THIS DOCUMENT AIMS TO ACHIEVE THE FOLLOWING:

➤ Outline what data has been received, the severity of reported patient harm and the timing and source of reports.
➤ Provide feedback to reporters and encourage further reports.
➤ Provide vignettes which clinicians can use to support learning in their own Trusts.
➤ Provide expert comments on reported issues.
➤ Encourage staff to contact SALG in order to share their own learning on any of the incidents mentioned below.

SUMMARY OF REPORTED INCIDENTS

A total of 2990 anaesthesia related incidents were reported during the specified time period. 79 incidents were reported using the anaesthetic eForm. 28% of these cases were reported as near miss (harm was prevented from reaching the patient). 39% of incidents reported via the eForm were reported to the NPSA within 1 day of occurrence.

2911 incidents were reported using Local Risk Management Systems (LRMS). 18% of these cases were reported as near miss. 50% of incidents were reported via LRMS to the NPSA within 37 days of occurrence.

All incidents graded as death or severe were reviewed by the National Patient Safety Agency and if identified as having potential cause for concern, were reviewed in turn by consultant anaesthetists 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, or identifiable information relating to the patient or staff is disclosed; only information about the incident). Most incidents were reported by consultant anaesthetists, although 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 820 completed reports submitted. The anaesthetic eForm can be found at: https://www.eforms.npsa.nhs.uk/asbreport.

As a result of the Arms 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 reported between 1st April 2011 and 30th June 2011. Six deaths were reported though LRMS and two deaths were reported via the anaesthetic eForm.

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 between 1st April 2011 and 30th June 2011. The categories were determined at local level.

Figure 2 Type of incident reported

LARYNGOSCOPE HANDLES

Following media coverage of potential cross infection from a contaminated laryngoscope handle leading to a patient death SALG would like to stress the importance of this issue and urge clinicians to ensure that local policies take into account the AAGBI guideline on infection control. If you are not satisfied that your local policies are robust enough to prevent cross-infection please raise the issue with your clinical and risk management colleagues.
Problems relating to anaesthetic equipment are common and highlight the importance of the machine check in the anaesthetic Sign-In, including a check between patients.

Equipment may fail in spite of pre-use tests, so the immediate availability of an alternative means of ventilation is vital.

Take special note of the position of the Auxiliary Common Gas Outlet, the integrity of the breathing circuit, the functioning of the ventilator and the function and seating of vaporisers. An MHRA alert on poorly seated vaporisers was highlighted in the previous SALG Patient Safety Update (July 2011). The MHRA alert can be found at: http://www.mhra.gov.uk/Publications/Safetywarnings/MedicalDeviceAlerts/CON085024.

Most anaesthetic machines only have 30 minutes back-up power supply when the battery is fully charged – remember to make sure that the mains supply is connected at all times, particularly when there is a change in
anaesthetic machine during a list. The power failure alarm should be included in the routine machine check.

Anaesthetists work as members of a team – good communication between members of the team is essential, particularly so that the anaesthetist is alerted when a change to the anaesthetic equipment is made.

Clinicians are asked to look out for the new AAGBI anaesthetic machine checklist which will emphasize the importance of pre-use checks

**OBSTETRIC ANAESTHESIA**

➤ “…patients were listed for elective Caesarean... Consultant Obstetrician was absent… obstetric secretaries were not aware of any cover… regular Obs Consultant was un-contactable... Labour ward was very busy with at least 2 very high risk patients and many patients close to delivery… the remaining 2 sections were cancelled. The earliest re-schedule date was 3 days later…”

Categorised as *Infrastructure*

SALG consider that in busy obstetric units it is unreasonable to expect staff covering the labour ward also to undertake elective caesarean lists. The AAGBI and OAA are currently revising their guidelines on the provision of obstetric anaesthetic services.

**LABELLING OF DRUGS**

➤ “Generic fentanyl ampoules ordered by pharmacy are arriving in boxes with red labels. The ampoules also have red labels. The red in question is similar if not identical to the red which the RCoA and AAGBI had agreed on 10 years ago to be the colour for neuromuscular blockers. In addition, generic Adrenaline is coming up with blue boxes and ampoule labels which are identical to the blue chosen for opioid/opiate labels. This can lead to more than a degree of confusion!..”

Categorised as *Medication*

The document “syringe labelling in critical care areas” was published in June 2004. SALG would like to remind anaesthetists to always check the drug ampoule and correctly label the syringe with the correctly texted label.

**TOTAL INTRAVENOUS ANAESTHESIA**

➤ “… Total intravenous anaesthesia with propofol / remifentanil target controlled infusion. Approx 15min into case , noticed that remifentail infusion line leaking from the connection between tubing and luer lock part of the line… no harm to patient…”

Categorised as *Medical Device Equipment*

Healthcare staff are asked to recall the SALG notice on Guaranteeing Drug Delivery in Total Intravenous Anaesthesia to avoid potential awareness or other patient safety incidents when administering this method of anaesthesia. Continued reports highlight the importance of vigilance.

**NEURAXIAL DRUG ERRORS**

➤ “2ml of phenylephrine (dose 25mcg ) was injected down the patient epidural catheter instead of being given intravenously to treat her hypotension”

Categorised as *Medication*

Neuraxial drug errors continue to be reported. When implemented fully, safer connectors will reduce errors, but the safer connectors will not prevent all incidents. Vigilance remains paramount to reduce drug errors.
PARACETAMOL

➤ “Second dose of IV paracetamol given one hour after PGD oral dose 1g.”

Categorised as *Medication*

For more reports on incidents relating to paracetamol and for SALG comments on those incidents please refer to the previous patient safety update.

MONITORING

➤ “… Following induction BP fell to 75/35. Ephedrine and metaraminol given. BP increased to 110/70. Agency ODP altered BP interval to 2.5mins without informing anaesthetist. Anesthetist proceeded to perform blocks. Noted after 10mins that no further BP recordings have been made… restarted. BP 85/35. No harm to patient. Default of machine is to turn off BP monitoring when interval is changed unless start is pressed again. Agency ODP unaware of this. Experienced substantive ODP also present in anaesthetic room. On questioning he was also unaware that this was a feature of the machine. Only the anaesthetist was aware and they had not been informed that the interval was changed…”

Categorised as *Medical Device/Equipment*

The AAGBI published an update to the Standards of Monitoring During Anaesthesia and Recovery in April 2011 recommending that NIBP monitors should indicate if the BP has not been measured within five minutes. It is hope that manufacturers will update NIBP monitors taking this guidance into account.

Readers are reminded that, aside from the omission of identifiable data, reports are reproduced as they were submitted by the reporter. For that reason grammar and spelling may be incorrect.

TIMELINESS OF REPORTING

Figure 2 Type of incident reported

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.