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Old Great Hall, College of Medicine, University of Lagos, Idi Araba, Lagos State

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Time
8.00 am - 5.00pm

- Programme & Book of Abstracts -
CRITICAL INCIDENTS AND NEAR MISSES DURING ANAESTHESIA: A PROSPECTIVE AUDIT

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Background: A critical incident is any preventable mishap associated with the administration of anaesthesia which leads to or could have led to an undesirable patients' outcome. Patients' safety can be improved by learning from reported critical incidents and near misses.

Materials and methods: All perioperative critical incidents (excluding obstetrics) occurring over 5 months were voluntarily documented in a profoma. Ages of patient, urgency of surgery, grade of anaesthetist and outcome were noted.

Results: Seventy three critical incidents were recorded in 42 patients (incidence 6.1% of 1188 procedures) with complete recovery in 88.1% (n=37) and mortality in 11.9% (n=5). The highest incidents occurred during elective procedures (71.4%), which were all supervised by consultants, and in patients aged 0 – 10 years (28.6%). Critical incident categories documented were cardiovascular (41.1%), respiratory (23.3%), vascular access (15.1%), airway trauma/intubation (6.8%), equipment errors (6.8%), difficult/failed regional technique (4.1%) and others (2.8%). The monitors available were: pulse oximetry (100%), precordial stethoscope (90.5%), sphygmomanometer (90.5%), capnography (54.8%), electrocardiogram (31%) and temperature (14.3%). The most probable cause of critical incident was patient factor (38.7%) followed by human error (22.5%). Equipment error, pharmacological factor and surgical factor accounted for 12.9% respectively.

Conclusion: Critical incidents will continue to occur even in the hands of the highly skilled and in the present of adequate monitoring. Protocols should be put in place to avoid human errors. Critical incident reporting must be encouraged in order to improve patients' safety and reduce morbidity and mortality.

Key words: safety, critical incident, critical incident reporting