Adverse Events in the OR – Anesthesia Response Guidelines

Upon recognition that a major adverse anesthesia event is in progress or has occurred:

1. The Primary Anesthesiologist should get help and mobilize according to the following protocol.

2. The Primary Anesthesiologist should continue patient care. Except in the very unusual circumstance that s/he becomes ill or disabled or is so shocked by the realization of the accident that s/he cannot function, the anesthesia provider should devote full attention to direct clinical care rather than to the necessary organizational and administrative considerations.

Get advice on how to finish the OR SIMS (electronic) case record (item 4(d) below)

DELAY TRANSFER of the patient in SIMS, if possible, until it is determined whether time intervals for high-resolution (i.e. 30-second) data should be captured. – see Appendix 1.

DO NOT DISCHARGE the patient from SIMS. Wait to discuss with Incident Supervisor. (Discharging a patient from SIMS will LOCK the record – no additional notes possible.)

3. The Primary Anesthesiologist should designate immediately an Incident Supervisor (e.g., a senior practitioner, site chief, or the person running the OR schedule and assignments), or during after hours the 2nd/3rd call as appropriate who:

   a. Assumess overall direction and control of the event.
   b. Organizes help and assigns tasks in the OR.
   c. Verifies incident has ended and there is no immediate recurrence (e.g. correct intubation and ventilation in the prototype example, continued availability of tank oxygen after a central oxygen supply failure, etc.).
   d. Involves consultants and advisors as indicated, including specifically the chief/chair of anesthesiology or appropriate designee, and any others who may help with care or recovery, such as neurologists, cardiologists, etc.
   e. Coordinates and facilitates communications (with the surgical team in the OR and then, along with the surgeon, and the primary anesthesia providers if appropriate, with the patient and/or family).
   f. Arranges relief of the primary caregiver(s) as appropriate to allow for documentation, communication with family, dealing with stress, etc.
4. The Incident Supervisor should:
   
a. Close that OR - where relevant and feasible, for the rest of the day
b. Place signage: “DO NOT DISTURB, ALTER or REMOVE ANYTHING in this OR until FURTHER NOTICE”
c. Make sure no one turns off or unplugs ANYTHING
d. Help the Primary Anesthesiologist complete the SIMS (electronic) record – DO NOT TRANSFER or DISCHARGE the patient until it is determined that charting is complete and, if appropriate, time intervals for high-resolution data capture have been selected
e. If SIMS not available, access the vital signs stored in the GE/Datex-Ohmeda S/5 monitor (or any memory in any other monitor or device used) and print this out or photograph the screen(s) if there is no printing capacity;
f. Sequester all involved equipment and supplies (and the trash and needle buckets)
g. Alter nothing (no cleaning, no disassembly, no repair); if it appears likely or even possible that an equipment failure (anesthesia machine ventilator, bubble detector on a rapid infuser, or whatever) contributed to an accident, it may be indicated to conduct an inspection/testing session involving the real-time participation of representatives of the involved practitioners, the equipment manufacturers, the equipment maintenance personnel, facility administration, and involved insurance companies/attorneys.
h. Discard nothing; sometimes the solution to a mystery can later be discovered in unexpected tiny details, such as an empty or missing or extra medication vial that suggests an accidental wrong drug administration may have caused the accident.
i. Lock away all of the above (this may be difficult in a busy facility; be reasonable; for example, if it is accepted by all involved that there was an unrecognized esophageal intubation involving apparent human error, it would be possible to release the OR and its equipment for use the next day and dispose of the trash).

5. The Incident Supervisor should contact the hospital administrator and risk manager (and the Primary Anesthesiologist should contact their insurance company and attorney if indicated).

6. The Incident Supervisor should arrange immediate comfort and support for the patient and/or family. He/she should share as much information as possible, and liaise with the Patient Advocacy Specialist.
7. The Incident Supervisor should designate a Follow-up Supervisor (who may or may not be the same as Incident Supervisor) who will:
   
a. Verify that the elements of this protocol have been applied.
   
b. Consider whether to organize a group debriefing (e.g., the day of the event or the following day) involving all those present during the event and function as scribe if indicated (note that there may be medical-legal implications of this and appropriate advice of counsel may be indicated). Maintain ongoing communications with all involved caregivers and patient representatives, coordinating and facilitating as much integration as possible.
   
c. Pursue the accident investigation in conjunction with involved quality assurance and risk management systems and personnel; eventually prepare a report as indicated, particularly focusing on lessons learned and actions needed to help prevent similar accidents in the future; participate in any peer-review activities conducted regarding the event.
   
d. File reports as indicated, such as with the HPB and ECRI if it appears that a medical device or medication hazard was involved in the cause of the accident.

8. Everyone should document everything:
   
a. Put strictly objective narrative entries in the medical record and incident report (but these can include background details on the involved thinking, such as, for example, the indication for invasive monitoring based on symptoms and signs of congestive heart failure).
   
b. Make additional detailed (including subjective impressions or value judgments) personal notes for later use created specifically while sitting with an attorney (personal or from the practitioner's insurance carrier) who keeps them as attorney-client work product.

9. The Incident Supervisor and Primary Anesthesiologist should try to review formal reports submitted by the institution to the authorities (provincial department of health/licensing body) both in order to know what they contain and also to add their observations or commentary if indicated.

10. The Incident Supervisor and Primary Anesthesiologist should continue involvement after the event when the patient survives:
   
a. Talk to surgeons and consultants about care; make suggestions as indicated.
   
b. Be visible, supportive, and not defensive with all involved.
   
c. Communicate as much as possible (see # 6. above).