

SAFE ANAESTHESIA LIAISON GROUP

Summary of incidents reported to the Anaesthetic eForm

11 AUGUST 2009 TO 26 FEBRUARY 2010



NHS

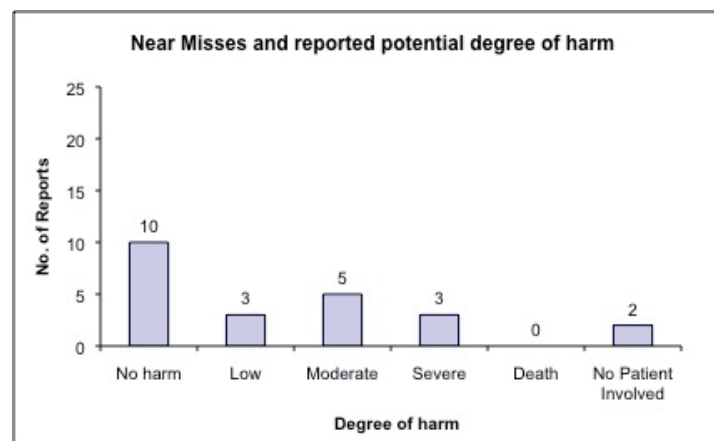
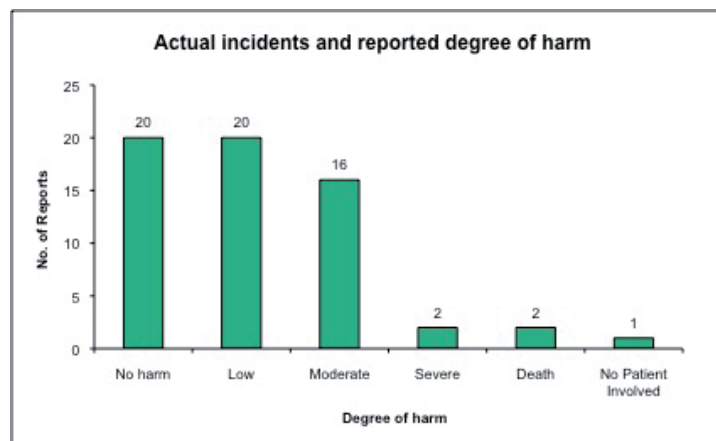
National Patient Safety Agency
National Reporting and Learning Service

61 actual incidents and 23 near misses were reported via the anaesthetic eForm within the time period above (84 in total).

All incidents graded as death or severe were subjected to the current National Patient Safety Agency (NPSA) serious incident review process and, if identified as having potential cause for concern, were reviewed by anaesthetic consultants from the Royal College of Anaesthetists (RCoA) or Association of Anaesthetists of Great Britain and Ireland (AAGBI). This review was carried out in accordance with the NPSA's data sharing protocol (no information about the trust is disclosed; only information about the incident). Most incidents were reported by consultant anaesthetists, but the eForm is available to all members of the perioperative team.

As with any voluntary reporting system, interpretation of data should be undertaken with caution as the data are subject to bias. Many incidents are not reported, and those which are reported may be incomplete having been reported immediately and before the patient outcome is known. Clarity of 'degree of harm' to patients who experience a patient safety incident is an important aspect of data quality.

Of the incidents, 45% were reported the same day and a further 10% within 24 hours



SUMMARY OF PATIENT DEATHS

- One post operative death involved a patient who had an infarction post vascular procedure
- One preoperative death concerned bleeding from a tumour in the bronchus which was identified before intubation

Although incident reports are fundamental to understanding patient safety, they alone cannot provide all the information that is required. As a result, it is not possible to conclude that any of the reported deaths were attributable directly to anaesthetic interventions.

SUMMARY OF THEMES OF DATA

Infrastructure issues (staffing/lack of trained staff, facilities): 20

- Surgeons not available
"Patient on emergency list for a laparotomy. Booked by a junior trainee, registrar did not know patient was booked. Patient unsure if they were going to have an operation... following many phone calls... found out that the consultant was not available until the afternoon."
- Radiographer availability out of hours
"Unable to send for a booked emergency as there are no radiographers available until 9am on a Saturday."
- Availability of blood due to off site laboratories and transport
"Patient bled post op. 2.5 hour delay in getting cross matched blood... Blood bank is on a separate site. Blood was cross matched in time... however 'got lost' in the system. Patient profoundly anaemic by the time blood arrived. No permanent harm to patient."
- Lack of ITU/HDU beds
- Staffing of obstetric theatres at minimal levels
- Theatre list errors

Medical device/equipment issues: 19

- Storage and management of oxygen cylinders
"...Requested oxygen cylinder for nebuliser and oxygen during procedure... I was given two oxygen cylinders which were both empty before receiving the third which was suitable."
- Brachial plexus injury despite use of positional aids and pressure relieving pads
"Brachial plexus injury: Pt positioned as per standard Trust policy (developed after recent similar incidents)... shoulder braces at acromion + gel pads (avoiding soft tissues of neck + shoulder), arms folded across chest, not abducted – head-down for only 45 min... neck neutral on pillow and visible during surgery, yet dense motor and sensory injury"

The reporter of this incident has been in correspondence and is keen to share local learning points nationally in liaison with the Safe Anaesthesia Liaison Group (SALG) salg@rcoa.ac.uk.

- Paediatric breathing circuits faulty (manufacturers alerted)
"...child induced using... Ayres T piece... No hole in bag... application of scissors averted harm... Other faulty circuits were found... The product rep was contacted."

- Vaporisers not properly seated
- Recognised oesophageal intubation with double lumen tube leading to perforation
- Occlusion of cable led to inadequate gas delivery
- Anaesthetic machine failures (usually resolved on restart)
- Availability of reliable capnography in obstetric department
- Fiberoptic endoscope not available due to not having been decontaminated after use

Implementation of care issues: 19

- Wrong site block
"Patient undergoing... arthroscopy had a limb block commenced on the wrong side... recognised and the procedure discontinued and performed on the correct side..."

SALG will be issuing a notification for clinicians to promote good practice and current guidance.

- Tooth displacement
"Tooth accidentally loosened and came out. Tooth retained in case could be reimplanted but dental team said it... would not be successful. Patient given apology and explanation. Legal dept informed. [The patient was a difficult intubation...I should have warned the patient beforehand, but didn't.]"
- Consistency of risk assessment of ASA4 patients undergoing surgery
- Availability of paediatric skilled nurses in recovery departments in general hospitals

Medication: 14

- Drug errors e.g. midazolam instead of naloxone, ephedrine into arterial line, wrong dose ketamine
"Planned sedation with midazolam 1.5mg and ketamine 20mg before attempting spinal... ketamine was 50 mg/ml. I gave 2mls... which was 100mg. Patient was anaesthetised rather than sedated... Do we actually need the higher strength ketamine?"
- Perioperative insulin management, no dextrose infusion running
"Insulin dependent diabetic on sliding scale... dextrose drip disconnected on the ward prior to transfer... patient was transferred... with just insulin infusion running. Diabetic chart did not follow patient"
- Preoperative thrombolysis management
- Anaphylaxis (antibiotics, induction agents)
- Bupivacaine reaction

Clinical assessment issues (including diagnosis, scans, assessments and tests): 10

- ASA4 patient not referred appropriately for assessment by consultant anaesthetist
Patient for (urgent surgery)...in patient for 6 weeks...on list today ...no anaesthetic consultant ... patient was ASA4 ...not been referred for an anaesthetic assessment...complex medical problems have been documented by the junior staff in the notes..."
- Pre-assessment time limited due to patients arriving on ward same day
- Investigations not carried out in pre assessment period
- Failure to notify results of pre assessment tests before admission requiring further test on day of admission with potential of cancellation

Documentation issues: 2

➤ Consent not signed

“Patient underwent surgery... with no written consent... SHO received verbal consent, signed the consent form but failed to get patient to sign... nurse at theatres saw surgical consent, spoke to patient... without realising patient had not signed... error picked up before surgical incision.”

➤ Allergies not noted preoperatively – no red armband

This report is based on data from the eForm only. The eForm is now available for the reporting of incidents in England and Wales and can be found at <https://www.eforms.npsa.nhs.uk/asbreport/>

In addition to quarterly summaries, SALG (which is a partnership of the RCoA, AAGBI and NPSA) will aim to produce analyses of the common or important themes that are identified. In addition to the themes related to brachial plexus injuries, wrong-site block, inadequate pre-operative preparation and blood availability that are evident in this summary, a number of systemic and human factors can be identified. These will be the focus for further analysis.

“Clinical Directors for anaesthesia and theatres should work with appropriate managers to establish comprehensive and integrated pre-operative assessment facilities and ensure that there is a lead anaesthetist for pre-operative assessment.”

AAGBI Safety Guide: Pre-operative Assessment and Patient Preparation 2, January 2010

A co-ordinated system for the urgent supply of blood products is established and maintained. Blood must be available quickly for all operative procedures. This will include the ability to communicate directly and immediately with the transfusion laboratory and for blood products to be transported between the laboratory and the unit without delay.

Dealing with haemorrhage NPSA sept 2007

<http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59873&p=2>

The analysis will cover RLS data which includes eForm and locally uploaded reports.

SALG will like to thank you all for continuing to report all incidents, either using the eForm or your local system, to allow learning locally and nationally.

Please e-mail salg@rcoa.ac.uk if you will like to be involved with helping SALG reach its aims.