A 16-yr-old patient underwent uneventful surgery for scoliosis. Un/eventful intraop course, which included a low-dose ketamine infusion. Ketamine infusion was supposed to be d/c’d in the OR but was not and the patient was transported to the PACU with it infusing. PACU nurses assumed that ketamine was part of the postop pain plan and sent the patient to the floor with it infusing. Floor nursing staff filed an incident report because ketamine was not part of the postop pain plan.

This report highlights an infusing error with ketamine that crossed three clinical areas: the OR, the PACU, and the inpatient unit. There is not enough detail regarding the care team model, but if care was rendered by a team (attending anesthesiologist and another provider), whose responsibility was it to ensure that the ketamine was discontinued? Albert Bandura, a Canadian American psychologist, cited as the original author of the quote, “Where everyone is responsible, no one is really responsible.” (Journal of Social Issues 1990;46:27-46).

In situations where the anesthesia care team involves more than one individual, specific roles and responsibilities are rarely defined, and every reader can likely recall incidents in which there were lapses in care due to this lack of clarity.

This phenomenon has been described in literature as “diffusion of responsibility,” in which individuals feel that others are responsible or have already addressed a problem (asamonitor.pub/3lwYB7). The literature also shows that the larger the group, the less likely each individual will feel responsible and intervene. Suggested solutions to address this problem include decreasing the size of groups and assigning clear roles and responsibilities. A perfect example of medicine’s understanding in addressing this phenomenon is illustrated in the evolution of Basic Life Support (BLS) and other advanced life support training, as well the maturation of in-hospital code teams. Current BLS training, as well the maturation of in-hospital code teams, which included a low-dose ketamine infusion. Ketamine infusion was supposed to be d/c’d in the OR but was not and the patient was transported to the PACU with it infusing. PACU nurses assumed that ketamine was part of the postop pain plan and sent the patient to the floor with it infusing.

Floor nursing staff filed an incident report because ketamine was not part of the postop pain plan.

This report highlights an infusing error with ketamine that crossed three clinical areas: the OR, the PACU, and the inpatient unit. There is not enough detail regarding the care team model, but if care was rendered by a team (attending anesthesiologist and another provider), whose responsibility was it to ensure that the ketamine was discontinued? Albert Bandura, a Canadian American psychologist, cited as the original author of the quote, “Where everyone is responsible, no one is really responsible.” (Journal of Social Issues 1990;46:27-46). In situations where the anesthesia care team involves more than one individual, specific roles and responsibilities are rarely defined, and every reader can likely recall incidents in which there were lapses in care due to this lack of clarity.

This phenomenon has been described in literature as “diffusion of responsibility,” in which individuals feel that others are responsible or have already addressed a problem (asamonitor.pub/3lwYB7). The literature also shows that the larger the group, the less likely each individual will feel responsible and intervene. Suggested solutions to address this problem include decreasing the size of groups and assigning clear roles and responsibilities. A perfect example of medicine’s understanding in addressing this phenomenon is illustrated in the evolution of Basic Life Support (BLS) and other advanced life support training, as well the maturation of in-hospital code teams. Current BLS training, as well the maturation of in-hospital code teams, which included a low-dose ketamine infusion. Ketamine infusion was supposed to be d/c’d in the OR but was not and the patient was transported to the PACU with it infusing. PACU nurses assumed that ketamine was part of the postop pain plan and sent the patient to the floor with it infusing. Floor nursing staff filed an incident report because ketamine was not part of the postop pain plan.

This report highlights an infusing error with ketamine that crossed three clinical areas: the OR, the PACU, and the inpatient unit. There is not enough detail regarding the care team model, but if care was rendered by a team (attending anesthesiologist and another provider), whose responsibility was it to ensure that the ketamine was discontinued? Albert Bandura, a Canadian American psychologist, cited as the original author of the quote, “Where everyone is responsible, no one is really responsible.” (Journal of Social Issues 1990;46:27-46). In situations where the anesthesia care team involves more than one individual, specific roles and responsibilities are rarely defined, and every reader can likely recall incidents in which there were lapses in care due to this lack of clarity.

This phenomenon has been described in literature as “diffusion of responsibility,” in which individuals feel that others are responsible or have already addressed a problem (asamonitor.pub/3lwYB7). The literature also shows that the larger the group, the less likely each individual will feel responsible and intervene. Suggested solutions to address this problem include decreasing the size of groups and assigning clear roles and responsibilities. A perfect example of medicine’s understanding in addressing this phenomenon is illustrated in the evolution of Basic Life Support (BLS) and other advanced life support training, as well the maturation of in-hospital code teams. Current BLS training, as well the maturation of in-hospital code teams, which included a low-dose ketamine infusion. Ketamine infusion was supposed to be d/c’d in the OR but was not and the patient was transported to the PACU with it infusing. PACU nurses assumed that ketamine was part of the postop pain plan and sent the patient to the floor with it infusing. Floor nursing staff filed an incident report because ketamine was not part of the postop pain plan.