CHAPTER
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Foreword

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We are pleased to be able to present this report of the 5th National Audit Project (NAP5) on Accidental Awareness During General Anaesthesia, jointly funded by the Royal College of Anaesthetists (RCoA) and the Association of Anaesthetists of Great Britain and Ireland (AAGBI).

A key recommendation of the Francis Inquiry and the Berwick report has been a requirement for increased candour from individuals and organisations when things go wrong. It is therefore heartening to see the specialty undertake a study that acknowledges the seriousness of accidental awareness during general anaesthesia, providing important new data on its frequency, seeking to understand why it occurs, and informing the profession to help further decrease its occurrence.

Accidental awareness during general anaesthesia (AAGA) is an intra-operative complication greatly feared by patients, and is a concern frequently raised during pre-operative visits. Although AAGA is not a common event, its impact on patients is such that it must not be ignored or trivialised. It is therefore important that we understand the factors that make its occurrence more likely, so that our practice can be improved and its incidence minimised. As with previous National Audit Projects, while the quantitative data derived from the project are important and may create headlines, it is arguably the qualitative information – that derived from numerous individual patient stories and the themes that emerge from them – that can teach us most.

NAP5 is perhaps the most 'patient facing' of these projects to date, and studies the largest number of individual patient stories: more than 400. The methodology of NAP5 offers a standardised approach to the investigation and analysis of cases of AAGA, and will continue to inform clinical and medicolegal practice in the future. It is our hope that NAP5, with support from anaesthetic and patient safety organisations, will result in the incorporation of new questions into surgical checklists to help prevent AAGA, and the adoption of standardised pathways for psychological support should AAGA occur.

We were delighted to have the endorsement of all four Chief Medical Officers of the UK at the start of the project, and we are pleased to welcome the expansion of a National Audit Project into Ireland for the first time, making this a truly international endeavour.

This study is the culmination of almost four years' work by a large number of multidisciplinary contributors, including specialist anaesthetic societies, psychologists, patients and medicolegal experts. A nationwide network of local co-ordinators across all UK NHS and Irish public hospitals have worked tirelessly to ensure that all new cases of AAGA were promptly reported, and we have achieved 100% participation across five countries, a truly remarkable achievement.

Our special thanks go to the NAP5 Clinical Lead, Professor Jaideep Pandit, and to Professor Tim Cook, RCoA NAP Advisor. Their leadership in the development and delivery of this project has been exemplary.