



Безопасная анестезия – пути реализации концепции в Украине

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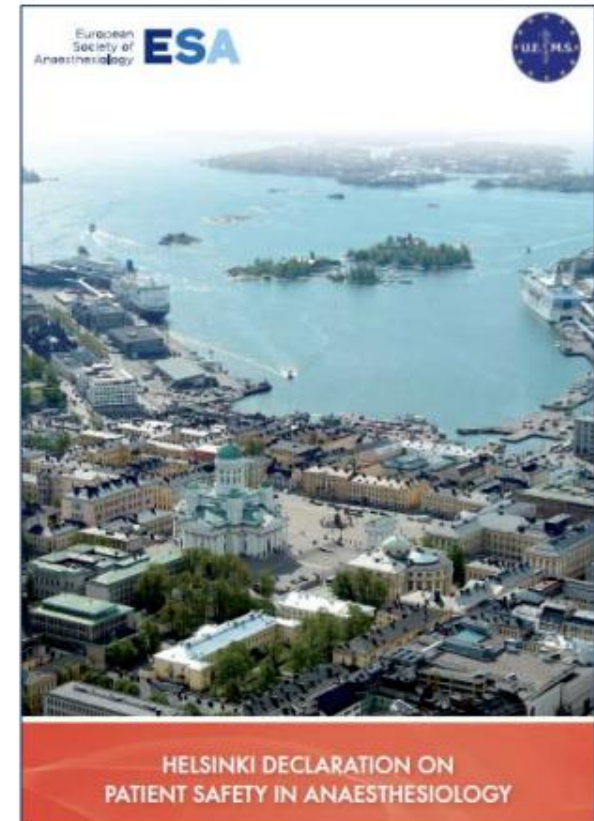
Киев
24 апреля 2014



No conflicts of interest



Helsinki Declaration on Patient Safety 2010



Как обстоят дела в Европе?

Safe anaesthesiology



World Health
Organization

Patient Safety

A World Alliance for Safer Health Care



The years after... What has
changed following the Helsinki
Declaration and WHO Checklist

Every life counts
Sign now

ESA



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PATIENT SAFETY STARTER KIT (USB-stick)



European
Society of
Anaesthesiology

ESA

HOME

BASICS

PODCASTS

HAZARD
WARNINGS

BASIC
LECTURES

CHECKLISTS



ESAS/EBA Society
European Board of Anaesthesiology

PATIENT SAFETY IN ANAESTHESIOLOGY

01

BASICS

02

PODCASTS

03

HAZARD
WARNINGS

04

BASIC LECTURES
WHO & ESA

05

CHECKLISTS

A Starter Kit in Patient Safety in Anaesthesiology to raise safety standards across Europe. Read, listen, learn and teach. Make anaesthesiology safer: save lives!

Developed and compiled by the ESA/EBA Task Force Patient safety (Gven Staender [chair] with Guttorm Brattebe, Andrew Smith and David Whitaker).



Helsinki Declaration: Implementation in 2012

Survey (Nov. 12) among

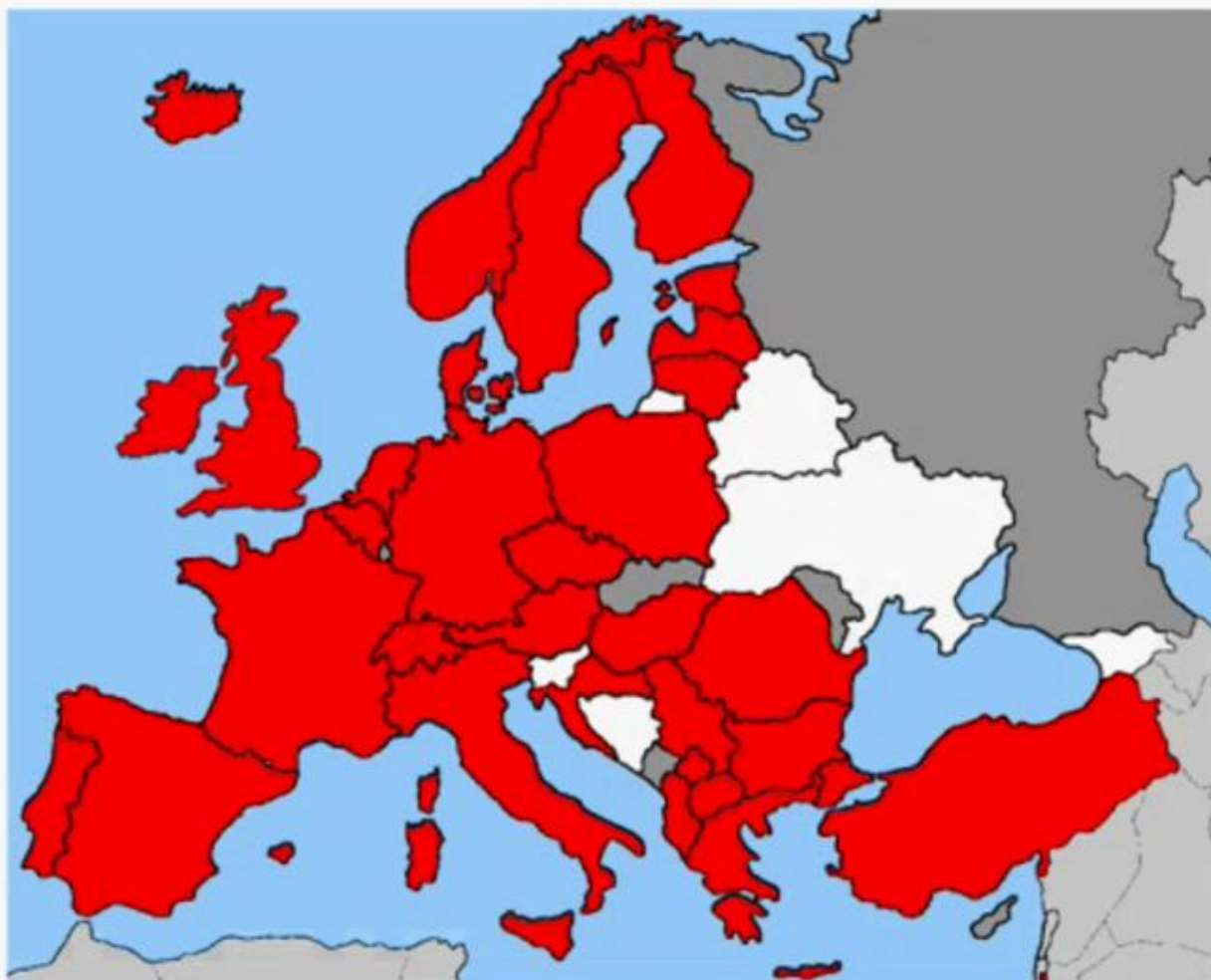
- ESA council members
- NASC members

Responses from all countries but:

- Montenegro
- Slovakia
- Moldova
- Luxembourg
- Russia



Monitoring Standards



Surgical Safety Checklist



World Health
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Before induction of anaesthesia

(with at least nurse and anaesthetist)

Has the patient confirmed his/her identity, site, procedure, and consent?

☐ Yes

Is the site marked?

☐ Yes
☐ Not applicable

Is the anaesthesia machine and medication check complete?

☐ Yes

Is the pulse oximeter on the patient and functioning?

☐ Yes

Does the patient have a:

Known allergy?

☐ No
☐ Yes

Difficult airway or aspiration risk?

☐ No
☐ Yes, and equipment/assistance available

Risk of >500ml blood loss (7ml/kg in children)?

☐ No
☐ Yes, and two IVs/central access and fluids planned

Before skin incision

(with nurse, anaesthetist and surgeon)

☐ **Confirm all team members have introduced themselves by name and role.**

☐ **Confirm the patient's name, procedure, and where the incision will be made.**

Has antibiotic prophylaxis been given within the last 60 minutes?

☐ Yes
☐ Not applicable

Anticipated Critical Events

To Surgeon:

☐ What are the critical or non-routine steps?
☐ How long will the case take?
☐ What is the anticipated blood loss?

To Anaesthetist:

☐ Are there any patient-specific concerns?

To Nursing Team:

☐ Has sterility (including indicator results) been confirmed?
☐ Are there equipment issues or any concerns?

Is essential imaging displayed?

☐ Yes
☐ Not applicable

Before patient leaves operating room

(with nurse, anaesthetist and surgeon)

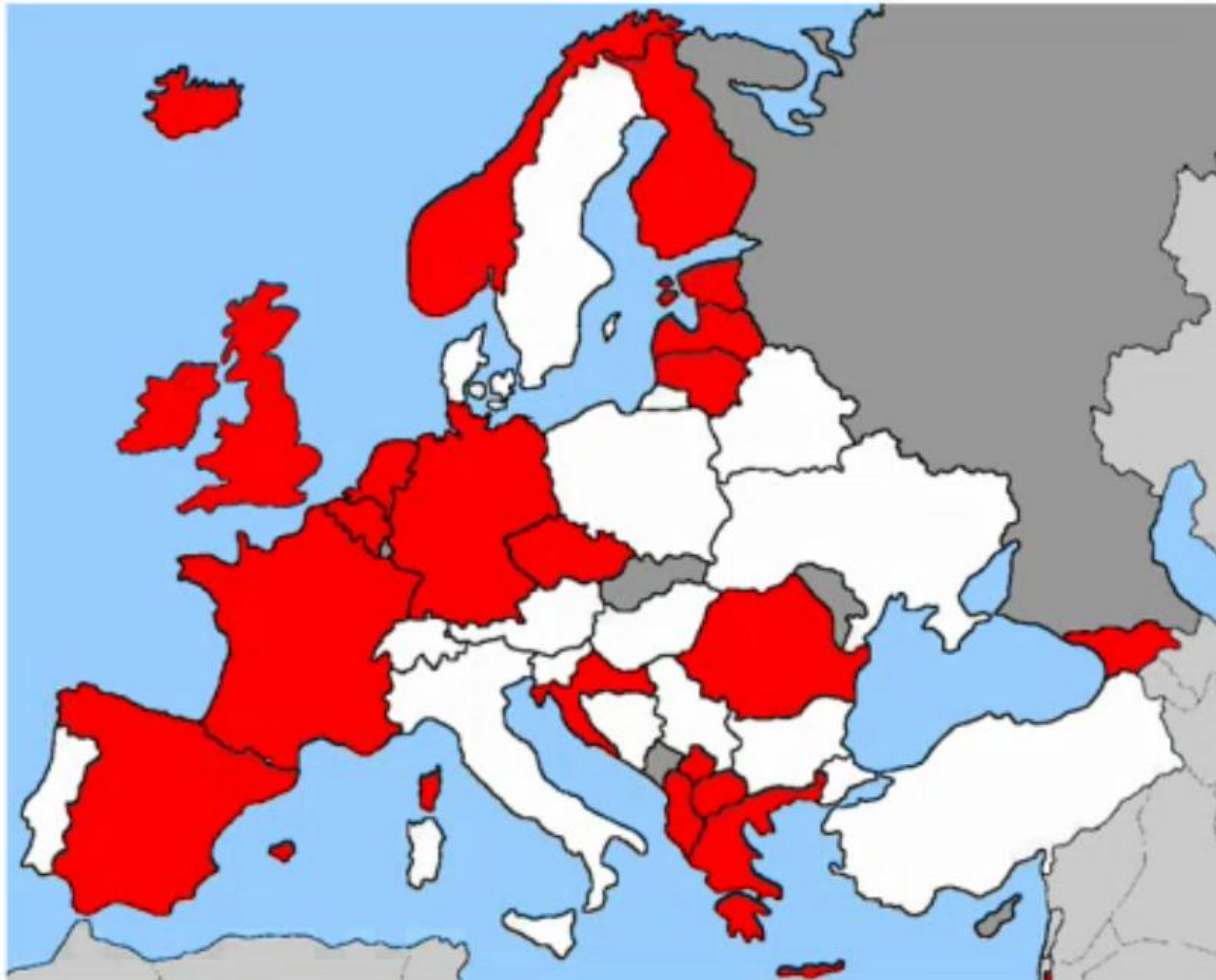
Nurse Verbally Confirms:

☐ The name of the procedure
☐ Completion of instrument, sponge and needle counts
☐ Specimen labelling (read specimen labels aloud, including patient name)
☐ Whether there are any equipment problems to be addressed

To Surgeon, Anaesthetist and Nurse:

☐ What are the key concerns for recovery and management of this patient?

PS Teaching & Training



European Patient Safety Foundation



Barcelona, Spain

Euroanaesthesia 2013
The European Anaesthesiology Congress
e-News

European
Society of
Anaesthesiology **ESA**

DAY 2 SUNDAY 2 JUNE 2013

Opening ceremony highlights: The new European Patient Safety Foundation



In an eventful and well-attended opening ceremony, ESA President Professor Eberhard Kochs last night welcomed delegates from all over the world to Euroanaesthesia 2013. He was joined on the podium by Local Organising Committee Chair Dr María José Yepes

Temño (University of Navarra, Spain) and also the Mayor of Barcelona Dr Xavier Trias i Vidal de Llobatera, who also gave a warm hello to delegates.

www.eupsf.eu



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European Patient Safety Foundation

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Sven Staender
Board Member

www.eupsf.eu



EUPSF
European Patient Safety Foundation



Bringing the EUPSF to you
wherever you are !

Webinar: December 3



Optimising
Patient Safety
Together !

DECEMBER 3, 2013

16:00

What is the EUPSF webinar?



European Patient Safety Foundation

- Every 10th patient in Europe experiences preventable harm or adverse events in hospital



European Patient Safety Foundation

Many of the features of patient safety do not involve financial resources

they involve commitment of individuals to practise safely





Is surgery dangerous?

An estimation of the global volume of surgery: a modelling strategy based on available data

Thomas G Weiser, Scott E Regenbogen, Katherine D Thompson, Alex B Haynes, Stuart R Liptitz, William R Berry, Atul A Gawande



Lancet 2008; 372: 139-44

- 56 WHO member countries
- 234,2 million surgical cases

perioperative complication rate	3-16%
permanent harm or death	0,4-0,8%

anaesthesia-associated mortality: **0,0008%**

Anesthesiology 2006; 105:1087-97



Optimising Patients Undergoing Surgery: OPUS Campaign

Complication Management!

1. Identifying Patients prone to Complications
2. Avoiding Complications
3. Early Identification of Complications
4. Early Treatment of Complications



OPUS Bundles

- **Preoperative assessment**

risk identification/stratification?

preoperative preparation

prewarming? NPO? antibiotics? new anticoagulants?

perioperative adjunctive protective therapy (β -blockers? statins? aspirin?)

- **Intraoperative management**

preoxygenation, type of anaesthesia, ventilation management, fluid management, awareness prevention, goal directed therapy, neuro-muscular blocking agents, regional anaesthesia, blood management

- **Re-evaluation at the end of surgery!**

endOPE, Surgical APGAR Score

- **Postoperative Management**

pain management, postoperative surveillance, complication management.

European Patient Safety Foundation



Как обстоят дела в Украине?

Наказ №303

...техніка безпеки при роботі в операційній...

Анализ ошибок – пятиминутки, клинические разборы больных, клинико-анатомические конференции

Технологии – маркировка шприцев, капнометрия, профессиональная компетенция

Процесс – checklists, distraction, incident reporting

Коммуникация – открытое обсуждение, “second victim”

Как обстоят дела в Украине?

Команда – talk about problems, think aloud

Индивидуальность – симуляция и тренинги

Наш опыт: энтузиазм и разочарование

- **We can think individually but must act TOGETHER**



Пути устранения красных пятен

Checklists

CONTENT

Intraoperative Myocardial Ischaemia	1
Anaphylactic Reaction	2
Haemolytic Transfusion Reaction	3
Air Embolism	4
Laryngospasm	5
Malignant Hyperthermia	6
Newborn Life Support	7
Severe Bronchospasm	8
Local Anaesthetic Toxicity	9
Hyperkalaemia	10
Aspiration	11
Severe Bleeding	12
Increased Airway Pressure	13
Differential Diagnosis Hypocapnia / low etCO ₂	14
Differential Diagnosis Hypercapnia / high etCO ₂	15
Differential Diagnosis Bradycardia	16
Severe Bradycardia	16a
Differential Diagnosis Tachycardia	17
Severe Tachycardia	17a
Differential Diagnosis Hypotension	18
Left Ventricular Shock	18a
Right Ventricular Shock	18b
Differential Diagnosis Hypertension	19
Differential Diagnosis Desaturation / Low SpO ₂	20

Surgical Safety Checklist



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☐ No

☐ Yes

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To Surgeon, Anaesthetist and Nurse:

☐ What are the key concerns for recovery and management of this patient?

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.

Revised 1 / 2009

© WHO, 2009

«Мы перевели и готовы поделиться»
С.Воротынцев, Т.Павлова

Пути устранения красных пятен

incident reporting, PS teaching and training

Strategy elements – National Societies

Patient safety in anaesthesia: assessment of status quo in the Berlin-Brandenburg area, Germany

Felix Balzer, Claudia Spies, Walter Schaffartzik, Dirk Pappert, Klaus-Dieter Wernecke, Rainer Kuhly and Willehad Boemke

From the Department of Anaesthesiology and Intensive Care Medicine, Campus Charité Mitte and Charité Campus Virchow-Klinikum, Charité – University Medicine Berlin (FB, CS, RK, WB), Berlin's Chairman of the German Society of Anaesthesiology and Intensive Care Medicine, Berlin (WS), Brandenburg's Chairman of the German Society of Anaesthesiology and Intensive Care Medicine, Potsdam (DP), SOSTANA GmbH, Berlin, Germany (KDW)

European Journal of Anaesthesiology 2011, Vol 28 No 10

ААУ
НМАПО
МОЗ





How can we improve Patient Safety in Daily Routine?



Recommendations

- Implement and use **Critical Incident Reporting Systems (CIRS)**
- Use **checklists** for preparation and crisis management
- Take care of **non-technical skills and team aspects** (use simulation & team training)
- Implement **policies** on:
 - Minimum interruptions
 - Minimum change in anesthetist
 - Open disclosure after severe events
 - Care for the 'second victim'
- Invest in **technology**:
 - Bar-code technology to minimise medication error
 - Capnography in OR, ICU and ER

Безопасная анестезия в Украине



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