



Letter to Editor

Preparedness for patient safety in orbital regional anesthesia in Nepal

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Dear Editor,

Eye surgeries are performed mostly under orbital regional anesthesia (blocks) owing to their reliability and high patient acceptance. The most commonly used orbital regional blocks include retro-bulbar (intra-conal), peri-bulbar (extra-conal) and sub-tenon named according to the site of deposition of local anesthetic agent. Many variations of these block techniques do also exist. Although these block techniques are considered relatively safe, they are not without any risks. Retro-bulbar hemorrhage, globe damage, optic nerve injury, brain-stem anesthesia, myotoxicity of extra-ocular muscles, 7th cranial nerve palsy and oculo-cardiac reflex are some of the known significant complications of these blocks (Kumar, 2006).

Though it is recommended that orbital regional blocks be performed by adequately trained specialists (American College of Eye Surgeons, 2001; The Royal College of Anesthetists [RCOA] and the Royal College of Ophthalmologists [RCO] UK, 2011), they are done by ophthalmic paramedics, in many developing countries including Nepal. I am not aware if any analysis of the patient-safety profile of the procedures performed by these staff has been carried out. Stemming of this practice, however, is evidently attributable to inadequate availability of qualified specialists in this part of the world.

The number of specialist-care providers has increased in recent years and is further increasing annually. More than 20 ophthalmologists and similar number of anesthesiologists are currently produced in Nepal every year. Therefore, the question arises 'Has it not been the time that these orbital regional blocks be performed by those trained specialists?'

'Doing no harm to the sick' is the first principle of care everyone must recognize. At the same time, being able to continuously improve the quality of service maintaining high standard of care depending on the available resources is the responsibility of care providers. In the context of better availability of resources and technology as well as care-pathway modernization, we should now define as to what the standard of care should be for a particular set-up for ensuring patient safety by reducing complications and clinical errors. Although it is not possible to prevent the errors to a zero level, there are evidences that upto 50 % of fatal incidents may be preventable (de Vries et al, 2008; Kelly, 2009).

Incidence of adverse events and complications are less likely to be admitted and reported in the absence of effective monitoring. Closed-claim investigation of adverse outcomes is not in common practice in our country. Incomplete and poor record keeping impede our learning from errors. It is very unlikely to get a readymade response when asked about the preparedness for safety of ophthalmic surgical patients even from university level teaching institutions and dedicated eye hospitals. Worldwide, the issue of patient

Received on: 30.11.2011 Accepted on: 03.12.2011

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safety has already become a discipline in itself and ophthalmology is not an exception (Kelly, 2009).

Patient safety is not possible unless stringent quality control measures are adopted and followed. The Nepal Ophthalmic Society - a concerned professional organization, should take the initiative in assessing the need and preparing surgical patient safety guidelines in consultation with other professional organizations and Nepal Medical Council. We can learn from India - our neighboring country where the practice of organizing ophthalmic surgical camps in places other than health institutions has been stopped in view of patient safety and quality of care. Attempting to improve a system is never late.

Performing ophthalmic surgery in optimally equipped and staffed facilities, comprehensive, clear and unambiguous record keeping for clinical audit and governance, compulsorily assigning qualified personnel for patient monitoring during surgery, providing Basic Life Support and Advanced Life Support training or equivalent with periodic refresher training are some of the recommendations made to improve patient safety during ophthalmic surgery under orbital regional blocks (ROAC and RCO, UK, 2011).

In conclusion, preparedness for patient safety during and after ophthalmic surgery should draw adequate attention of all the concerned stakeholders in Nepal.

References

American College of Eye Surgeons (2001). Guidelines for cataract practice. www.aces-abes.org (accessed on 24.11.2011)

de Vries EN, Ramrattan MA, Smorenberg SM, Gouma DJ, Boermeester MA (2008). The incidence and nature of in-hospital adverse events: a systemic review. *Qual Saf Health Care*; 17: 216-23.

Kelly SP (2009). Guidance on patient safety in ophthalmology from the Royal College of Ophthalmologists. *Eye*; 23: 2143-51.

Kumar CM (2006). Orbital regional anesthesia: complications and their prevention. *Indian J Ophthalmol*; 54: 77-84.

The Royal College of Anesthetists and the Royal College of Ophthalmologists (2011). Joint guidelines: local anesthesia for ophthalmic surgery. www.rcoa.ac.uk/docs/OphthalGuidelines2011.pdf (accessed on 24.11.2011).

Source of support: nil. Conflict of interest: none