SAFE ANAESTHESIA LIAISON GROUP

PATIENT SAFETY UPDATE

April – June 2017

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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 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 (M&M) meeting, and we would also like to hear your feedback on the 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

DEATHS IN ASSOCIATION WITH ANAESTHESIA, THE CORONER AND LEARNING

The Coroner's court in England and Wales provides a service to the public by investigating the cause of a person's death when there is any uncertainty of the how, why and when.[1] A similar but slightly different process functions in Scotland and Northern Ireland.[2,3] At the conclusion of an inquest, the coroners publish their determination setting out their findings and offering a narrative conclusion. If the coroner believes that action should be taken to avoid further deaths, then they have a duty to issue a report known as *Report to Prevent Future Deaths* (PFD) under regulation 28 of the Coroners and Justice Act 2009 asking for a response from the relevant organisation within 56 days. For anaesthesia, the coroner may send PFD reports to an anaesthesia related organisation/body of their choosing for example, RCoA, AAGBI or other subspecialty society. It is usual for the organisations to collaborate in providing a relevant response to the coroner and to ensure that the detail and action points are shared amongst anaesthetists. Coroners send all PFDs to the Chief Coroner and the reports are published on the on the Courts and Tribunals Judiciary website; the Chief Coroner's office is currently uploading all reports from July 2013 to the website. SALG begins the case summary section of the PSU with news from the coroner's court.

1. (www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner)
2. (www.copfs.gov.uk/investigating-deaths/our-role-in-investigating-deaths)
3. (www.justice-ni.gov.uk/articles/coroners-service-northern-ireland)

Case 1 – a central venous line was inadvertently inserted into the patient's artery. The line had been inserted under ultrasound guidance, but the mistake was not detected. Of note, arterial puncture can occur despite the use of ultrasound and skill is required in interpreting the ultrasound images. It is important to confirm correct placement using additional confirmation tests such as transducing the pressure waveform and performing blood gas analysis on a sample taken from the vessel puncture if there is doubt.[1]

1. Task Force on central venous access. Practice guidelines for central venous access: a report by the American Society of Anesthesiologists. *Anesthesiology* 2012;116:539-73.

Case 2 – a patient undergoing lumbar discectomy sustained trauma to the common iliac artery which remained undetected until the patient was in extremis. Resuscitation was delayed and the patient died of multi-organ failure. Major vessel injury is a rare but recognised complication of posterior lower spinal surgery.[1] This patient was persistently hypotensive in recovery and the attending clinicians did not consider concealed retroperitoneal haemorrhage as a cause.

1. M Leech *et al*. Abdominal Aortocaval Vascular Injury following Routine Lumbar Discectomy. *Case Reports in Anesthesiology* 2014 Article ID 895973. (http://dx.doi.org/10.1155/2014/895973).

Case 3 – a patient was admitted with a severe chest infection and with their condition deteriorating, they required intubation and ventilation. While waiting for a bed in ICU, a temporary arrangement was created in the theatre recovery. Those attending were not familiar with the anaesthetic machine provided and did not appreciate that a mechanical switch existed on the machine that had to be operated to switch fresh gas supply between the ventilator circuit and the accessory common gas outlet. The consequence of this was that the machine delivered recycled exhaled gases. The anaesthetic gas monitoring alarm was set at factory defaults and the low FiO_2 was not detected. This set of circumstances led to the patient receiving a hypoxic mixture of gases and they sustained a hypoxic cardiac arrest. The coroner noted that clinical practice was at variance with the AAGBI machine check and monitoring standards on repeated occasions.

LEARNING POINTS FROM REPORTED INCIDENTS

The coroner was particularly struck by the admission of several clinicians that they had not been trained to use the anaesthetic machine and yet they proceeded to use it. Alarm settings remained at default settings which were inadequate for this patient and permitted hypoxic gas delivery (default FiO_2 of 0.18).

Case 4 – a patient requiring resuscitative vascular surgery was rushed to theatre for control of bleeding and the circumstances meant that the anaesthetists felt there was no time to perform the routine machine check. During the early part of the case multiple alarms were sounding relating to the patient's blood pressure, oxygen saturations and to the machine function itself and so the machine was switched to manual ventilation mode. After 20 minutes, the FiO_2 was note to be 0.05 and a rapid examination of the machine revealed a poorly seated vaporiser on the back bar. The coroner concluded that hypoxic gas delivery contributed to the patient's death. The investigation found that the clinicians involved were not aware of the anaesthetic machine functions and its safety limitations. The particular breathing system used on this occasion retains the reservoir bag within the circle circuit both during manual and mechanical ventilation and during low flow anaesthesia will take some time to empty when there is a leak in the system such that the ventilator will entrain air. Anaesthetists should know how their anaesthetic machine works and in particular under fault conditions. Anaesthetic machines should be checked before use and alarm settings should be set according to the patient's condition (AAGBI machine checklist). Switching to a self-inflating bag would have avoided delivery of a hypoxic gas mixture, but with ventilation of the lungs proving no concern the usual trigger to that action was missing. The advice from SALG is that a low oxygen concentration alarm should always be assumed to be correct. If the cause of the low FiO_2 is not immediately obvious, a switch in ventilation device should be considered.

Case 5 – a patient received a general anaesthetic via a supraglottic airway device (SAD) for a total knee replacement. During the procedure the patient's oxygen saturation levels fell and this led to a change in airway management from SAD to tracheal tube. An oesophageal intubation was not detected despite an absent $ETCO_2$ trace and the patient died following a cardiac arrest. The coroner made heavy reference to the lessons contained in the NAP 4 reports in his narrative. In particular they highlighted that there was a lack of understanding of capnography during cardiac arrest. The coroner also identified that anaesthesia teams should train for crises so as to avoid errors attributable to task fixation and confirmation bias around the causes of an absent expired CO_2.

The RCoA in conjunction with the AAGBI and DAS are preparing their reply to the coroner.

The February edition of *Anaesthesia News* will provide further detail of the specialty response to this case. In the meantime:

> During cardiac arrest with ongoing CPR capnography shows an attenuated capnography trace. A flat trace indicates absent lung ventilation, most likely oesophageal intubation or tracheal tube obstruction, which should be actively excluded.

The revised Never Events framework is due to be published shortly by NHS Improvement. This revision includes the addition of undetected oesophageal intubation and subsequent ventilation as a never event.

MORE LEARNING POINTS FROM REPORTED INCIDENTS

Old lessons, new learning: TIVA and prone surgery

- *Remifentanil infusion given sub cut as the cannula tissued but the resistance was low so the high pressure alarm didn't go off and there were no physiological changes.*
- *Patient underwent prolonged spinal surgery, in prone position. Hypotensive for long periods during surgery. Post-operatively has developed an acute kidney injury, may need RRT, acute hepatic ischaemic injury and possible ischaemic bowel on CT scan. Currently being treated in ICU with inotropes to support blood pressure and hopefully allow injuries to recover.*

Issues with TIVA infusion sites[1] and organ ischaemia secondary to impaired splanchnic circulation[2,3] in the prone position have been cited in the PSU before but these cases serve as timely reminders of the potential problems associated with the integrity of peripheral vascular access during TIVA and the effects of hypotension and poor prone positioning.

1. SALG Guaranteeing Drug Delivery in Total Intravenous Anaesthesia October 2009 (www.rcoa.ac.uk/system/files/CSQ-PS-2-Safety-notification-TIVA.pdf).
2. M Chikhani *et al*. The effect of prone positioning with surgical bolsters on liver blood flow in healthy volunteers. *Anaesthesia* 2016; 71:550-555 (http://onlinelibrary.wiley.com/doi/10.1111/anae.13416/epdf).
3. B Feix *et al*. Anaesthesia in the prone position. *Continuing Education in Anaesthesia, Critical Care and Pain* 2014;14(6):291-297 (https://academic.oup.com/bjaed/article/14/6/291/247907).

LEARNING POINTS FROM REPORTED INCIDENTS

DELAYS IN CARE – A WIDE RANGE OF CAUSES

- *A middle aged man admitted in acute renal failure... awaiting a bed at hospital A – admission accepted. Two days later became unwell early evening (no medical reg during the day due to staff shortages). Deteriorated, seen by outreach, ICU resident gave phone advice to FY1. Further deterioration... seen by ICU resident and accepted for ICU-fluid overload. Arrived two hours later peri-arrest. Needed intubation and ventilation, cardiac arrest shortly after. Died.*
- *Older patient ventilated on ICU with MI and community acquired pneumonia developed an acutely ischaemic right lower limb. Referral was made to vascular surgery from which a CT, heparin infusion and review on the following Monday was recommended by the on-call registrar. Over the next 24 hours, the patient improved from a respiratory point of view but fixed mottling developed in the leg, renal and hepatic function deteriorated and the patient developed SVT. A further referral to vascular surgery on saturday afternoon prompted a review... an above knee amputation and revascularisation of the thigh by the on-call vascular consultant, without which the patient would have died. The cause of the ischaemia was an arterial clot, visible on the CT. It may have been possible to revascularise the leg on friday, soon after the ischemia was noted and avoid the AKA and multi-organ deterioration in the intervening 24 hours, had the patient received an urgent review on Friday. The patient could have been too unstable to transfer to but could have been reviewed locally. Recent withdrawal of local vascular surgery services merit consideration.*
- *Late evening older man admitted with DKA and infected foot on a background of vascular disease, hypertension and Type 2 diabetes: diagnosed in A&E. Treated according to DKA protocol and seen by ED reg on admission however not seen by medics throughout the night. Decreased GCS and continued acidosis when seen 9 hours later by HDU SHO (no medical input overnight). Referred to surgeons for infected foot debridement. Patient came to theatre early afternoon, GCS about 6, hyperventilating due to acidosis, unresponsive to CVP line insertion. Upon commencing debridement the patient suffered a run of VT and then had a PEA arrest. He underwent 6-cycles of CPR with adrenaline and bicarbonate. ROSC was not achieved at 6 cycles and the universal decision was to discontinue the resusc attempts.*
- *Patient was brought to the ED unresponsive. He was found to have a subdural haematoma. The neurosurgical centre asked for immediate transfer; however there were long delays in anaesthetic responses, and the patient did not leave the hospital until late evening.*
- *Neurosurgical patient referred for care. Critical care consultant asked if needed to bring patient straight away for treatment and transfer, or whether happy to wait until able to transfer another patient to the ward. Neurosurgeons stated they were happy to wait. Patient arrived on unit 8 hours later. ICP bolt inserted, reading 75. Patient scanned, not for surgical treatment. Treatment withdrawn, patient died 10 hours later.*
- *Patient induced for theatre, uncomplicated induction, grade 1 view of cords. Placement confirmed with $ETCO_2$, good chest rise, misting of tube. Surgery began... abdomen insufflated - patient became bradycardic - patient then went tachycardic (no drugs administered) ? SV... output lost - arrest call put out. 2 mins CPR, 1x adrenaline given, output returned. Stopped CPR. Echo demonstrated good heart movement and EF approx 60%, CXR organised, art line organised, surgery abandoned, ICU bed organised. Whilst waiting for CU, haemodynamic requirements increased. BP very labile, metaraminol infusion started. Spr organising /expediting ICU bed. Pink frothy sputum coming from ET tube. Suctioned. US guided CVC inserted for further pressors... no immediate complications. Wire seen in lumen... aspirating all lumens well. BP dropping, metaraminol bolused, sats dropping, called SpR. After 2 hours patient rearrested – crash call put out. Approx 30 mins of CPR. No sustained output. No discernible cardiac motion on echo. Senior decision to stop CPR.*
- *Two day delay for fractured neck of femur surgery for IV antibiotics to treat pneumonia and rehydration. Intra operatively multiple blood components and Intravenous fluids (12.5 litres) received in just over 24 hours. Day 1 post operatively the patient had a peri-arrest due to hypoxia... 1 cycle of CPR no loss of output. Transferred to HDU for BiPAPfor pulmonary oedema. Possible fluid overload - Hb possibly dilutional. Notes state low BMI.*

The Health Services Investigation Board (HSIB) is reviewing the care of a critically unwell patient who died within 24 hours of admission to hospital[1]. Their interim report identifies the difficulties in appreciating the severity of illness and the changes in a patient's condition. In addition the report raises the issue of implementation and efficacy of current strategies and points to the deficiencies in the contextual, organisational and human factors involved in

determining the severity of a patient's condition and the treatment decisions that follow. Further reports will follow as the investigation process proceeds.

Patient outcomes differ not only because patients are individuals but also because of variation in care whether that is clinical or system driven. These cases shine a light on variation in practice, away from what might be considered good practice. The variation may be in escalation protocols, the seniority or clinical experience of the decision makers or in local transfer resources and protocols and communication or due to weekend working. Whatever the variation and its reasoning, there is potential for adverse impact on patient safety, outcome and quality of care. *The* Get It Right First Time project aims to reduce unwanted variation in practice by sharing national data with clinicians and managers and monitoring for change and improvement. Thirty specialties have signed up to the programme and general surgery and orthopaedics have published their first report on the project outcomes link here.

1. HSIB Interim Report: Recognising and responding to critically unwell patients. 27 November 2017 (http://bit.ly/2r7o1fl).

VASCULAR ACCESS

- *Central line inadvertently placed in right carotid artery. Young patient developed left hemiparesis.*

In an analysis of closed claims for CVC insertion in the USA in the years 1970-2000, 16/110 claims were associated with carotid puncture and five of these resulted in a stroke. Ultrasound was not used in any of these cases in keeping with the practice of the time. Although the incidence of arterial puncture was quite high (1.9-9.4%) there were few claims for injury.[1] A similar review of the NHS Litigation Authority database of cases related to central venous access by anaesthetists reported a total of 14 claims were raised due to arterial puncture. Eight of these were carotid artery puncture (internal jugular approach) of which five resulted in death and four attributed to stroke.[2]

Safer vascular access guidelines describe current practice for CVC insertion and management of complications.[3]

1. K Domino et al. Injuries and Liability Related to Central Vascular Catheters: A Closed Claims Analysis. *Anesthesiology* 2004;100:1411-1418 (http://bit.ly/2mxmTw1).
2. T Cook. Litigation related to central venous access by anaesthetists: an analysis of claims against the NHS in England 1995–2009. *Anaesthesia* 201;66:56-66.
3. A Bodenham *et al*. AAGBI: Safe vascular access 2016 *Anaesthesia* 2016;71:573-585 (http://onlinelibrary.wiley.com/doi/10.1111/anae.13360/epdf).

NAP3

- Patient admitted for AAA repair under spinal anaesthetic. Post surgery patient unable to move lower limbs, MRI showed likely spinal haematoma causing compression and myelinopathy.
- *A chronic pain patient received a lumbar epidural. He reported increased back pain to his GP who contacted the pain team and the patient was seen as an urgent follow-up in clinic approx one month later. An urgent MRI was requested that day. The patient subsequently arranged for a private MRI which revealed an epidural abscess and he was admitted for IV antibiotics. He is currently still an in-patient.*

Delay in diagnosis is a common feature in the care of vertebral canal haematomas associated with central neuraxial blockade. The NAP3 report suggested that this is due to failure to appreciate the significance of leg weakness or numbness.[1] Full recovery of neurological function is dependent upon immediate recognition, investigation and treatment.

Back pain is a common presenting feature in cases of epidural abscess and may present within a few days of the block or up to several weeks after. It is often missed as a symptom. Presence of an epidural catheter increases the risk of abscess. NAP3 suggested that patients receiving epidurals should have a letter for discharge describing what symptoms they might expect if they develop an epidural abscess to help speed up diagnosis.[1]

1. Major complications of central neuraxial block: Report on The Third National Audit Project of the Royal College of Anaesthetists. *British Journal of Anaesthesia* 2009;102(2):179-190 (www.nationalauditprojects.org.uk/NAP3_home).

TRACHEOSTOMY CARE

- *I was the doctor on call for night shift in the intensive care unit. I was bleeped by a nurse to say a patient had suddenly become very breathless, had stridor and that the nurse thought the patient's tracheostomy had been displaced. I was asked to come urgently. Along with another doctor (CT2 ACCS) I ran to the patient's bed and reached there in a few seconds. The nurses were trying to bag mask through the tracheostomy with oxygen attached. I took over the airway management of the patient and tried my best to manage the airway as per standard guidelines. My assessment was that the tracheostomy had been displaced thus leading to obstruction in the airway. The patient eventually had a cardiac arrest, had CPR, I intubated the patient while CPR was on-going and the patient returned to spontaneous circulation in about 10 minutes. In the following days, clinically it is suspected that the patient has suffered brain damage due to hypoxia during the cardiac arrest.*

➤ *Rapid desaturation of a patient ventilated via a tracheostomy during turning of the patient which resulted in a cardiac arrest. Despite prolonged resuscitation the patient died.*

When things go wrong with a tracheostomy, very quickly the situation becomes a life-threatening one. In its major findings, NAP4 stated that "displaced tracheostomy, and to a lesser extent displaced tracheal tubes, were the greatest cause of major morbidity and mortality in ICU".[1] The National Tracheostomy Safety Project (NTSP) aims to improve safety and quality in tracheostomy care. Review of care has shown that most problems with tracheostomies are predictable and amenable to prospective quality improvement strategies. The NTSP website provides helpful information on the safe care of patients with tracheostomies with links to e-learning modules and downloadable resources for both routine and emergency care.

Multidisciplinary guidelines for the emergency care of tracheostomies and laryngectomies were published in 2012 with an aim of improving the management of critical incidents.[2] The emergency algorithm gives clear and simple guidance on assessing tracheostomy patency and empowering the responders to remove the tube there is no sign of effective ventilation ($ETCO_2$) and the patient's condition is not improving.

1. 4th National Audit Project of The Royal College of Anaesthetists and The Difficult Airway Society. Major Complications of Airway Management in the United Kingdom Report and findings 2011 (http://bit.ly/2mzmRUl)
2. B McGrath et. Multidisciplinary guidelines on the management of tracheostomy and laryngectomy airway emergencies. *Anaesthesia* 2012:67;1025-1041 (http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2044.2012.07217.x/epdf)

VENOUS THROMBO-EMBOLISM

➤ *Patient underwent routine tonsillectomy - did not receive VTE prophylaxis (anti-embolic stockings) in line with NICE/hospital guidelines – patient was readmitted initially with secondary haemorrhage and subsequently with PE.*

There is insufficient detail in the case summary to make any comment on the assessment of VTE and bleeding risk and the subsequent management. However the case stands as a reminder that VTE and bleeding risk should be assessed on admission and again within 24 hours and whenever the clinical condition changes so as to affect thrombo-embolic and bleeding risk.[1,2] NICE and SIGN provide guidance.[1,2]

1. Venous thromboembolism overview. NICE, 2016 (https://pathways.nice.org.uk/pathways/venous-thromboembolism).
2. Prevention and management of venous thromboembolism. SIGN, 2010. (www.sign.ac.uk/assets/qrg122.pdf).

AIRWAY COMPLICATIONS

➤ *Patient was extubated in the morning and had to be re-intubated later in the day due to retained secretions. The re-intubation was a Grade 1 intubation and straightforward. A bougie was not used. Following intubation, a tracheal tear was noticed. Patient subsequently developed a tension pneumothorax followed by a cardiac arrest.*

Although tracheal injury during intubation is rare and is most often associated with the use of bougies and airway exchange catheters, injury can happen during routine tracheal intubation.[1,2,3]

1. S Contractor et al. Injury during anaesthesia. Continuing Education in Anaesthesia, Critical Care & Pain 2006;6(2):67-70. (https://doi.org/10.1093/bjaceaccp/mkl004)
2. D Evans et al Iatrogenic airway injury. *British Journal of Anaesthesia Education* 2015:15(4):184-189 (https://doi.org/10.1093/bjaceaccp/mku026)
3. T Cook et al. Complications of airway management. *British Journal of Anaesthesia* 2012:109(S1);i68-i85 (https://doi.org/10.1093/bja/aes393)

THE SLIPPERY SLOPE FROM SEDATION TO ANAESTHESIA – THE 4 PS

➤ *I was the anaesthesia registrar on call overnight and was called to assist with pain management for a patient who had undergone a below-knee amputation the previous day and was in severe pain despite morphine PCA. He was writhing on the bed in pain, but intermittently drowsy. I was unaware that the hospital guidelines preclude the use of ketamine on wards, so I administered 20mg ketamine IV, which appeared to extravasate into subcutaneous tissues. A few minutes later the patient was still in severe pain so I administered a further 30mg ketamine IV via a different cannula. I remained with the patient at all times. 2-3 minutes later he stopped breathing and I was unable to rouse him - he had no pulse so I commenced CPR immediately and called the nurses for help. They put out a cardiac arrest call immediately and took over CPR whilst I ventilated the patient using a bag-mask-valve. By the time the arrest team arrived (in less than 2 minutes) the patient had a pulse and was making respiratory effort so CPR was stopped.*

The take home messages from this scenario include: take extra care using potent drugs outside the familiar, comfortable, highly supervised setting of theatre/recovery; only use drugs you are familiar with, and whose consequential effects you can manage; ensure you know/follow hospital policy: hospitals should also ensure trainees/everyone knows such policies.

"Sedation is a continuum of a depressed conscious state with unpredictable inter-individual dose responses to the drugs used, which may result in unconsciousness. The unconscious patient is unrousable, even by painful stimulation. Deeper levels of sedation are indistinguishable from general anaesthesia".[1] The facilities and support required to deliver sedation, including assistance for the anaesthetist, should always meet the requirements as defined in the GPAS[1] and in the AAGBI's guidance, The Anaesthesia Team.[2]

1. Guidelines for the Provision of Anaesthesia Services (2017). *RCoA* www.rcoa.ac.uk/gpas2017
2. The Anaesthesia Team 2010, *AAGBI*. http://dx.doi.org/10.xx36/g.AT3.2010

DEFIBRILLATORS AND EXTERNAL PACING FUNCTION

- *Elderly patient for DHS. In theatre being positioned on table, became bradycardic and dropped BP. Unresponsive to atropine. Developed complete heart block. Unable to pace due to fault with defib. Continued deterioration. Decision made, in view of comorbidities and quality of life, not to attempt CPR/resuscitation. Patient died.*

SALG does not have detail as to the fault with this particular defibrillator. In 2013 following reports of failure to capture, the MHRA raised awareness that external pacemakers functioning via the defibrillator pads may deliver inadequate current and rate to capture the patient's conducting system. Alterations to the default current and rate settings may be required.[1] In addition to this it is important to note that some defibrillators functioning in pacing mode require the rhythm to be sensed by the ECG leads as opposed to the defibrillator pads and so both methods of rhythm assessment need to be connected. Local annual CPR updates should ensure that users are aware of their individual device function.

1. Defibrillators/monitors used for external pacing with non-invasive transcutaneous pacemaker modules - risk of inadequate external pacing (http://bit.ly/2mHdovb).

APPENDIX: INCIDENT DATA SUMMARY

A total of 11,538 anaesthesia-related incidents were reported during the specified time period. One incident was reported using the anaesthetic eForm; this was not reported to the National Reporting and Learning System (NRLS) within one month of occurrence nor reported to the eForm as 'near miss' (harm was prevented from reaching the patient). 11,537 incidents were reported using Local Risk Management Systems (LRMS); 7,125 (62%) of these incidents were reported within one month. Of the incidents reported via LRMS, 1,332 (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 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 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.

INCIDENT DATA SUMMARY

April–June 2017

Figure 1 – Degree of Harm (actual incidents)

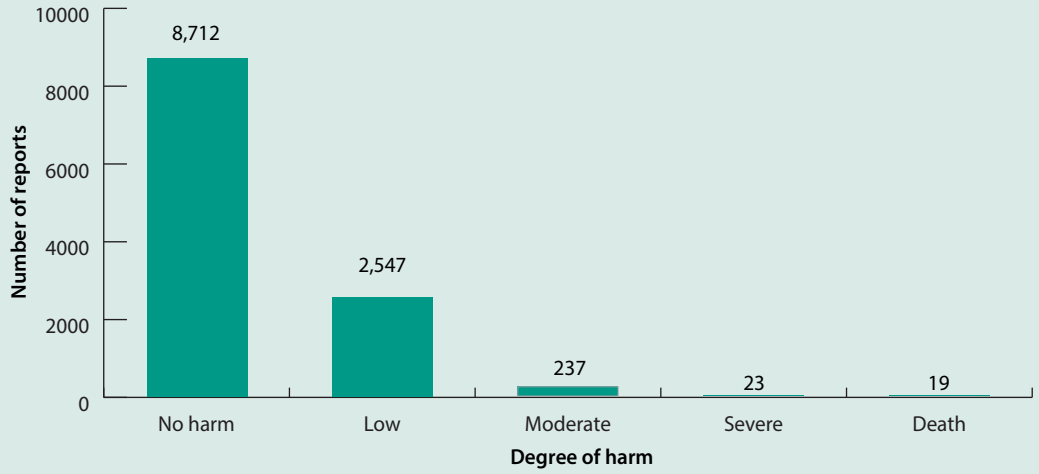

Figure 1 shows the degree of harm incurred by patients within the anaesthetic specialty during the period April– June 2017. 19 deaths were reported though LRMS and none via the anaesthetic eForm.

Figure 2 – Incidents by incident type

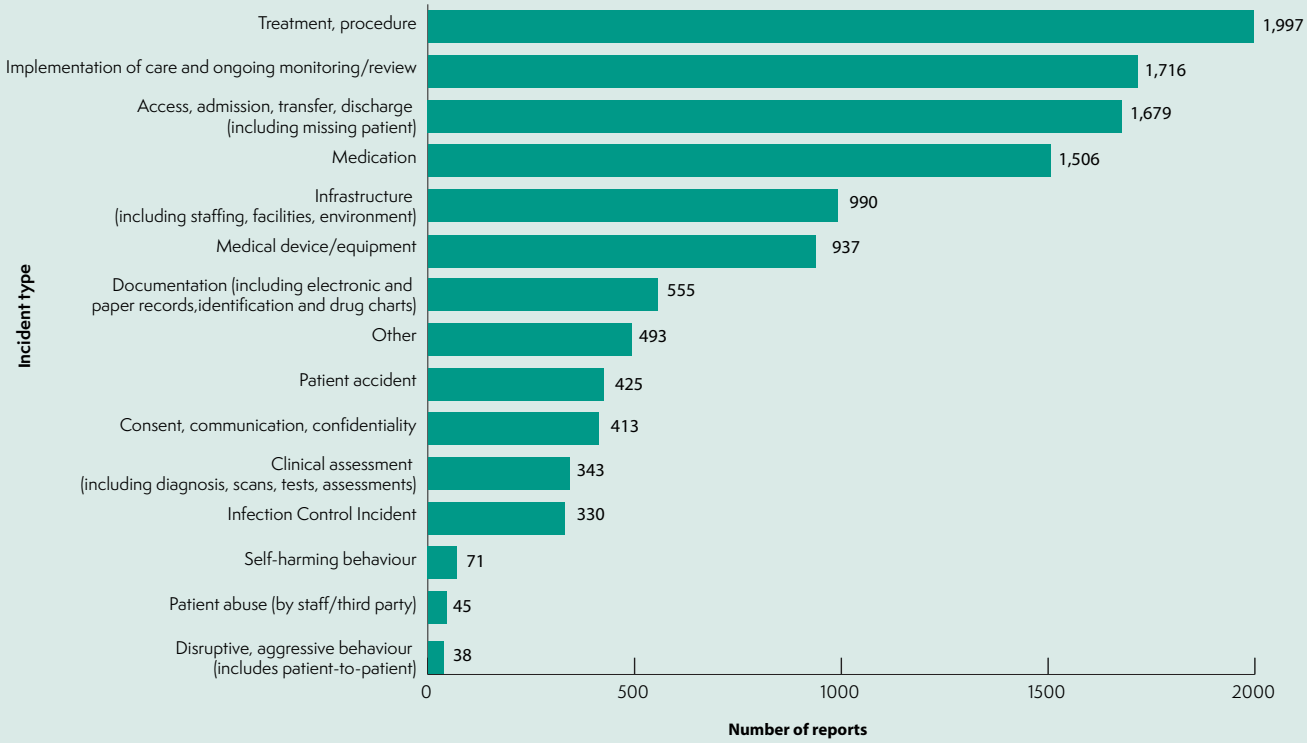

Figure 2 shows the type of incidents that occurred within the anaesthetic specialty that were reported using LRMS or the anaesthetic eForm for the period April – June 2017. The categories were determined at local level.

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