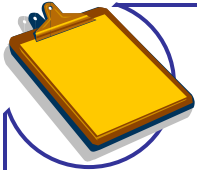


CQI Alerts

Mar
2006

OBSERVATIONS BY THE CONTINUOUS QUALITY IMPROVEMENT PROGRAM FOR UWMC ANESTHESIOLOGY



DOCUMENTING NEUROMUSCULAR BLOCKADE

For medico-legal purposes, the anesthetic record should always include documentation of the adequacy of reversal of neuromuscular blockade.

Please describe in the comments section:

- sustained head lift (5 seconds)
- sustained hand grasp
- sustained 100Hz tetanus
- negative inspiratory force <-40/ccm, etc.

Otherwise, it is impossible to assess of whether the patient had adequate reversal of neuromuscular blockade prior to extubation.



ADMINISTERING CEPHALOSPORINS

If your patient has a history of an immediate Immunoglobulin E (IgE) mediated hypersensitivity reaction to penicillin, do NOT give the patient a cephalosporin.

Symptoms of immediate IgE mediated hypersensitivity:

- Angioedema
- Hypotension
- Wheezing
- Urticaria (with these other symptoms)

Alternatives to cephalosporin for these patients:

- Vancomycin
- Clindamycin



NOTING THE BLOCK SITE

Consider marking block sites ahead of time. This will reduce confusion if block placement requires repositioning of the patient.

- If the patient is awake, check with the patient before drawing landmarks.
- If the patient is already sedated or asleep, confirm the surgical site with the surgeon.
- Initial the limb to be blocked so that the limb can be identified with the patient either prone or supine.



EPIDURAL CHOICE FOR PAIN MANAGEMENT AFTER ABDOMINAL SURGERIES

Pain management after lower abdominal surgeries may or may not require epidural placement. For upper abdominal surgeries, consider an epidural, especially for patients with tolerance to opioids.

For epidurals for postop local anesthetic infusions:

- For upper abdominal surgeries, place at T5-T8
- For lower abdominal surgeries, place at T10-T12

For preop testing of epidurals and intraop repeat injections, use lidocaine 2% (not bupivacaine in 0.25% concentrations)

Questions? Contact the Acute Pain Service.