



Learning From Others:

Anesthesia
Quality Institute
ANESTHESIA INCIDENT
REPORTING SYSTEM (AIRS)

A Case Report From the Anesthesia Incident Reporting System

Review of unusual patient care experiences is a cornerstone of medical education. Each month, the AQI-AIRS Steering Committee abstracts a patient history submitted to the Anesthesia Incident Reporting System (AIRS) and authors a discussion of the safety and human factors challenges involved. Real-life case histories often include multiple clinical decisions, only some of which can be discussed in the space available. Absence of commentary should not be construed as agreement with the clinical decisions described. Feedback regarding this article can be sent by email to I.mueller@asahq.org. Report incidents or download the AIRS mobile app at www.aqiirs.org.

Case 2015-11: Not Everyone Likes a Surprise

The author comments on a generic safety issue at her institution:

As an attending, I review charts and read about my cases the night before. When an elective case from another room is moved into my room for the convenience of the schedule, it can be a mild annoyance, since I am unable to review the chart in advance. But if it turns out to be a complex case, and I don't have the time to review it well, this is a safety concern. When I don't even get told about the case, and it just magically appears, then it is even worse, since I might have had the time earlier to review the case had I known about it.

We are not always interchangeable at the last minute. The O.R. has complicated cases that need to be reviewed. We send a mixed and bad message to everyone by haphazardly doing this.

Discussion

The potential for tension between O.R. operational efficiency and quality of care is nothing new, but as time and financial pressures intensify, it sometimes seems that these conflicts are more common. This conflict, however, is not inherent in the "efficient" management of surgical schedule, but rather most often arises due to poorly implemented scheduling practices and insufficient contingency planning. Archer and Macario have argued that, contrary to common assumptions, well-designed efficiency processes will increase, not detract from, the quality of care delivered and that processes that adversely impact on quality of care are inherently *inefficient*. "Frenetic activity or unsafe practices undertaken to 'increase efficiency' are futile and dangerous. Only if the operating room allocations are nearly correct from the beginning can a well-meaning and coordinated anesthesia and surgical team have a positive effect on operating room efficiency."¹ These issues are magnified when emergent or relatively arbitrary changes are made in the schedule in the absence of a well-planned system to guide decisions. A 2010 review of the published literature on O.R. scheduling noted that there is a dearth of quality data on emergent or non-elective

cases compared with elective surgeries.² Yet unanticipated changes in the schedule due to add-on cases generate the greatest amount of uncertainty and disruption, and it is precisely these cases that are associated with increased clinical risk! Thus, in order to maximize "efficiency," we must be cognizant of best clinical care practices and incorporate them into operational decision-making.

It is intuitive that the more complete and relevant information we have about our patient's histories and underlying medical conditions, the better-equipped we are to make rational evidence-based decisions about their care.³ That, after all, is one of the principal reasons for a preoperative evaluation in the first place. The advent of electronic medical records that permit remote access has dramatically changed our ability to be well prepared for the next day's cases. We now can easily be familiar with our patient's history, laboratory and imaging results, previous anesthetics, and supplement our knowledge with a quick search of the current literature to develop a thoughtful and properly tailored anesthetic plan. But as the reporter of this month's case described, that may be for naught if sudden, unannounced changes are made in the surgical schedule in a way that precludes the effective transmission of that knowledge.

Inadequate or inconsistent handoffs of care are a cause of error, complications and patient harm.^{4,5} Ironically, one study found that errors of omission of information were more common with patients of increasing complexity.⁶ This may be due to the sheer volume of data that needs to be transferred; in the absence of an organized, structured system there is a greater propensity to forget some of the details. Most of the burgeoning literature on handovers of care has focused on the transfer of responsibility from one environment to another (operating room to ICU, for example) or from one intraoperative team to another in the middle of the case. Little information exists on the impact of schedule changes and transfer of care before the anesthetic itself begins. We can, however, extrapolate what has been learned from studies of these other handovers and how successful strategies

can mitigate loss of information. Preoperative briefings, where the entire O.R. team has a brief discussion of the patient and planned operation, have been shown to reduce delays and breakdowns in communications.⁷ Organized handoff processes, rather than “off the cuff” discussions, can reduce the omission of key data and information when care is transferred from one team to another.⁸

The reporter’s closing remarks are important to consider. What does it say about us as professionals – and what message does it send to our surgical colleagues – if we think that preparation for the management of an anesthetic can be dismissed in the name of convenience and scheduling? What are the parameters under which such changes should be made, and what are the processes to implement so that all of the critical information about the patient and the anesthetic and surgical plan is transmitted clearly and effectively to the new anesthesiologist? “Running the board” is a skill that requires more than the ability to move cases around to fit into open time slots. Due consideration of the nature of the operation, complexity of the patient’s underlying medical condition, and skills and preparation of the individual anesthesiologist all are critical factors that must play into the decision. Sometimes what appears to be superficially the most “efficient” plan might actually be the least efficient for the patient’s best outcome.

References:

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