

# PATIENT SAFETY UPDATE



October – December 2015



PUBLISHED APRIL 2016

# LEARNING POINTS FROM REPORTED INCIDENTS

## October 2015 to December 2015

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](mailto:SALG@rcoa.ac.uk).

The clinical scenarios published in the PSU are taken from the National Reporting and Learning System database on a quarterly basis and are anonymised real cases reported as causing severe harm or death. The text is changed very little, keeping the story real. There are often common themes within the cases and learning points, with supporting evidence when available, are summarised for the benefit of the readership. Some cases deliver learning without the need for third-party analysis. This PSU has examples of both.

## ASPIRATION OF GASTRIC CONTENTS

*I saw patient the morning of the operation. He had been cancelled due to profuse diarrhoea on the operating table on the Friday, since then he said he had been well, and no further episodes, I also asked him about vomiting, he stated a phlegmy cough. Query vomit the evening before but none since and felt well. In theatre the patient had a GA with LMA then spinal, with no problems with spont breathing on LMA, transferred to operating table and placed in the lateral position and prepared for surgery, at around KTS just after the patient started to move, noted large amounts of coffee grounds in the LMA... LMA removed and suction+++, patient continued to have op, with a face mask and oral - pharyngeal airway in situ. During the op large amounts of coffee ground fluid came out. With airway being maintained by consultant anaesthetist, after op patient become very distressed and hypoxic, and was intubated, and vented, ETT sucked out and coffee grounds vomit found. Patient transferred to ITU on closer inspection there had been a note of vomiting, but had stopped with cyclizine, and no ongoing concerns.*

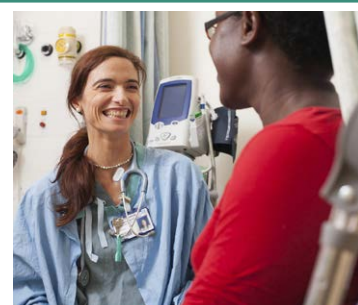
*Misplacement of WHO checklist - locum anaesthetist didn't complete initial check in the anaesthetic room... patient's notes sent down with wheel chair by accident – delay approx 15 mins. Therefore Team distracted. Patient aspirated on LMA supreme – desaturation on transfer to theatre from anaesthetic room and subsequent lithotomy position. NG tube placed in theatre via LMA supreme port-aspiration. >500ml of stomach contents aspirated. Patient given 100% oxygen, suxamethonium 100mg, propofol 50mg modified RSI. Intubated with bougie on table grade 2 view. Suctioning via endotracheal tube - nothing aspirated. Fio2 60% and ventilated for the rest of the operation, low pressures, good tidal volumes. Duty consultant informed. Plan to continue to extubate and monitor patient in recovery for a slightly prolonged duration to ensure patient stable to be discharged to ward.*

*We transferred an obese ITU patient to the CT scanner. Whilst lying flat the patient started to feel nauseous and vomited. We turned the patient to the recovery*

## SAVE THE DATE

## PATIENT SAFETY CONFERENCE 2016

The annual SALG Patient Safety Conference will be held on **30 November 2016** in Edinburgh. Further details will be circulated closer to the time.



position and reached for the suction attached to the wall. The suction hosing was not long enough to reach the scanning table and we were therefore unable to suction the patients' airway until an extension had been attached. During this time the patient aspirated some vomit and became hypoxic. Despite supporting her ventilation she arrested on the CT scanner table. We put out a crash call and performed CPR and were able to resuscitate the patient.

The choice of airway management techniques is individual case and anaesthetist dependent, however the management of subsequent airway complications in anaesthesia is more clear-cut. Robinson et al in their review on the subject of aspiration provide useful insights to decision making regarding airway management.<sup>1</sup> They state that if aspiration is diagnosed, the airway should be secured and the trachea suctioned, preferably before positive pressure is applied. In addition, they stressed the finding from the 4th National Audit Project (NAP4) that "aspiration counted for more deaths than failure to intubate or ventilate." NAP4 advises that all patients "must be assessed for aspiration risk before surgery" and that airway management should be consistent with the identified risk."<sup>2</sup>

1. Robinson, M. and Davidson, A. Aspiration under anaesthesia: risk assessment and decision-making. *Continuing Education in Anaesthesia, Critical Care and Pain*. 2013. <http://bit.ly/1VSZmlz>.
2. Cook T, Frerk C. 4th National Audit Project (NAP 4): Major Complications of Airway Management in the United Kingdom Report and Findings, March 2011, The Royal College of Anaesthetists and The Difficult Airway Society [www.rcoa.ac.uk/nap4](http://www.rcoa.ac.uk/nap4).

## ANAPHYLAXIS

Patient was administered a general anaesthetic for removal of uterine polyp. On induction patient went red, bradycardic then went into coarse ventricular fibrillation. Despite efforts of medical and registered theatre practitioners they were unable to convert back to a perfusing rhythm and the patient was certified dead.

NAP6 is collecting data on cases of anaphylaxis associated with anaesthesia<sup>1</sup>. This is a rare and potentially lethal complication of anaesthesia. It is anticipated that the audit will provide data on common triggers, at risk patient groups, clinical presentation and treatment strategies.

1. NAP6 Perioperative Anaphylaxis. Sixth National Audit Project of the Royal College of Anaesthetists. RCoA (<http://bit.ly/1MSI7KZ>).

## ACCESS TO CARE

Patient was on the emergency list on Monday morning for a defunctioning palliative stoma. High risk anaesthetic so a daytime case. All week the patient got bumped by more urgent cases. Pressure on theatres escalated to Director of Clinical Services on Thursday morning but on that day patient too unwell for theatre. Rallied on Friday but still too unwell for GA. Attempted stoma under local anaesthetic but the patient had perforated and had peritonitis. Patient died overnight.

Patient underwent emergency surgery for a fractured neck of femur. Hypotensive in recovery and on return to ward. Admitted to ICU the next day for haemodialysis and subsequently died. PM: 1a ) Multi – Organ Infarction 1b ) Hypotension and Atherosclerosis of the origins of the Coeliac Axis and the Superior and Inferior Mesenteric Arteries 1c ) Fat / Bone Marrow Emboli during surgery for Hip Fracture.

These cases draw attention to patient access to appropriate care with respect to time and level of care. The RCoA sets out standards for the provision of services in the Guidelines for the Provision of Anaesthetic Services (GPAS) 2016 document.<sup>1</sup> Readers' attention is drawn to chapter 5, "Guidance on the Provision of Emergency Anaesthesia Services 2016."

1. Guidance on the Provision of Emergency Anaesthesia Services 2016. RCoA ([www.rcoa.ac.uk/node/21665](http://www.rcoa.ac.uk/node/21665)).

## SAFE USE OF LOCAL ANAESTHETIC DRUGS

25 year old very anxious patient for ERPC. Requested spinal anaesthesia. Straight forward spinal anaesthesia with 1.8 ml of heavy prilocaine 2% (patient weighed 48 Kg). Less than satisfactory block. Lignocaine 80mg (without adrenaline) infiltrated by surgeon. Almost immediately patient felt faint and lost her hearing... this lasted quite a few minutes. Resolved spontaneously. No CVS manifestations to this apparent LA toxicity.

The BNF publishes recommendations on the safe administration of local anaesthetics and highlights the risk of inadvertent intravascular injection.<sup>1</sup> The use of local anaesthetic drugs is also a specific competency in the Foundation Programme curriculum, due to recognition of the widespread use of these drugs.<sup>2</sup> Fortunately there was no requirement for lipid rescue therapy as set out in the AAGBI severe local anaesthetic toxicity guidance.<sup>3</sup>

1. Local anaesthesia. BNF (<http://bit.ly/1SB3DZZ>).
2. The FP Curriculum 2012. The Foundation Programme. (<http://bit.ly/1Ry8TJr>).
3. AAGBI Safety Guideline – Management of Severe Local Anaesthetic Toxicity. AAGBI (<http://bit.ly/1MShvsI>).

# LEARNING POINTS FROM REPORTED INCIDENTS

## CORNEAL ABRASIONS

*Patient received spinal and sedation for a hip replacement on the trauma list. Effective spinal but patient became agitated as sedation took effect with flailing arms. Patient reported in recovery to have a painful eye (the eye which was uppermost when positioned for surgery). Examination revealed a small corneal abrasion. Treated with saline eye wash and topical antibiotics. Patient received an apology and appeared happy with the overall treatment received.*

Ocular injuries, usually corneal abrasions, are reported to occur in 0.1% of general anaesthetics.<sup>1</sup> Segal et al. report that the use of facemask oxygen therapy during transfer to the PACU is a common time for corneal abrasions to occur – just the time when sedated patients may be less in control of their faculties.

1. Contractor, S. and Hardman, J. Injury during anaesthesia. *Continuing Education in Anaesthesia, Critical Care and Pain*. 2006 <http://ceaccp.oxfordjournals.org/content/6/2/67.full>.
2. KL Segal et al. Evaluation and treatment of perioperative corneal abrasions. *Journal of Ophthalmology*. 2014 (<http://bit.ly/1SmcHgZ>).

## DEVICE RELATED PRESSURE ULCERS

*Developed pressure ulcers to both corners of mouth, from pressure from ET ties. No anchorfast available during this time.*

Medical device-related pressure ulceration is more common in the head and neck area; a review of the subject has suggested that a patient treated using a medical device is 2.4 times more likely to develop a pressure ulcer than a patient without any medical device.<sup>1</sup>

1. JM Black et al. Medical device related pressure ulcers in hospitalized patients. *Int Wound J*. 2010;7(5):358-65. (<http://bit.ly/1Tiemso>).

## THE OLD CHESTNUTS – HANDOVER AND COMMUNICATION

*Patient admitted with diagnosis of cerebral infarct but history in notes suggest likely encephalitis. These notes were then subsequently not available on the ITU. Relatives informed of poor likely prognosis by me but when case reviewed by Dr X and Dr Y, full treatment of encephalitis should have been ongoing during weekend. Family very distressed by this lack of continuity and poor practice. Very concerned by change of treatment and not continuing encephalitis management over weekend.*

In the first ombudsman report ever published on complaints in English trusts it was stated that poor communication and delays in treatment were frequent sources of patient complaints.<sup>1</sup> It is accepted that patient complaints provide insight on patient safety-related issues.<sup>2</sup>

1. Complaints about acute trusts 2013-14 and Q1 and Q2 2014-15. *Parliamentary and Health Service Ombudsman* (<http://bit.ly/1y0QYpi>).
2. T Reader et al. Patient complaints in healthcare systems: a systematic review and coding taxonomy *BMJ Qual Saf* bmjqs-2013-002437 29 May 2014 doi:10.1136/bmjqs-2013-002437 (<http://bit.ly/1ScVCaG>).

## APPENDIX: INCIDENT DATA SUMMARY

A total of 9,415 anaesthesia-related incidents were reported during the specified time period. 3 incidents were reported using the anaesthetic eForm; 2 (66%) of these incidents were reported to the National Reporting and Learning System (NRLS) within one day of occurrence. None of the incidents reported to the eForm were reported as 'near miss' (harm was prevented from reaching the patient). 9,412 incidents were reported using Local Risk Management Systems (LRMS); 219 (2.3%) of these incidents were reported within one day and 4,901 (52%) were reported more than 30 days after they had occurred. Of the incidents reported via LRMS, 1,223 (13%) 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. 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.

*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.*



# INCIDENT DATA SUMMARY

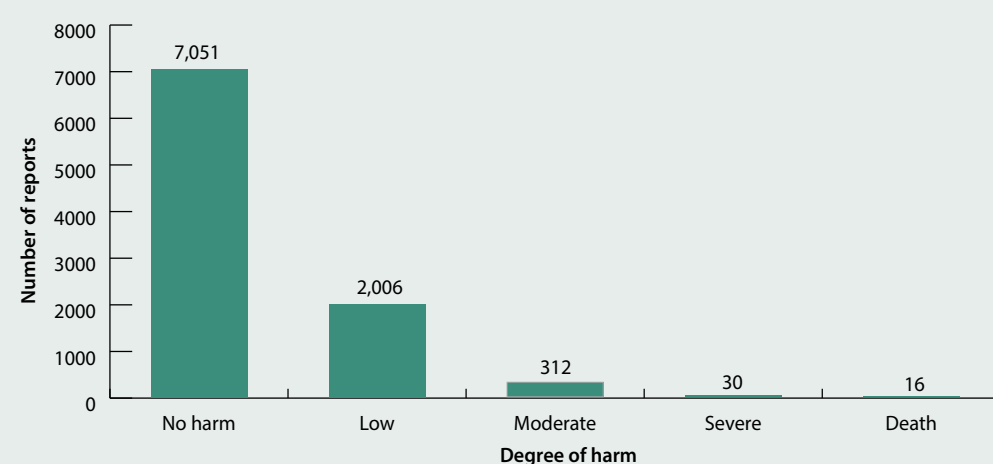
October – December 2015

## 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](http://www.eforms.nrls.nhs.uk/asbreport).

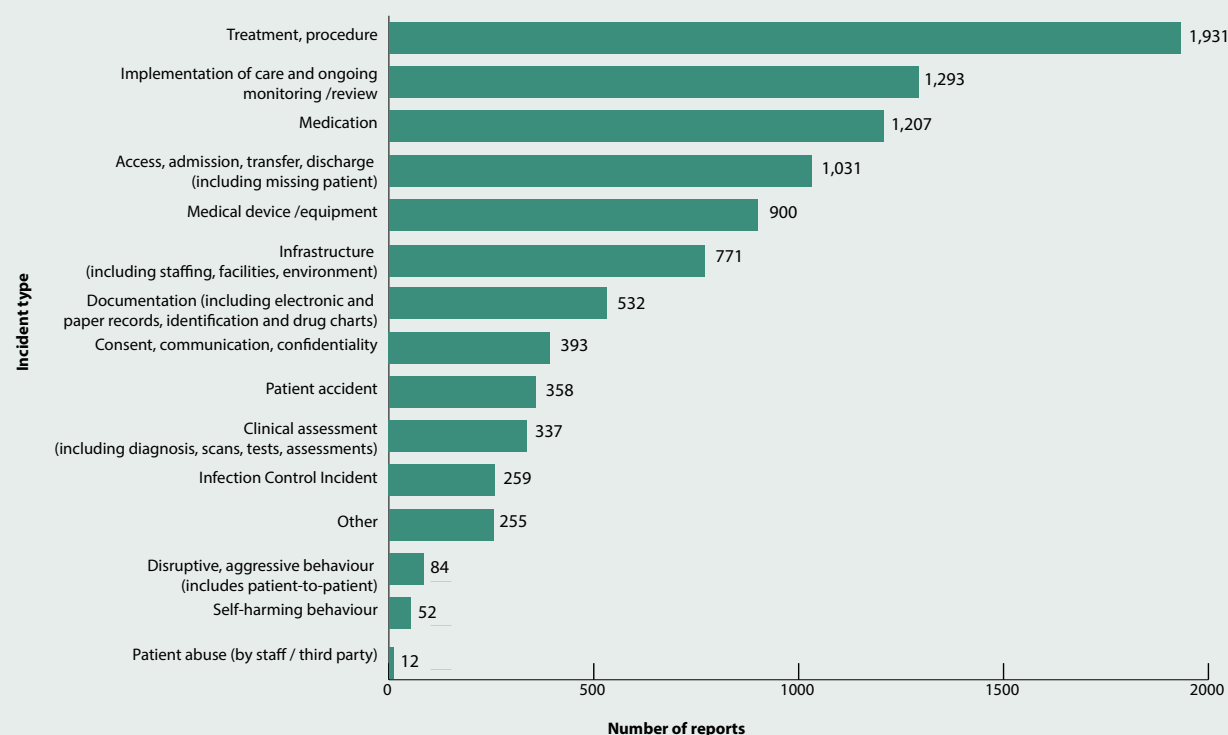
The RCoA and AAGBI continue to work with the NRLS team at Imperial and the patient safety function of NHS England. SALG would like to reinforce that processes for sharing and learning incidents remain firmly in place. Staff are urged to continue to use the eForm (or your local reporting systems) to report 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.

**Figure 1 – Degree of Harm (actual incidents)**



**Figure 1** shows the degree of harm incurred by patients within the anaesthetic specialty during the period October – December 2015. 16 deaths were reported though LRMS and none via the anaesthetic eForm.

**Figure 2 – Incident types**



**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 October – December 2015. The categories were determined at local level.

© The Royal College of Anaesthetists (RCoA) 2016

All enquiries in regard to this document should be addressed to the Royal College of Anaesthetists,  
Churchill House, 35 Red Lion Square, London WC1R 4SG

020 7092 1571 [salg@rcoa.ac.uk](mailto:salg@rcoa.ac.uk) [www.rcoa.ac.uk](http://www.rcoa.ac.uk)

Registered Charity No: 1013887 Registered Charity in Scotland No: SCO37737 VAT Registration No: GB 927 2364 18