

Family Member Mishaps on Labor and Delivery: How Close is Too Close?

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- Patient-centered care promotes optimal health outcomes, encourages family participation on L&D and improves patient satisfaction
- Occasionally, family member involvement leads to medical mishaps, but rarely results in harm

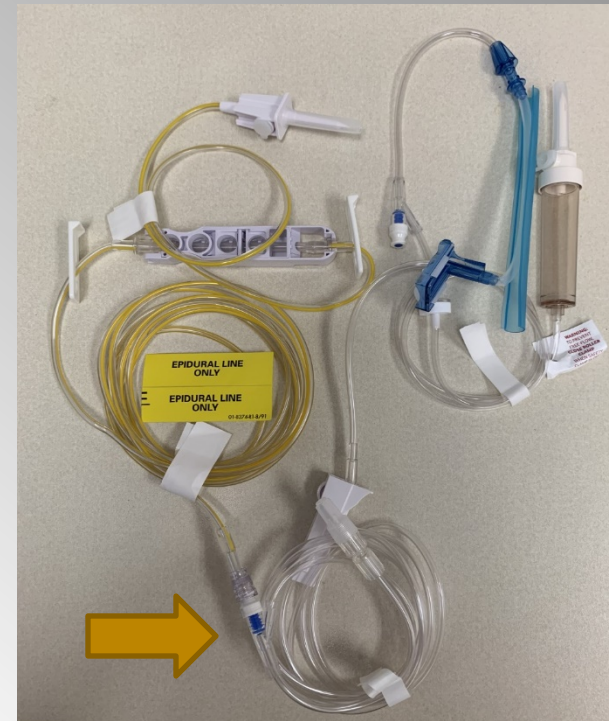
Case

20 y/o G2P1 @ 40+6 WGA, eIOL

- Uneventful CSE
- 0.2% ropivacaine and fentanyl 2 mcg/ml at 10 ml/hr for labor analgesia

- C/o inadequate pain control
- L&D RN discovered epidural catheter tubing connected to IV tubing port

- Family member connected epidural catheter tubing to IV without notifying staff
- No complications, estimated 40-60 mg of ropivacaine and 80-100 mcg fentanyl delivered IV over a period of 4 hours



Discussion

Recognition of the L&D unit as a complex environment is vital to anesthesiology trainees and requires exercises in situational awareness

Effective communication amongst healthcare providers, patients and family members ensures patient safety

