

Safety in ENT surgery

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Patient safety is a new healthcare discipline that emphasizes on the reporting, analysis, and prevention of medical error that often lead to adverse healthcare events.

For ENT surgery, safety is a major issue due to many factors:

- (1) Age groups requiring such surgeries.
- (2) The airway dilemma.

To err is human (Institute of Medicine, 1999)

The Institute of Medicine found in 2000 that: 'Approximately 98 000 patients die from preventable medical errors each year more than from motor vehicle accidents, breast cancer, or AIDS'.

It is human nature, it happens, and the only way to monitor, control, and prevent occurrence of such errors is to have a sound organizational reporting system.

The reporting system should be based on no naming, no blaming, and no shaming technique. There should be what is known as an incident report or occurrence variance report to document, analyze, and prevent reoccurrences of such errors in a systematic, organized way.

Although creating a culture of safety is important, creating a culture of systems is a more fundamental challenge.

Safety involves safety of patients, providers, and medical equipment.

International patient safety goals

- (1) Patient identification:
 - (a) Right patient for right surgery is the goal. We have to properly identify our patients (by at

least two unique identifiers). In today's practice, you may have two children with the same initial names for the same surgery and may even include the same surgeon. Imagine the chances of misinterpretation, especially when the operation room is away from the inpatient department and when children wear the same operation room dresses, they all look alike.

- (b) Considering that for those children group age, the scope of ENT procedures is limited (tonsillectomy, adenoidectomy, and tube insertion). We have to take into account that those children are usually irritated and cannot properly identify themselves and the procedures planned for them.
- (c) Bracelets' are essential, with the patient name, procedure name, room number, and surgeon's name.
- (2) Improve staff communications:
 - (a) Read back spoken or phone orders to the person who gave the order. This is especially applied when ordering medications for the postoperative period or for any emergency telephone ordering of a procedure or medications.
 - (b) Create a list of abbreviations and symbols that are not to be used.
 - (c) This is especially required during handover (endorsement).
- (3) Avoid medication errors:
 - (a) Ten rights of medication administration:
 - (1) Right patient, right drug, right dose, right time, right route, right education, right to

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refuse, right assessment, right evaluation, and right documentation.

- (b) For ENT surgery, there are some more issues to be considered:
 - (1) During surgery, some surgeons prefer to infiltrate tissues with vasoconstrictor agents (diluted adrenaline) which should be done with great caution and right measures, otherwise, if without proper monitoring and experienced personnel (in preparation and administration), it is better to be avoided.
 - (2) Hypotensive anesthesia, this magical concept of bloodless field, is a real dilemma. During surgery, controlled hypotension should be applied as much as the experience of the anesthetist permits, not as far as the surgeons require. As it is a technique of pure experience and facilities, forcing the anesthetist to reach a deep level of hypotension could carry a lot of risk, especially in theaters where the surgical list is carried out by junior anesthetists, with variable degrees of supervision.
- (4) Proper infection control:
 - (a) A lot of surgical staff (surgeons, nurses, anesthetists) do not consider ENT surgery a clean surgery (except for ear surgery), which is totally wrong.
 - (b) Every infection control measure should be applied and considered for all ENT surgeries, like any other surgery.
 - (c) Nowadays, there is an increasing rate of secondary postoperative bleeding and wound dehiscence that is reported to occur (especially with tonsillectomies and turbinectomies) and in much of these cases, improper infection control precautions during the first surgery can be contributory to the complications.
- (5) Wrong site surgery:
 - (a) Wrong side (right or left), wrong procedure (adenoidectomy or tonsillectomy or both ±tubes), and wrong surgeon are all to be avoided.
 - (b) All these mistakes should not be easily considered. Each of them is considered a catastrophe of inefficient administrative system.
 - (c) Multiple steps of identification and verification for the right procedure, right surgery, and right surgeons should be done, considering the opportunity of human or machine error.
 - (d) Such errors are always system errors, not individual human errors.
 - (e) Surgical safety checklist should be applied at every surgery.
- (6) Avoid patient fall:
 - (a) Avoid slippery floor.
 - (b) Mark patients with high risk of fall.
 - (c) Proper monitoring and observation in the postanesthesia care unit (especially for children):
 - (1) At last, safety is the responsibility of everybody in the organization, not only doctors or quality personnel.
 - (2) All efforts should be directed toward creating a culture of safety, to be built in within the hearts and minds of the staff, to be properly followed and transferred from a generation to the other.