4. **Skin/soft tissue injury:** A patient was induced in the operating room with propofol, rocuronium and fentanyl. The IV was examined when the patient was noted to be minimally sedated, and the patient was found to be infiltrated. Another IV was placed and the patient induced. A warm pack was placed at the site of the infiltrated IV and the patient suffered no further sequelae.

5. **Unplanned reintubation:** Patient with history of difficult intubation and tongue cancer status post excision was extubated. Difficult airway cart was present. Patient became apneic post-extubation and required several attempts at reintubation. In the interim patient became asystolic requiring CPR. The patient achieved ROSC and is planned for tracheostomy.

Hand hygiene? What hygiene?

Click here to watch a quick video of dos and don'ts for hand hygiene when entering and exiting the rooms of patients on Contact Plus pre cautions.

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!