

Communication issues and lack of time sense

1. The event:

An emergency caesarian is to be performed on a woman due to changes in the baby's heartbeat, which indicates that the baby may be starved for oxygen. The obstetrician who has previously attempted to deliver the baby by placing a suction disc on the baby's head is concerned for the baby's condition and wants to start operating immediately. The anesthesiologist does not want to expose the mother to full anesthesia and chooses to administer a spinal anesthesia. The two doctors discuss which anesthesia to use on the patient. There is disagreement over which type of anesthesia is the best in the critical situation at hand. The obstetrician is having difficulties controlling his nerves, and makes remarks to the effect that it is the anesthesiologist's responsibility if the procedure does not go quickly and smoothly. The anesthesiologist tries to focus but the needle does not go in correctly and he has to make another attempt. It takes several attempts before the spinal anesthesia is in place and functional.

One hour passes from the time the decision was made to deliver the baby using a suction disc – subsequently a caesarean section – and until the baby was delivered. Upon delivery, the baby's condition is critical, and it may have suffered a brain injury.

The event is reported to the local reporting system.

2. Local action:

The event is analyzed and the following root causes are found, among others:

1. Lack of joint guidelines for anesthesia of women undergoing an emergency caesarean section as well as lack of a clear definition of the distribution of competencies increases the risk of potential disagreements between the obstetrician and the anesthesiologist in the stressful emergency situation.
2. Lack of methods for assuring that the treating doctors pay attention to the time factor increases the risk of violating acceptable time limits.
3. When the staff does not track the baby's condition by monitoring its heart rate, the baby cannot be delivered at the pace, which offers the overall best conditions for mother and child.

Consequently, the hospital implemented the following action plan:

A joint guideline is drawn up for the Anesthesiological Department and the Maternity Department, which describes the type of anesthesia to use in different situations.

A plan is made for how to inform doctors, who are focused on providing care, about relevant information about the time factor. This may be done by having the nurse tell the anesthesiologist whenever two minutes have past and/or two unsuccessful attempts have been made to insert a needle. The doctor must acknowledge this aloud and revise his/her plan subsequently.

The baby's heart rate must be monitored, even after the mother has been taken to the operating room. This is done to produce a more reliable and current indication for how quickly the delivery is to take place. For this reason, CTGs must be run in the operating room – also during emergency caesarean sections.

3. National action:

As an assessment of the above situation concluded that it was primarily caused by local communication and organizational issues, the event and attendant analysis was not reported to the national system (National Board of Health).