Please fill in IR1 forms for the following:

**Definitions**

- **A critical incident**: event which led to harm or could have led to harm if it had been allowed to progress. AAGBI & RCoA

- **A patient safety incident**: any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care. been involved in, may have witnessed that caused no harm or minimal harm, with a more serious outcome; prevented patient safety incidents/near misses. NPSA

- **An adverse incident**: event, circumstance or departure from acceptable standards of practice that could have or did lead to unintended or unexpected harm, loss or damage to people, property, environment or reputation of the Trust. accidents, clinical incidents, non clinical incidents, near misses, critical incident, medication incidents and adverse events. Southern HSC Trust

**Cardiovascular**

- Cardiac arrest
- Arrhythmias requiring intraoperative temporary pacing, cardioversion or defibrillation
- Myocardial infarction in theatre or recovery
- Hypotension requiring unanticipated continuous infusion of vasopressor
- Pacemaker or AICD malfunction requiring therapy or urgent reprogramming
- Untreated hypotension resulting in organ impairment

**Respiratory**

- Wrong gas administered
- Failure to monitor for or respond appropriately to oxygen desaturation
- Unanticipated difficult airway with prolonged desaturation or requirement for needle cricothyroidotomy or surgical airway
- Dental damage
- Airway trauma requiring treatment or follow up (nerve palsy after lge)
- Unplanned reintubation
- Postoperative respiratory arrest
- Airway foreign body (tooth, piece of equipment, throat pack etc)
- Unanticipated new onset pulmonary oedema
- Aspiration requiring higher than planned postoperative FiO2 or delaying recovery discharge
- Severe bronchospasm requiring intravenous beta-agonist
- Endobronchial intubation with atelectasis requiring treatment or prolonged recovery stay
- Unanticipated requirement for postoperative ventilation or CPAP/NIV

**Neurological/ophthalmic**

- Residual neuromuscular blockade
- Unanticipated delay in regaining consciousness requiring treatment or additional investigation
- Stroke
- High spinal
- Perioperative seizures in patient without epilepsy
- Requirement for opioid or benzodiazepine antagonist
- Loss of vision
- Corneal abrasion
- Unanticipated delirium requiring treatment
- Intraoperative awareness
- Neuraxial infection
- Epidural haematoma
- New peripheral neurological deficit

**Endocrine, electrolytes, thermoregulation**

- Perioperative thyroid storm
- Malignant hyperthermia
- Inadvertent hypothermia where intraoperative warming was not used
- Inadvertent hypoglycaemia
- Uncontrolled hyperglycaemia (> 15mmol/L)
- Irrigating fluid absorption syndromes
- New hyponatraemia related to intravenous fluids or perioperative medication

**Medications**

- Anaphylaxis
- Other medication reaction requiring treatment
- Significant medication errors including potassium chloride, IV administration of epidural medications, oversedation with Midazolam
- No/incorrect DVT prophylaxis
• No/incorrect anticoagulant bridging
• Extravasation of drug requiring monitoring or treatment
• Unintended intra-arterial injection of drug
• Prophylactic antibiotics not given
• Medications not (dis)continued as planned

Renal
• New acute kidney injury (AKIN 2 or above)

Regional
• Nerve block on wrong side
• Spinal or epidural in patient with unrecognised contraindication
• Local anaesthetic toxicity
• Failed regional anaesthesia leading to unanticipated GA

Other procedural
• Central line complications requiring treatment:
  • Pneumothorax requiring drainage (needle or drain)
  • Air embolus related to line placement or removal or use of infusion device
  • Thoracic duct injury from central venous catheter placement
  • Loss of guidewire into circulation or trapped guidewire requiring intervention
  • Pericardial effusion or tamponade secondary to central line insertion
• Ventilator-related barotrauma
• Subcutaneous emphysema
• Arterial line complications:
  • Limb ischaemia secondary to arterial line insertion
• Chest drain complications:
• Lung parenchymal damage during chest drain insertion
• Operation on incorrect side (wrong site surgery)
• Incorrect procedure on correctly identified patient
• Procedure-related bleeding requiring surgical intervention or transfusion
• Tracheostomy:
  • Bleeding during tracheostomy requiring therapeutic bronchoscopy to evacuate clots
  • Loss of airway during tracheostomy
• Nasogastric tubes: Undetected misplaced nasogastric tube, or detected misplacement with organ injury
• Blood products complications:
  • Unanticipated massive transfusion (activation of red alert)
  • Transfusion of ABO-incompatible blood components (in conjunction with SHOT)
• Surgical fire
• Injury to staff member including needlestick

Equipment
• Equipment failure or malfunction
• Equipment not available due to breakdown
• Equipment usage error
• Technical support unavailable

Administrative, patients flow
• Delay
  • Patient delay in theatre due to consent not signed
  • Delay in supply of blood during red alert

• Delayed transfer from theatre to recovery > 15 minutes due to lack of staffed recovery bed
• Delayed discharge from recovery > 2 hours due to lack of ward beds
• Cancellation
• Day of surgery cancellation (elective, any reason)
• Translator not available leading to alteration to list or cancellation
• Unplanned admission
  • To ICU/HDU for reasons not otherwise specified
  • To recovery: unplanned overnight stay in recovery
  • Overnight stay in recovery for medical reasons but Intensivist not consulted
  • Unplanned hospital admission from Day Surgery
• Pre-assessment / investigations
  • failure to detect significant comorbidity leading to altered case management
  • No pre-assessment resulting in altered case management
  • Notes or investigations not available at time of assessment or investigations not done
• Misidentification of patient not detected prior to arrival in operating theatre
• Breach of confidentiality
• Deviation from protocol (including failure to call for senior help when needed)
• Activation of theatre alarm system