

PURPOSE: Use this tool to describe what happened, why did it happen, and what we did to fix it?

NOTE: Please remember to de-identify. De-identification of protected health information is an essential method for protecting patient privacy.

EXAMPLE

SAFETY TIPS:

- Develop training and education tools for airway management.
- Develop protocol to identify individuals at risk and how to identify these individuals during transfer of care.

RULE:

- Always use a cuff leak test on high risk patients.

CASE IN POINT:

A 65-year-old male was admitted to the CICU postoperatively. Intraoperative course was notable for him being both a difficult mask and intubation, requiring multiple direct laryngoscopies. The OR anesthesia team transferred this information to the ICU care team, during the course of the standard sign-out. The patient was weaned and extubated at 4am. Upon extubation, he was unable to move adequate air and was desaturating.

The emergency anesthesia team was mobilized and intubated him fiberoptically without difficulty.

SYSTEM FAILURES:

Knowledge, skills & competence. Care providers lacked the knowledge needed to identify potential sequelae of multiple laryngoscopies.

Task factor. The patient's condition was inappropriate for standard protocol.

Team factor. There was a breakdown in information transfer between care teams.

OPPORTUNITIES FOR IMPROVEMENT:

Regular **training and education** on how to evaluate individuals with difficult airways for extubation, including use of cuff leak test.

Develop protocol to identify those patients who are not appropriate for standard protocols.

Develop care transfer criteria, which includes a **readback** of complications or deviations from the expected.

ACTIONSTAKEN TO PREVENT HARM:

The ICU team caregivers will have an airway lecture at the beginning of each rotation of residents. The OR and ICU team will implement a readback system. Patients with identified difficult intubation will have a cuff leak test performed prior to extubation.

SAFETY TIPS:

RULE:

CASE IN POINT:

SYSTEM FAILURES:

OPPORTUNITIES FOR IMPROVEMENT:

ACTIONSTAKEN TO PREVENT HARM: