



Organization, Standardization and Simplification of Access to Emergency Anesthesia Medications in the Pediatric Operating Rooms: A Quality Improvement Initiative

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Pre-Intervention	27 Providers
100%	Atropine, Succinylcholine, Epinephrine
55% Aware Divisional Consensus	
--80%	Correct Epinephrine Location
--40%	Correct Sux & Atropine Location
45% Unaware Divisional Consensus	
--Epinephrine 4 locations	
52% Never Struggled with Workplace Organization	
--80% Receptive to Using Device that Facilitated Organization	

Post-Survey

- **CRNA's (7/15)**
- 42% Never use Device, Always 14%
- Epi 1 & 10 mcg/mL, Atropine, Succinylcholine
- 57% Separation of IM Drugs Helpful
- 71% Not Improved Ability to Respond to Emergency
- Improved Safety Breaks (57%); Sign-out 50%
- 85% More Secure Attachment, 57% Better Location, 57% Better Design, 43% Consensus on which Drugs, 14% Labels, 14% Education
- 57% Improved Culture of Safety at Duke—predominantly, 43%, assured drug location when taking over a case
- 29% No improvement
- **Attendings (9/11)**
- 66% Use of Device
- 75% Improvement in Location Consistency of Drugs
- Response to Emergency, 50% Mostly, 25% Never
- Reference Point Prior to Induction 50% Definitely, 25% Mostly
- 85% New Location, 57% Design Improvements
- Barriers: Education 37%, Unawareness 75%, Inability to Adapt 37%
- 62% Definitely Improved Safety, 25% No Effect
- Recommend? 63% Probably with Design Changes

