

REGULAR

WEBAIRS NEWS

DISTRACTIONS IN THE OPERATING THEATRE

**INTRODUCTION**

Distractions in the operating theatre are believed to be one of the many contributing factors that may cause clinical incidents in the perioperative period. While there have been no randomised controlled trials in an operating theatre environment of which the authors are aware, this principle is generally accepted in the community where activities such as texting on mobile phones whilst driving are believed to cause road accidents.

CASES REPORTED

In the webAIRS database a search performed on 13 July 2019 revealed 24 reports where the word 'distraction' was used in the narrative and an adverse event or a near miss occurred as a result of the distraction. Seven of the reports were associated with a drug error which included two cases where the drug given was of the same class as the intended class, four where it was of a different class and one case where double the dose was given resulting in an overdose.

User error with a medical device occurred in nine cases. These were varied and included lost guide wires with CVP insertion, the use of a chlorhexidine impregnated catheter where a patient had recorded an allergy to chlorhexidine,

failure to connect or turn on various devices, and a wrong site block.

There was a failure to notice something important in six cases, which included deterioration of the patient, a TIVA leak, an oesophageal intubation and a retained throat pack. In addition, there were two cases where failure of a piece of equipment caused distraction, making it difficult to monitor the patient but no adverse event occurred.

DISCUSSION

Distraction is known to increase the chance of error in the aviation industry¹ and, as a result, code 135.100 has been issued under the US Government code of regulations. It is commonly known as the sterile cockpit rule and states that no flight crew member may perform any duties during a critical phase of flight that is not required for the safe operation of the aircraft. There are specified critical phases of flight such as take-off and landing, and any other time as directed by the flight captain. All the incidents in this series occurred at a critical phase of anaesthesia. Most of them occurred either immediately before induction of anaesthesia or within the first 10 minutes of anaesthesia. A small number were associated with restoration of circulation and ventilation after coming off cardiopulmonary by-pass.

The American Society of Anesthesiologists issued a statement on distraction in 2015² and this contains recommendations that could be worth implementing in Australia and New Zealand.

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References

1. Electronic Code of Federal Regulations section 135.100. Flight Crewmember Duties. e-CFR data is current as of July 11, 2019. <https://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=03efb7c1b34301bf39ff6d98084cdd45&rgn=div8&view=text&node=14:3.0.1.1.11.2.3.25&idno=14>
2. Statement on Distractions. Developed by: Committee on Quality Management and Departmental Administration, American Society of Anesthesiologists. <https://www.asahq.org/standards-and-guidelines/statement-on-distractions>.