SAFE ANAESTHESIA LIAISON GROUP

Summary of reported incidents relating to anaesthesia

27 FEBRUARY 2010 TO 3 OCTOBER 2010

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 vignettes with which clinicians can identify and use as learning in their own Trusts.
➤ Provide expert comment on reported issues.
➤ Encourage medical staff to contact the Safe Anaesthesia Liaison Group (SALG) in order to share their own learning on any of the incidents mentioned below.

SUMMARY

A total of 6,805 anaesthesia related incidents were reported during the specified time period. 242 incidents were reported using the anaesthetic eForm. In 21% of these cases it was reported that harm was prevented from reaching the patient (near miss). Via the eForm, 50% of incidents were reported to the National Patient Safety Agency (NPSA) within one day of occurrence.

6,563 incidents were reported using Local Risk Management Systems (LRMS). In 18% of these cases it was reported that harm was prevented from reaching the patient (near miss). Via LRMS, 50% of incidents were reported to the NPSA within 42 days of occurrence.

All incidents graded as severe or death were subjected to the current NPSA serious incident review process and, if identified as having potential cause for concern, were reviewed 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 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.

THE FUTURE OF INCIDENT REPORTING

The anaesthetic eForm has been live for use in England and Wales since 30 November 2009. From when the anaesthetic eForm pilot began in May 2008 until 3 October 2010 there have been 608 completed reports submitted. The anaesthetic eForm can be found at: https://www.eforms.npsa.nhs.uk/asbreport.

Following the review of arms length bodies published in July 2010 and the planned closure of the NPSA, the reporting aspect of the NPSA’s work will continue within the structure of the NHS Commissioning Board. SALG would like to reinforce the importance of continuing to report patient safety incidents using the eForm or your LRMS 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. Of the 28 deaths reported five were reported via the eForm and 23 through LRMS. Of these, seven were referred for anaesthetic opinion.

INCIDENT TYPE

Figure 2 shows the type of incidents that occurred within the anaesthetic specialty that were reported using the LRMS or the anaesthetic eForm.
SUMMARISED EXAMPLES OF REPORTED INCIDENTS FROM ALL CATEGORIES (REPRODUCED AS RECEIVED)

➤ Block inserted into wrong eye. Theatre hat obscuring pre-op marking.
➤ Previous case was using auxiliary gas outlet. Forgot to flick switch back to CGO so did induction on adult with no volatile agent or nitrous. No adverse outcome.
➤ 1 litre bag disconnected from central line... bag gradually filled with air... reconnected and then pressurised. Air infusion via central line noticed by anaesthetist and stopped immediately 5–10ml air suctioned from CVP line... potentially fatal.
➤ Two patients were on ward awaiting the same procedure, and the wrong patient was clerked in the pre-anaesthetic check. It was not until the patient arrived in the anaesthetic room that the mistake was realised.
➤ Patient with PDPH had blood patch and developed sciatica post Neurological signs... Needed MRI, but exceeded weight limit on scanner. Took five days to arrange scan. Cauda equina compression, went for urgent surgery.
➤ Patients clopidogrel omitted despite having a drug eluting stent inserted within a few months of procedure. No risk assessment made. No information given to patient regarding risk of stent occlusion.
➤ Pt transferred... decompression for symptoms of cauda equina. No blood investigations ... from referring hospital. The patient was deemed fit to have an anaesthetic (ASA I) on preoperative assessment done by me. ...surgeon ...discovered that there were Harrington rods... it meant that this 1 level discectomy/decompression would now need 4–5 levels... major surgery anticipated to last for a few hours with considerable blood loss... reluctant to anaesthetise this patient at 10PM... due to the infrastructure... (no blood bank on site, no recovery staff... after hours... the surgery was deferred for the next day / day after.
➤ Whilst injecting a drug into intrathecal space, instead of bupivacaine 3.5mls diamorphine 3.5mg was injected.
➤ Administered 50mg suxamethonium when intended to give 10mg atracurium – both drugs in 5ml syringes with red labels.
➤ No nursing recovery staff available due to workload in main theatres and ongoing staffing issues. Five GA cases (four paediatric cases). High workload compounded by lack of recovery staff. Each case, except the first one i.e. all paediatric cases had to be recovered by the anaesthetist hampering turnaround in theatres. Theatre manager advised ‘just carry on’ and no cancellations. Sub-optimal recovery staffing increasing risk of incident.
➤ Critically low stock levels of routine essential equipment hampering safe anaesthesia. Sevoflurane vaporisers empty at start of paediatric list (Policy limiting availability in force) No octopus connectors for intravenous lines. No throat packs and only one set of Magills disposable forceps for the list. ODA constantly having to leave the theatre area to search for routine essential equipment that is not immediately to hand. Dangerous operating environment created by policy of reducing stock levels to minimum.
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

SALG COMMENTS ON SOME IDENTIFIED THEMES FROM PREVIOUS REPORTS

Wrong Site Block
SALG have recently (November 2010) published a Safety Notification regarding Wrong Site Block which was prompted by incident reports. The Notification can be viewed online at www.rcoa.ac.uk/safety and will also appear in the January 2011 issue of the RCoA Bulletin. A notice also appeared in the November 2010 issue of NPSA ‘Signals’. Clinicians are reminded that appropriate use of the WHO Safer Surgery Checklist should prevent Wrong Site Block occurring and are encouraged to read the NPSA supporting information thoroughly.

Epidural Monitoring
SALG recommend that clinicians who use epidurals for post-operative analgesia communicate clearly with ward staff regarding the timing of the removal of the epidural, particularly in relation to the use of heparins for venous thromboembolism prophylaxis. It is vital that all ward staff caring for patients with epidurals (nurses, therapists and non-anaesthetic medical staff) are familiar with the symptoms of epidural haematoma and can spot complications when they occur. MOTOR BLOCK, ESPECIALLY OF NEW ONSET, SHOULD ALWAYS BE RE-ASSESSED URGENTLY AND URGENT IMAGING CONSIDERED.

The AAGBI is in the process of producing a glossy and wall chart aid, to be published early in 2011, on regional anaesthesia in patients taking drugs that interfere with coagulation. These publications will provide guidance on this issue. Please also note that this was also covered in the National Audit Project 3 (NAP3) report in considerable detail. Especially chapters 7, 15 and appendix 3.

Brachial Plexus Injury
A WebEx session, hosted by SALG, was held in September 2010 regarding brachial plexus injury resulting from patient positioning, and in particular the use of shoulder supports in Trendelenburg. This topic was brought to the attention of the Group by a clinician who wished to share local learning on the topic. SALG recommends that extreme caution should be used when positioning patients in a head-down position, particularly for long periods. The use of shoulder supports in this position carries a significant risk of injury to the brachial plexus. This has also prompted a wider investigation of the inclusion of patient positioning on the curriculum. Should clinicians have any experiences which they would like to share on this topic, they are encouraged to do so by contacting the SALG Administrator.