PATIENT SAFETY UPDATE
Including the Summary of Reported Incidents relating to anaesthesia
04 OCTOBER 2010 TO 31 MARCH 2011

THIS DOCUMENT AIMS TO ACHIEVE THE FOLLOWING:
➤ Outline which data has been received from whom and when.
➤ Help reporters to understand how their reports are used and therefore encourage improvement in the quality of reported data.
➤ Provide the vignettes with which clinicians can identify and use as learning in their own Trusts.
➤ Provide expert comments on reported issues.
➤ Encourage medical staff to contact SALG in order to share their own learning on any of the incidents mentioned below.

SUMMARY
A total of 5,760 anaesthesia related incidents were reported during the specified time period. 133 incidents were reported using the anaesthetic eForm. 32% of these cases were reported as near miss (harm was prevented from reaching the patient). 40% of incidents reported via the eForm were reported to the NPSA within 1 day of occurrence.

5,627 incidents were reported using Local Risk Management Systems (LRMS). 19% of these cases were reported as near misses. 50% of incidents reported via LRMS were reported to the NPSA within 38 days of occurrence.

All incidents graded as death or severe were received by the National Patient Safety Agency (NPSA) and, if identified as having potential cause for concern, were reviewed in turn 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.

ANAESTHETIC eFORM
The anaesthetic eForm has been live for use in England and Wales since 30 November 2009. Since the anaesthetic eForm pilot began in May 2008 until 31 March 2011 there have been 741 completed reports submitted. The anaesthetic eForm can be found at: https://www.eforms.npsa.nhs.uk/asbreport.

As a result of the Armes Length Bodies review last year, the NPSA will be closing in 2012. Responsibility for the NRLS will move to the NHS Commissioning Board. SALG would like to reinforce the importance of continuing to report patient safety incidents using the eForm or your local system during the transition so that trends and incidents can be acted upon and learning maximised.
DEGREE OF HARM (ACTUAL INCIDENTS)

Figure 1 shows the degree of harm incurred by patients within the anaesthetic specialty. All of the 16 deaths were reported though LRMS.

Figure 1 Reported degree of harm (actual incidents)

INCIDENT TYPE

Figure 2 shows the type of incidents that occurred within the anaesthetic specialty that were reported using LRMS or the anaesthetic eForm. The categories were determined at local level.

Figure 2 Type of incident reported
SUMMARISED EXAMPLES OF REPORTED INCIDENTS FROM ALL CATEGORIES (REPRODUCED AS RECEIVED)

➤ “Severe tachycardia in a patient on the ward following elective hip replacement. The hospital has no on call anaesthetic cover apart from the anaesthetists covering the lists. Patient has been seen by a junior doctor, suspected as acute AF and transferred to accident and emergency department…”

➤ “Throat pack not removed at end of operation and swallowed by patient. An Abdominal X-ray confirmed the presence of the throat pack in the patient’s stomach. This was removed by endoscopy and the patient was discharged. Trust Patient Safety Team have graded the incident ‘Never Event’.”

➤ “Child for surgery pre-assessed on inpatient documentation then admitted to day surgery unit on day stay documentation so had 2 sets applicable to current admission. Given pre-op oral paracetamol on ward, signed-for on day stay documents. As this had not been specifically requested by anaesthetist was nearly given 2nd dose intra-operatively as working off the alternate set of documents. This type of incident remains a risk where a patient has 2 sets of documents relating to a single admission all duplicated .”

➤ “Elderly Patient cancelled from the trauma list for two days. When patient arrived in theatre reception, patient confirmed he had not been given anything to eat or drink for 3 days previously. Patient was hungry, thirsty and anxious. Staff concerned that he was not in the fittest state to have best surgical results.”

➤ “Patient stated no movement in his toes or legs - had epidural in situ following bowel surgery. Nursing staff had not recorded motor block. Sensory levels only recorded once since surgery. Patient states couldn’t get out of bed due to no movement - nothing documented in nursing notes.”

➤ “Called to recovery to see patient with swollen tongue and partial airway obstruction. Decision to check airway and if necessary intubate endoscopically. No fibreoptic bronchoscope available at short notice due to sterilisation issues. Fortunately, able to ventilate with face mask while this was being sorted. Endoscope finally available after 15 minutes. Unacceptable delay with fibreoptic endoscope availability.”

➤ “SpR anaesthetising for a new list in a different to normal theatre complex. Trainee usually works in cardiac anaesthesia and allocated to general anaesthesia. Having anaesthetised the first patient in the anaesthetic room, moved into theatre where there is a new type of anaesthetic machine that he had not seen... Returns the patient to the anaesthetic room and attempts to familiarise himself with the machine… Still unable to use machine, calls for help. Explanation of machine given (whilst patient is anaesthetised and connected). No further problems for the remainder of the list.”

➤ “Patient for elective inguinal hernia repair under general anaesthetic. Inadvertently given double the intended dose of gentamicin prophylaxis. 2 anaesthetists on list (1 cons 1 trainee). 240mg administered by one anaesthetist shortly after induction. Another dose of 240mg had been drawn up for the next patient which was then given by the second anaesthetist. The total dose of 480mg would be a normal therapeutic dose. electrolytes checked the next day - unchanged from pre-op.”

➤ “Patient listed for total hip replacement. Femoral and lateral cutaneous nerve of thigh blocks performed under minimal propofol sedation. Wrong side block performed. Correct site surgery performed. Prior to blocks sign in check performed by ODP whilst anaesthetists out of room. Correct site not reconfirmed by anaesthetists prior to performing block. Neither patient nor ODP corrected anaesthetist till after block performed. Consultant anaesthetist distracted. Moral - being reminded of a problem does not make you immune to the mistake. Make sure you take part in all the theatre process steps required to prevent patient harm. Wrong side block led to less adequate analgesia, otherwise no harm.”
PARACETAMOL ERRORS IN FOCUS

54 incidents where paracetamol was used as a keyword were identified within the reports. 39 of these were considered relevant. The themes identified were dosage, communication and variation in policy and some examples are provided below. Please visit the MHRA website for information on a change in paracetamol dosing for children. It is intended that this will prevent repetition of some of the reported issues [http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON123113].

➤ “Patient had a dose of paracetamol before going to theatre and then was given another dose whilst in theatre. 5th dose in 24 hours.”

➤ “Patient returned from theatres having received 120mgs PR paracetamol, equal to 40mg/kg. Nurses believe that should only have 20mgs/kg as a single dose. SHO reviewed patient, LFTs checked and ENT Registrar notified. No harm to patient.”

➤ “Patient weighing 3.5 kg given 50 mg of IV paracetamol in theatre. This is double the dose stated in BNF. Paracetamol not given on the ward post op due to double dose given in theatre…”

➤ “Patient was given the prescribed 1gram paracetamol on the ward at 08:13hrs as part of pre-med. On return to ward after procedure it was noted on the anaesthetic chart that 1gram of IV paracetamol had been given at 09:30 hrs…”

➤ “Staff nurse found that a patient who had returned from theatre had been given 75mg of diclofenac in the anaesthetic room after having 400mg of ibuprofen 10:00. The patient had also been given paracetamol at 08:00 and a further dose was then given in the anaesthetic room at 11.20. I had clearly documented on the drug chart and in the anaesthetic booklet the doses and the times they were given…”

➤ “Documentation not completed after administration of paracetamol andVoltoral PR in theatres. Mum present at handover of child in recovery along with another staff nurse. Parents asked when next dose of pain relief could be given; I replied that I could give the patient some immediately as the information document showed nothing had been administered. Mum then advised me she believed that pain relief had been given in theatres… I contacted theatres and spoke to ODP who then contacted the anaesthetist who confirmed this. Paracetamol 250mg and Voltoral 25mg were administered PR @ approx 1130 by consultant anaesthetist. No further medication given and ward sister/senior Nurse on - call was notified.”

TIMELINESS OF REPORTING

Figure 3 shows the timeliness of reporting incidents via the anaesthetic eForm (directly received into the NRLS) and via LRMS (uploaded to the NRLS periodically via local systems). That is, the time difference between an incident occurring and the incident being reported to the NPSA.

Figure 3 Reporting timelines of anaesthetic incidents
Safer Administration of Insulin – NPSA Rapid Response Report

SALG have expressed their concern that the NPSA Rapid Response Report “Safer Administration of Insulin” has not been noted widely enough. You are urged to read the Report (published 16 June 2010) and share with your colleagues. We would also ask for your vigilance for pending guidance.

Brachial plexus injury resulting from patient positioning during surgery

Anonymised feedback to SALG can be now be viewed online. SALG are in the process of engaging with surgical colleagues in order to publish a summary of the main concerns and how to avoid them.

Wrong Site Blocks During Surgery

Following their notification regarding the avoidance of Wrong Site Blocks, SALG received much local learning and feedback. This feedback is now available to view on the SALG website. A group of anaesthetists in Nottingham shared a scheme of work entitled Stop Before You Block. With the endorsement of SALG and RA-UK the Group has published a poster for use in all UK hospitals. Please download the poster here.

Poorly Seated Vaporisers

The MHRA has received reports of incidents where the failure to correctly attach vaporisers to the anaesthetic machine back-bar has led to anaesthetic gas leakage and potential patient awareness. This may be more pronounced where vaporisers are attached to anaesthetic machines from an alternative manufacturer. The alert reference is: http://www.mhra.gov.uk/Publications/Safetywarnings/MedicalDeviceAlerts/CON085024

Single Use Ampoules

SALG would like to highlight the recent NPSA Signal on the use of single drug ampoules for more than one patient. They would like to remind clinicians that no financial implications should be considered when disposing of ampoules after use, regardless of the remaining drug volume. The only way to prevent cross infection and drug contamination due to use for multiple patients was to recommend that ampoules never be used for more than one patient.

Oxygen Safety in Hospitals – NPSA Rapid Response Report

SALG would like to emphasise the fifth action point of the NPSA Rapid Response: Oxygen Safety in Hospitals following concerns raised by clinicians with SALG. It is recommended that: “Oxygen is prescribed in all situations in accordance with BTS guidelines [author’s emphasis]…” The British Thoracic Society guidelines can be accessed by clicking here.

SALG would also like to remind anaesthetists and other healthcare professionals that patients with unexpected oxygen requirements must receive a medical re-assessment.

Any staff members measuring oxygen saturation using pulse-oximetry need to be aware of the limitations of this method. The MHRA issued ‘Top Ten Tips for pulse oximetry’ with the AAGBI at the end of last year: http://www.mhra.gov.uk/Publications/Postersandleaflets/CON100224

Inadvertent Administration of Paralysing Agents

SALG would like to draw clinicians attention to the NPSA Signal “Residual anaesthetic drugs in cannulae” following a number of recent reports on this issue.

Spinal and Intrathecal Needle Evaluation Project

In association with the OAA, SALG endorse an evaluation tool for recording opinions, successes and failures in using new equipment in line with the NPSA Alert on Safer Spinal, Intrathecal and Epidural devices. The evaluation form and more information on the project can be found on the OAA website.

SALG Safety Network and Risk Management Forum

The SALG Safety Network continues to increase in strength and number. All anaesthetists and members of the theatre team are welcome and encouraged to join. SALG are also proud to host a Risk Management Forum for administrative Risk and Patient Safety Managers. It is our experience that a strong relationship between clinicians and risk managers ensures a more robust safety culture and so we urge all risk managers to join. For more information of either of these two groups or to join please email the SALG administrator.