In 1844, a dentist named Horace Wells delivered general anesthesia to a patient who felt no discomfort during a normally painful procedure. Dr. Wells likely could not fathom that this new anesthesia would change the path of medicine forever. The medications and techniques available at that time were rudimentary, but something incredible had been discovered, and these inquisitive individuals continued to advance the science. As you might expect, it became clear early on that anesthesia could also be risky and had the potential to cause great harm. However, these gallant doctors accepted the challenge and continued their pioneering efforts, leading to the anesthesia techniques available to us today.

While we are trained to safely administer anesthesia to our patients, OMSNIC data continues to indicate that 1 in 18 OMS will experience an office anesthetic death during a thirty year practice. Therefore, this issue focuses on our responsibilities as OMS to assess our patients adequately, prepare our team for emergency situations, and continue to be vigilant in our emergency preparedness efforts.

With Advanced Anesthesia Comes Great Responsibility

Outpatient anesthesia is now, and has been for many years, an essential component of oral and maxillofacial surgery. Now, in most cases, we have the ability to complete both simple and complex procedures of the maxillofacial region in an outpatient setting, all the while assuring our patients will have no pain or recall. The patient's overall care can be managed in the office surgical suite, while we perform the procedure and administer the anesthesia. We should be grateful to our mentors and our medical colleagues who worked hard to make anesthesia delivery a core part of our surgical training. I am sure each and every one of you have a mentor who taught you the ins and outs of anesthesia, preparing you to carry the torch that is the operator/anesthesia model we use in practice today.

Just like surgery, providing advanced anesthesia comes with great responsibility. We are obligated as surgeons to give our patients the best surgical care available. Safe and effective anesthesia care is part of the operator/anesthetist model. The delivery of anesthesia care must meet the standards of our medical colleagues. However, complications can and do occur, and we must be prepared to handle problems when they arise.

Airway Loss and Cardiovascular Failure at the Forefront

At OMSNIC, we have over twenty-five years of data regarding anesthesia complications, ranging from death and disability to complaints of insufficient anesthesia. Two specific areas, however, seem to stand out when one looks at our high severity claims: airway loss and cardiovascular failure seem to be at the forefront of anesthesia calamity. From 2000-2014, 415 anesthesia related claims were reported to OMSNIC. Of these, 157 are listed as anesthesia death or brain damage. The majority of these cases started with airway loss that led to cardiovascular failure.
Sedation Complications

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Delays in recognition of the problem and inadequate or delayed resuscitation further complicated these events. In this issue of the OMS Guardian, we will highlight some of the complications we have seen in the claim review process and provide suggested ways to help mitigate them.

Let us first look at some of the most common causes of mortality, according to OMSNIC data:

- Loss of Adequate Oxygenation
- Delay in Recognition of the Event
- Delay in Instituting Proper Resuscitation
- Failure to Appropriately Resuscitate
- Failure of Patient to Respond
- Inadequate Pre-op History
- Judgment on Location for a Procedure
- Judgment on Drug Selection
- Judgment on Level of Anesthesia
- Inadequate Assistance

Patient Assessment Is Paramount

Do not be afraid to discuss anesthesia options with your patient. In some cases, local anesthesia may be the best option. For patients who are truly higher risk, consider taking them to a hospital where you would have the medical resources if necessary. Know your comfort zone as a surgeon and a provider of anesthesia, and stay within those boundaries.

Before you start, know your patient. Be diligent with their medical history. Routinely assess your patient’s airway and lung and cardiac capacity. Check their neck and oral range of motion. Ask for their weight, and calculate a BMI. Look directly at the airway, and give each patient a Mallampatti Classification. Finally, give each patient an ASA number. Record your complete patient assessment in the chart. In spite of all of this knowledge, complications can still arise, but you will have demonstrated that you made the best effort possible.

Surgical Time Out

In past articles, I have discussed the importance of a Checklist as well as performing a Surgical Time Out. Watch this short video to see how a Checklist and Time Out can help you assess your patient prior to surgery and avoid clinical mistakes.
Team Training

Training is essential to keep your team sharp. AAOMS has mandated BLS and ACLS certification for all surgeons who provide outpatient general anesthesia and sedation. Having BLS and ACLS trained nurses and assistants to help administer anesthesia is also important. The Dental Anesthesia Assistant National Certification Examination (DAANCE) Program created by AAOMS is a great way to test and focus the anesthesia skills of your staff. Additionally, OMSNIC offers an “Office Emergency Training Program” - a series of downloadable presentations on different medical emergency situations that you can regularly review with your team. All of these programs focus on airway management and reestablishing blood flow and oxygenation to the major organs. Specific actions must be completed to resuscitate the failing patient. It is crucial that we know the necessary steps, and can execute them properly. In today’s world, we have access to excellent drugs and hi-tech monitors, including capnography. However, the best monitor is your team. Train your staff to watch the patient carefully before, during, and after anesthesia, because their eyes and ears are the best monitors available. You and your team are the first line of defense and may be able to see and hear things before the monitors do. Each day, and with each patient, you have to ask yourself: “Will my team respond quickly and appropriately if an emergency occurs?” Remember, “an ounce of prevention is worth a pound of cure.”

Each day, and with each patient, you have to ask yourself: “Will my team respond quickly and appropriately if an emergency occurs?”

- Download a “Sedation and Anesthesia Record” to document your physical assessment of each patient and the anesthesia administered.
- Download a “Time Out Checklist” to verify your patient and treatment plan prior to surgery.

See the OMSNIC Online Resources page for more information on how to download these forms.
omsnic.com
How to find additional risk management resources relevant to this issue on www.omsnic.com.

Click this link to access the following educational risk management resources:

- Office Emergency Training Program
- Resident Risk Management Series
- RMC 413 (5% Premium Credit Course)

Visit the OMSNIC Resource Center “Informed Consent” folder to download the documents referenced in this issue. Forms are organized by the headings indicated below.

**Informed Consent Forms - Anesthesia**
- Sedation and Anesthesia Record

**Office Forms - Clinical**
- Crash Cart Checklist
- Emergency Record
- Time Out Checklist

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LOG IN TO OMSNIC.COM TO ACCESS THESE RESOURCES

**Policyholders:** Your User ID is your OMSNIC policy number (begins with a 2). If this is your first time logging in, your password will be the last 4 digits of your Social Security number. Otherwise, enter the password you created when you first logged in.

**All Others (including staff):** Sign in with your previously created login, or, if this is your first time visiting our website, register as a guest.

You can retrieve your User ID or reset your password through the “Forgot User ID/Password?” link.