THANK YOU

The Safe Anaesthesia Liaison Group would like to thank Dr Isabeau Walker for authorship of the last nine issues of the Patient Safety Update.

THIS DOCUMENT AIMS TO ACHIEVE THE FOLLOWING:

➤ Outline the data received, the severity of reported patient harm and the timing and source of reports
➤ Provide feedback to reporters and encourage further reports
➤ Provide vignettes for clinicians to use to support learning in their own Trusts and Boards
➤ 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

THE M&M TOOLKIT HAS BEEN LAUNCHED

A toolkit designed to make effective use of time during M&M meetings was launched on Wednesday 23 October at the annual patient safety conference. The toolkit is available online.

The SALG Patient Safety Updates contain important learning from incidents reported to the National Reporting and Learning System (NRLS). The Royal College of Anaesthetists (RCoA) and the Association of Anaesthetists of Great Britain and Ireland (AAGBI) would like to bring these Safety Updates to the attention of as many anaesthetists and their teams as possible. We would like to encourage you to add this Update to the agenda of your next morbidity and mortality meeting and we would also like to hear your feedback on learning points.

Feedback from M&M meetings on how the Patient Safety Update has informed action can be sent to the SALG administrator at SALG@rcoa.ac.uk.

ON THE SALG AGENDA

The following topics are currently under discussion by SALG:

Emergency grab bags
An audit; ‘Regional survey of portable emergency equipment and drugs carried by resuscitation teams in Severn and Peninsula hospitals’ has shown considerable variation in the contents of emergency equipment bags carried by anaesthetists to cardiac arrest and other in-hospital emergencies. A summary of the audit is available upon request from the SALG administrator. The Resuscitation Council (UK) has issued advice as to what these bags should contain and this is shortly to be updated. Readers are urged to check their own equipment against the advice.

Anaesthetists’ involvement in procurement
Anaesthetists are encouraged to become involved in the procurement process for the drugs and equipment they use in light of the incident report regarding bupivacaine detailed on page two of this publication, incidents featured in previous issues of the Patient Safety Update and anecdotal reports. By having an input to purchasing decisions clinicians may be able to prevent confusion arising between new or similar packaging being introduced for different drugs that may in turn lead to patient safety incidents. They should also be involved in decisions about changing equipment suppliers as a lack of familiarity with a device is a well recognised cause of safety incidents.
LEArNING POINTS FrOm rEPOrTED  INcIDENTS

The following extracts are from the eForm and from incidents reported to the LRMS graded as death or severe harm.

Lipid to the rescue!

➤ Uneventful supraclavicular nerve block under US control for awake elbow surgery. Regular negative aspiration and injection. Good LA spread seen. 50:50 mixture of 2% lignocaine with 1:200,000 adrenaline and 1% prilocaine, 30ml in total – patient 89kg. Rapid onset of block. Within five minutes, bradycardia from 60 to 42 – partial response to glycopyrrolate and ephedrine to 48 – patient felt fine. Then sudden profound bradycardia... associated with reduced conscious level. 100% oxygen via anaesthetic circuit. Patient breathing spontaneously. Immediately given 1mg of adrenaline IV with immediate return of rhythm – tachycardia with some broadening of complexes. BP dropped to 60/20. Intralipid given – 2x 100ml boluses and then the remaining 300mls infused at 999ml/hr via pump. Rapid stabilisation – heart rate settled back to normal over the subsequent 15 minutes. Patient fully awake and responding appropriately but complaining of low back pain and pain in legs. No perioral tingling or ringing in ears. Intralipid terminated after total of 500ml given. Patient remained fully stable and surgery undertaken as planned after 45 minutes – fantastic block. Patient transferred to HDU for overnight observation. Lipase and amylase normal the following morning. Repeated at 48 hours. Patient completely well and discharged home from HDU. Events fully explained to patient and wife. Presumed bolus effect with brief episode of LA toxicity...

➤ I attended a cardiac arrest call in theatre... On my arrival I found a patient with GCS of 6. She was receiving high flow oxygen via facemask, and six milligrams of midazolam was given intravenously with no improvement. The surgeon explained that the lady started fitting immediately after the 20ml of 0.5 % levobupivacaine was injected into sacroiliac joint under radiological control. I initiated the protocol for local anaesthetic toxicity. Immediately after the first dose of intralipid, the patient opened her eyes. The rest of the intralipid was transfused as per protocol. We observed a full recovery. The patient was transferred to a ward for continuous monitoring and observation. Arrangements to rule out pancreatitis were made and the patient was discharged two days after the incident with a full recovery and no complications.

Intralipid is well established as a treatment for local anaesthetic systemic toxicity (LAST). Do you know where it is kept in your theatre? The AAGBI Safety Guideline describes immediate management of LAST; assess and treat ‘ABC’ and control seizures, as described above. Intralipid has now been used to successfully treat systemic toxicity associated with a range of lipophilic drugs: Lipid emulsion infusion: resuscitation for local anesthetic and other drug overdose. The LipidRescue™ website has been compiled by an expert in the field and contains many case reports, up-to-date guidance and reviews.

Near miss (and not so near miss) drug errors

➤ SpR drew up water to mix with antibiotics, but had drawn up L-bupivacaine in error. On a separate occasion, bupivacaine was drawn up instead of saline to flush a central line; fortunately the errors were both noticed before the patients came to harm.

➤ A patient on an elective gynaecological list was given a dose of thiopentone 500mg instead of the intended antibiotic, co-amoxiclav 1.2g during the maintenance phase of anaesthesia. The error was noted shortly after the entire dose of thiopentone had been given. Antibiotic was correctly administered soon afterwards and the surgery continued. Apart from some transient hypotension at the time of administration, which responded well to vasopressors, the patient suffered no apparent harm as a result. The vials of co-amoxiclav and of thiopentone (which was a non-standard, non-UK formulation brought in to address a UK supply problem) are almost identical…
We have just changed our supplier for water and saline 10ml plastic ampoules, on cost grounds. The new water ampoules are a similar shape to L-bupivacaine (square in cross section). The new saline ampoules have the same green colour as the bupivacaine ampoules. Reported to Commercial Medicines Unit. The trust has agreed to revert to the original supplier of water and saline ampoules.

Patient for laparoscopic cholecystectomy. Previous problems with PONV therefore planned to use TIVA with propofol and remifentanil. After induction and intubation noticed that a lot more remifentanil had been given than I would have expected. On inspecting the pump I realised I had inadvertently programmed it as if containing 1% propofol. Pump stopped and reprogrammed correctly, patient required 0.5mg metaraminol to treat hypotension (systolic BP 75) but no other adverse effects… When programming pumps for TIVA following this incident I check the settings with the anaesthetic assistant and complete programming of one pump before turning the other pump on…

Medication errors occur in approximately 1:200 anaesthetics, the majority near miss incidents. The ‘human factors’ leading to medication errors have been well described and have remained unchanged over the last two decades. They are:

- failure to check or misread vials/labels
- distraction or lack of vigilance
- inattention or carelessness
- pressure of work
- communication failures.

The International Medication Safety Network issued a position statement in November 2013 calling for changes in industry to deal with the problem of ‘look alike’ or ‘sound alike’ drugs, taking human factors theory into account. Healthcare providers are advised to assess medicines names, labels and packages before purchasing decisions are made. Even with perfect eyesight, font-size six labels and date stamps on plastic ampoules are almost impossible to read.

No delay: Clear communication and escalate upwards

Patient on CICU deteriorated overnight and needed urgent cardiac echo to look for pericardial collection and tamponade. On-call cardiology SpR contacted in morning to do urgent echo. Five hours later… (no TTE yet); patient suffered cardiac arrest. TOE performed by me during resuscitation confirmed tamponade. An earlier identification of pericardial collection by TTE would have prompted an earlier return to the operating theatre, and potentially avoided the cardiac arrest, and could possibly have avoided the severe heart failure and death… I was the cardiology registrar on call… As the day evolved, it became apparent that the day was going to become particularly busy and that this would prevent me attending to the patient… I hadn’t heard back from the CICU team and made the assumption that his condition hadn’t deteriorated…
Patient admitted with thigh/buttock abscess. Known drug abuser injecting IM. Anthrax was confirmed late on the same day… (patient died). Necrotising infection should have been identified sooner to allow for early surgery and debridement which could have facilitated a better outcome for this patient. Primary surgery was delayed by 24 hours due to the uncertainty around the patient diagnosis. The patient died of multiorgan failure brought on by sepsis caused by an anthrax infection.

An action plan was drawn up by the reporters from the key learning points from this incident:

1. If a difference of opinion exists between trainees/middle grades of different disciplines, escalation to consultant level should occur.
2. Delaying surgery at night or if the morning emergency theatre is not vacant should be agreed by the consultant on call, as competition for the emergency theatre in the afternoon is known to be intense at times.
3. Current discussions about having a 24/7 emergency theatre available should be put into action.

Communication failures are often found to be the root cause of errors in the NHS. The NHS Institute for Innovation and Improvement promoted two tools to facilitate good communication: for the person giving the message – SBAR – situation-background-assessment-recommendation; and for the person receiving the message – Listening – importance of this skill.

The topic of Seven Day Services is firmly on the agenda of NHS Medical Director for England Professor Sir Bruce Keogh, the Academy of Medical Royal Colleges, and is supported by the BMA. As a first step, the Seven Day Services Forum is focusing on improving diagnostics and urgent and emergency care. It is also currently exploring proposals for improvements and examining the key issues which affect delivery of a seven day service. The first cohort of early adopter organisations have recently been announced in order to develop and spread models of care supporting whole system change at scale and pace.

Central lines

Patient from CCU brought to theatre for insertion of CVP line. After the procedure he began having difficulty breathing and so he was intubated. An emergency call was put over the theatre intercom for consultant anaesthetist’s help. After intubation the patient suffered a cardiac arrest. Resuscitation attempts were commenced but were unsuccessful…

Patient’s central line from theatre was not stitched in correctly. After rolling the patient the central line became dislodged, resulting in the patient having a cardiac arrest due to no inotrope delivery…

Patient booked on CEPOD list for sigmoid colostomy due to recurrent sigmoid volvulus. Multiple comorbidities… Discussed with consultant… HDU admission and CVC insertion with K+ replacement pre-operatively… Multiple attempts by three on call anaesthetists to site CVC (left internal jugular and right subclavian veins); no success. Called anaesthetic consultant… attended from home. CXR performed pre-operatively-loculated haemothorax in left upper zone. Patient haemodynamically stable and no respiratory compromise. Anaesthetic consultant and surgical consultant decide to proceed with surgery. Anaesthetic: GA (uneventful induction ); left IJV CVC inserted while anaesthetised – no difficulty. Surgery uneventful – patient had some requirement for vasopressors but no ventilatory difficulty noted. At end of surgery Hb drop noted from 12 (pre-op) to eight. On table CXR performed prior to extubation: large loculated haemothorax L upper zone and blunting of costophrenic angle on left-large haemothorax…

Never Event. Patient had an oesophagectomy. Post-operatively the patient had two gastromyro swallows to assess the oesophageal anastomosis. On discharge it was recommended a repeat gastromyro swallow. This was arranged for (six weeks later). During this investigation it was noted the central line introducer was in situ…

Arterial lines

Ischaemic left arm secondary to brachial arterial line. 33+4 trisomy 21. Arterial line sited for laparotomy/duodenoduodenostomy/resection of Meckel diverticulum and Ladd procedure. GTN/warming/heparin commenced on PICU. Discussion with Vascular Surgeon – no other treatment possible…
Epidurals
➤ Patient sustained motor blockade post epidural insertion. Epidural stopped and recommenced day-1 post-op after resolved motor function witnessed. Motor blockade reoccurred after recommencing epidural; did not resolve after discontinuation. MRI completed and suspected epidural haematoma located.
➤ Patient had epidural catheter inserted for post-op analgesia. Unable to move legs morning two days later. MRI scan performed urgently which demonstrated an epidural haematoma. Referred to neurosurgeons...

Nasogastric tubes
➤ Asked by nurses to check an NG position on an unventilated patient on ICU. Although NG appeared to go to the right, it appeared below diaphragm and discrete from right main bronchus, therefore I stated that it was OK to use. At around 8 am this morning (following day), I was informed by overnight medical staff that the patient had started NG feed; (three hours later) the patient had partly coughed the tube out, so feed was stopped. Requested a further CXR; this showed that the NG tube was definitely in the right main bronchus. It appears with hindsight that the NG tube was intra pulmonary. It is likely that the patient received 102ml of NG feed into his right lung.

These are salutary tales that remind us that routine procedures can be associated with significant harm. Retention of central line guidewires is a recurring mishap, also noted in the international literature (read more). Properly used arterial lines have an excellent safety record and ischaemic episodes are rare. The brachial artery is the main artery supplying the forearm and should be used with great care. Unexpected weak legs with an epidural are a red flag (for vertebral canal ischaemia, haematoma or abscess and should prompt early senior anaesthetic input with MRI arranged early unless there is clear evidence that there is no problem. Delay in decompression may lead to permanent neurological damage. Misplaced nasogastric tubes are one of the 25 never events identified by the Department of Health; an excellent e-learning module has been produced to reduce errors associated with misplaced nasogastric tubes.

Difficult extubation
➤ Patient with a known grade-4 intubation, was unable to intubate in an emergency situation (after extubation), and despite requesting the difficult airway trolley, the trolley did not arrive from theatres and instead recovery intubation trolley was sent round. Patient sustained a hypoxic cardiac arrest...

Best to plan for the worst; it may happen. The Difficult Airway Society have produced difficult extubation guidelines that describe various strategies for those at both low risk and high risk for complications on extubation.

Care of the elderly, your high risk patients
➤ 100-year-old patient admitted to theatres for emergency NOF repair. Anaesthetic performed with regional block, spinal and propofol sedation. During operation patient became agitated and restless. Reassurance given but no avail. Consultant just outside theatre, CT1 and CT2b in theatre. Increased propofol sedation from CPT of 0.2 to 0.4. No effect. Bolus of propofol 20mg given. Drop in BP with poor pulse oximetry pick-up. Boluses of metaraminol given, BP remained low. No respiratory effort, help called. Consultant called into theatre. BVM applied to patient with 100% oxygen and bagged. Consultant gave bolus of ephedrine. Poor seal obtained from BVM – decision to intubate. Emergency buzzer pressed. Two further anaesthetists arrived with additional ODP and nurse. Patient successfully intubated, cardiac arrest called. Two cycles of CPR and 1mg of adrenaline administered. ROSC. Operation completed under desflurane. Patient breathing spontaneously, required boluses of metaraminol peri-operatively. Poor return of neurological function on removal of anaesthetic gases. Returned patient to recovery and monitored...
➤ Patient went into PEA arrest in recovery post spinal anaesthetic with sedation for a right hemiarthroplasty. Patient was 97 and had hypertension, ischaemic heart disease (MI previously) and paroxysmal AF. ASA 3. Return of spontaneous circulation achieved after one cycle of CPR and adrenaline. ITU consultant attended and decision was made not to resuscitate if patient arrested again. Family called. Patient arrested again and was kept comfortable. Family informed on arrival.

Anaesthesia in the elderly is far from benign and experienced hands are required. The AAGBI produced a consensus guideline on the management of proximal femoral fractures in 2012, and an AAGBI guideline ‘Perioperative Care of the Elderly 2013’ will be published at the end of 2013. The Anaesthesia Hip Fracture Sprint Audit Project (ASAP) has just been completed and has 11,000 patients in the database. The preliminary findings will be presented at the AAGBI Winter Scientific Meeting 15–17 January 2014.
PATIENT SAFETY CONFERENCE 2013

The SALG Patient Safety Conference 2013 was held on Wednesday, 23 October. In addition to the varied and stimulating programme, ten posters were displayed and their content has been summarised below. If you would like the references for these summaries, further information on any of the topics covered, or if you would like to get in touch with any of the authors, please do so via the SALG administrator at SALG@rcog.ac.uk. Please note that these summaries are provided for information only and SALG does not necessarily encourage the replication of the proposed practices below.

**A re-audit of post-operative handover from anaesthetists to the recovery team**
C Dallimore, R Bevan, S Clements, L Warnock
Ysbyty Gwynedd, Bangor, UK

The objective of the work was to improve handover of patient information to ensure quality of care after an initial audit of 96 patients showed a failure to meet Royal College of Anaesthetists standards. A simple SBAR handover poster was created to prompt efficient verbal handover. A re-audit of 39 patients revealed 33% of handovers met all audit criteria compared to 24% in the initial audit. The greatest improvements were made in handover of airway difficulties, post-operative fluid and medication prescribing. The documentation of a post-operative plan and theatre origin remained poor. It was concluded that the introduction of an SBAR poster improves handover but there remains room for improvement.

**Assessing the administration of cricoid pressure amongst theatre staff**
S Denning, K James and B Ho
Royal Derby Hospital, Derby

We surveyed staff to test knowledge and application of adequate cricoid pressure among theatre staff at Royal Derby Hospital. Fifty-two staff, including ODPs and anaesthetists, were asked to give the correct value for cricoid pressure and apply adequate force (30-40N) to the 50ml syringe apparatus. Depression of the plunger by 17ml indicated 30N. Overall 52% of staff were able to correctly state the required force (71% of anaesthetists, 34% of ODPs) with only 40% being able to apply >30N. We recommended that the syringe apparatus be used as a training aid immediately prior to applying cricoid pressure to improve patient safety.

**Does ‘in-situ’ simulation training influence safety culture in the theatre environment in a university teaching hospital?**
T Hinde, T Gale, I Anderson, P Sice
Derriford Hospital, Plymouth Hospitals NHS Trust

Inter-professional ‘in-situ’ simulation is used as a training tool in our theatre directorate with the aim of improving crisis behaviours. This study aimed to assess the impact of ‘in-situ’ simulation on the safety culture of theatres. A validated Safety Attitude Questionnaire was administered to 54 staff members before each simulation scenario and then re-administered to the same staff members after six to 12 months. Analysis demonstrated a statistically significant improvement in both safety (p<0.001) and teamwork (p=0.013) climate scores (components of Safety Culture) six to 12 months after training. Our study supports the implementation of ‘in-situ’ simulation as a useful intervention to improve safety culture in theatres. Evidence suggests that improvements in these domains result in a positive effect on patient morbidity and mortality and thus safety.

**Emergency guidelines, drugs and equipment availability status**
C Phoenix, D Laws
City Hospitals Sunderland, Tyne & Wear

Access to emergency guidelines, drugs and equipment is a fundamental safety issue in the operating theatre. The Audit Recipe Book standards include that adrenaline and anaphylaxis guidelines should be available within one minute and dantrolene and intralipid within three minutes. We installed current guidelines within wall mounted document folders in all anaesthetic rooms, improved the accessibility of emergency drugs in all theatre suites and defined ‘parking spaces’ for emergency equipment. Audited performance was markedly improved and team-based training is planned to consolidate improvements.
E prescribing systems: unforeseen problems which may compromise patient safety.
Dr K Walker, ST6 Anaesthetist
Hampshire Hospitals Foundation Trust, Basingstoke
The role of e-prescribing in hospitals is expanding. The introduction of these systems may lead to unforeseen problems. I audited anaesthetists’ use of the JAC prescribing system, via questionnaire, at Basingstoke (2012-2013). Only 35% could record drug administration on JAC. Investigation revealed trainees did not have the correct IT privileges. Liaison with IT, Head of Pharmacy, and the Clinical Director resulted in changes to their IT settings. A re-audit eight months later revealed 45% could now record drug administration. This has had a patient safety benefit, as it has reduced the likelihood of duplicate doses of potentially dangerous drugs being administered.

In-situ theatre simulation training
A Vaughton, L Richardson, R Ford
Poole Hospital NHS Trust, Dorset
In-situ theatre simulation training allows rehearsal of rare, life-threatening emergencies by a multidisciplinary surgical team. Benefits include team training, identification of latent safety threats and assessment of current systems. Regular theatre simulation training has been instigated in our trust to expose staff to adverse anaesthetic incidents. Feedback from staff has been extremely positive and to date, this in-situ training has brought about a number of changes in practice. The multidisciplinary response to emergency scenarios in theatre needs to be rapid, fluid and efficient. Embedding this training into routine practice furthers education, improves theatre staff confidence and ultimately enhances patient safety.

Patient monitoring post intrathecal diamorphine – maintaining the standard in 2013
B Armstrong, P Yoxall
St Helens and Knowsley Teaching Hospitals NHS Trust, Prescot
All patients receiving intrathecal diamorphine for caesarean section should also receive regular monitoring of vital signs (pulse rate, blood pressure, respiratory rate, oxygen saturation) for 12 hours post-operatively, as per departmental protocol (taken from NICE recommendations). This is essential for patient safety. Current practice was re-audited in 2013 with the aim of completing the audit cycle (following implementation of recommended action plans from previous audit). A retrospective case notes review (over one month) of all cases meeting the inclusion criteria showed that high standards of compliance with departmental protocol for patient monitoring post intrathecal diamorphine were being maintained.

Safer intensive care unit handover: development and implementation of a seven step standard operating procedure and structured handover sheet
R Grimaldi, A Green, D Hinge, R van der Most, R Galloway and J Pateman
Royal Sussex County Hospital, Brighton
Our Intensive Care Unit (ICU) incident reports showed 13% related to handover. Together with clinical experience, this emphasised ICU handover was unstructured, compromising patient safety. Lessons from the WHO and Formula One on how teams accurately complete tasks under pressure inspired development of a 7-Step Standard Operating Procedure (SOP) for ICU handover, together with a Structured Handover Sheet. We filmed a simulated handover ‘before’ and ‘after’ the SOP and have used it for local and regional training. It has been implemented as Trust protocol and is rapidly gaining local and regional interest.

The Royal London MATCH Project
E Cook, SR Ford, T Stephens, H Mills, O Glesa, PJ Shirley, AT Abraham, A Hunningher
The Royal London Hospital, London
A 2012 Royal College of Surgeons visit to the Royal London Hospital identified a need to improve teamwork amongst staff. The pilot MATCH (Multidisciplinary Action Training in Crises and Human factors) training course, for the multidisciplinary theatre team, focused on four areas of theatre safety culture; effective team-working, use of the WHO surgical checklist, human factors in crisis management and the use of After Action Review (AAR) as a debriefing and team learning technique. Following positive feedback, the MATCH course has been adapted to reflect published evidence for teamwork training. The importance of team briefing and debriefing is emphasised. Simulation and AAR debriefing are used to enhance the clinical relevance of the training. MATCH will hopefully lead to improvements in patient safety measures and theatre performance and enhanced staff safety attitudes.
APPENDIX: INCIDENT DATA SUMMARY

A total of 4,447 anaesthesia-related incidents were reported during the specified time period. Only 19 incidents were reported using the anaesthetic eForm; Nine (47%) of these incidents were reported to the National Reporting and Learning System (NRLS) within one day of occurrence. Four (21%) of the incidents reported to the eForm were reported as ‘near miss’ (harm was prevented from reaching the patient). Four thousand, four hundred and twenty eight incidents were reported using Local Risk Management Systems (LRMS); 28 (0.6%) of these incidents were reported within one day and 2,195 (50%) were reported more than 30 days after they had occurred. Of the incidents reported via LRMS, 540 (12%) were reported as ‘near miss’.

All incidents reported via the eForm, and all those reported to the LRMS graded as ‘death’ or ‘severe harm’, were reviewed by the Patient Safety Team, now part of the Patient Safety Function within NHS England (formerly the NHS Commissioning Board). Consultant anaesthetists from the RCoA or AAGBI reviewed incidents identified as having potential cause for concern. No information about the Trust was disclosed in this review; only information about the incident. Most incidents reported via the eForm were completed by consultant anaesthetists, although the eForm is available to all members of the peri-operative 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 that 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 was designed to allow specific clinical information relating to anaesthetic incidents to be reported by anaesthetists and other members of the anaesthetic team, and can be found at: www.eforms.nrls.nhs.uk/asbreport.

The RCoA and AAGBI continue to work with the NRLS team at Imperial and the patient safety function of NHS England. SALG would like to reinforce that processes for sharing and learning incidents remain firmly in place. Staff are urged to continue to use the eForm (or your local reporting systems) to report patient safety incidents so that trends and incidents can be acted upon and learning maximised. The eForm is particularly useful as it provides a mechanism by which high quality information can be reported rapidly by members of the anaesthesia team and disseminated nationally.

DEGREE OF HARM (ACTUAL INCIDENTS)

Figure 2 shows the degree of harm incurred by patients within the anaesthetic specialty during the period 1 April 2013 to 30 June 2013. Thirteen deaths were reported though LRMS and two via the anaesthetic eForm.
INCIDENT TYPE

Figure 3 shows the type of incidents that occurred within the anaesthetic specialty that were reported using LRMS or the anaesthetic eForm for the period 1 April 2013 to 30 June 2013. The categories were determined at local level.