

# SAFE ANAESTHESIA LIAISON GROUP

Summary of incidents reported to the Anaesthetic E-form project

**20 MAY 2008 TO 10 AUGUST 2009**



**NHS**  
National Patient Safety Agency  
National Reporting and Learning Service

**204 actual incidents, 46 hazards and 30 near misses were reported by the project sites within the time period above (280 in total).**

All incidents were reviewed within 24 hours of receipt by National Patient Safety Agency (NPSA) staff and if any were identified as having potential cause for concern, they were reviewed by a consultant from the Royal College of Anaesthetists for further opinion. A consultant was contacted weekly to give an overview of the incidents reported during that week. This overview was carried out in accordance with the NPSA's data sharing protocol (no identifiable information is disclosed; only details of the incident). Most incidents were reported by consultant anaesthetists, but the form 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 280 reports, 117 (40%) were reported the same day and 15 (5%) within 24 hours.

The 280 reports include the actual harm, and (for hazards/near misses) the potential for harm. There were 6 deaths (+3 potential), 22 severe harm, 73 moderate harm, 87 low harm and 85 no harm. Four incidents were ungraded.

## SUMMARY OF PATIENT DEATHS

- ▶ One patient, who had been resuscitated previously, died in the anaesthetic room before anaesthesia was given.
- ▶ Three intra-operative deaths; two major haemorrhages (bronchial tumour, spinal surgery) and a cardiac arrest during acute abdominal surgery.
- ▶ Two post operative deaths: one patient in a state of acidosis and an elective surgery patient.

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

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### **Drug issues: 39**

- Insulin regimes not prescribed or adhered to
- Adverse reactions and anaphylaxis to Gelofusin, muscle relaxant, antibiotics and induction agents
- Overdose of antibiotics, paracetamol
- Drugs in wrong boxes, different drugs in identical packaging, drugs drawn up and wrongly labelled, expired drugs mixed with in-date drugs
- Wrong volatile agent selected, inadequate reversal, epidural block inadequate,
- Wrong drug selected when distracted, incorrect prescription for weight of patient,
- Prescribed pre-operative drugs not given

### **Equipment issues: 57**

- Failure of: capnograph, cell saver, end tidal monitor, soda lime (wrongly placed) vaporizer, warming device
- Anaesthetic machine not checked, APL valve sticking, breathing circuit attached incorrectly
- Fiberoptic laryngoscope not available, no laryngoscope handles

### **Anaesthetic/other clinical problems: 107**

- Poor diabetic pre-op management, inadequate pre-assessment, sliding scale mismanagement
- Patient fingers trapped in table, post dural headache, high spinal bloc, spinal hematoma, wrong side bloc, malignant hyperpyrexia
- Extravasation of fluids, surgical emphysema after laparoscopy
- Unexpected failed intubations, laryngospasm, aspiration/regurgitation, tooth displacement
- Incorrect pregnancy test results, delay in blood results
- Inadequate IV equipment for bariatric patient
- Accidental disconnection of anaesthetic circuit by surgeon, bed wheels occluding anaesthetic circuit, bed controls broken

### **Other: 77**

- Non-availability of ITU or HDU beds, recovery room full
- Theatre lists incorrect and changed at short notice, prolonged anaesthesia due to no surgical instruments, no notes available, incorrect wristband
- Power cuts and generator tests, unreliable/no battery power on anaesthetic machines
- Surgical site not marked
- Porter delays

This report is based on data from the eForm pilot sites only. The eForm has now gone live nationally and can be found at <https://www.eforms.npsa.nhs.uk/asbreport/>. In addition to quarterly summaries, SALG (the Safe Anaesthesia Liaison Group – a partnership of the Association of Anaesthetists, NPSA and Royal College of Anaesthetists) will produce analyses of common or important themes. Please continue to report all incidents, either using the eForm or your local system, so we may maximise learning locally and nationally.