European Society of Anaesthesiology ESA

U.E.M.S. Section European Board of Anaesthesiology

Annual Departmental Patient Safety Report

Annual Departmental Patient Safety Report
(part 1 – structure)

(This report can either be used locally in your department or sent to ESA –patientsafety@esahq.org - in order to share your safety data with others)

Report for the year ☐☐☐☐ time period
Start date: ☐☐-☐☐-☐☐☐☐ End date: ☐☐-☐☐-☐☐☐☐

Name of hospital	
Address:	
Country:	

Number of beds in the hospital:	
Number intensive care beds for ventilating patients:	
Number of theatres where anaesthesia services provided:	
Do you have a chronic pain clinic?	
Number of procedures per year:	
% of patients with general anaesthesia:	
Number of residents in training:	
Number of anaesthetic nurses:	
Number of fully trained medical anaesthesia providers:	

principal requirements of Helsinki Declaration

% of theatres equipped to comply with minimal monitoring standards recom. by the EBA % ☐
Please tick if the numbers are an accurate measure or estimated acc. ☐ est. ☐
% of recovery areas equipped to comply with minimal monitoring standards recom. by the EBA % ☐
Please tick if the numbers are an accurate measure or estimated acc. ☐ est. ☐
% patients going to any post-anaesthesia-care unit (e.g. recovery-room, intermediate care etc.) % ☐
Please tick if the numbers are an accurate measure or estimated acc. ☐ est. ☐

Which of the following protocols are available in your hospital?

Tic if available (av) or in preparation (pr) or leave empty for no protocol available.

Preoperative assessment and preparation	av		pr	
Checking equipment and drugs	av		pr	
Syringe labelling	av		pr	
Difficult /failed intubation	av		pr	
Malignant hyperpyrexia	av		pr	
Anaphylaxis	av		pr	
Local anaesthetic toxicity	av		pr	
Massive haemorrhage	av		pr	
Infection-control	av		pr	
Post operative care including pain relief	av		pr	

% of procedures for which WHO Safe Surgery Saves Lives Checklist is carried out: % ☐
Please tick if the numbers are an accurate measure or estimated acc. ☐ est. ☐

Annual Departmental Patient Safety Report

(part 2 – risk management & outcome)

Does your institution produce an annual report on patient morbidity and mortality? Yes ☐ No ☐

Does your institution comply with anaesthesiology recognised sedation standards for safe practice? Yes ☐ No ☐

Does your institution contribute to the recognised national or other major audits of safe practice and critical incident reporting systems? Yes ☐ No ☐

Does your institution provide the resources to contribute to these audits? Yes ☐ No ☐

Please name some of the national or other major audits of safe practice and critical incident reporting systems to which members of the local department have contributed data in the last 12 months:

measures taken and results obtained in improving patient safety locally

Please list the three most important Patient Safety Initiatives taken locally in the last 12 months.

safety initiative 1

Safety hazard recognised	
Action taken	
Improvement outcome	

safety initiative 2

Safety hazard recognised	
Action taken	
Improvement outcome	

safety initiative 3

Safety hazard recognised	
Action taken	
Improvement outcome	

Safety hazard / risk recognised awaiting attention

One	
Two	
Three	

Any comments on patient safety initiatives you have been taking a in the last 12 months:

Annual Departmental Patient Safety Report

(part 2 – risk management & outcome)

Any particular patient safety lessons arising in the last 12 months that your department would wish to share with others:

Sign _____ Date __ __ - __ __ - __ __ __ __

Signature of person submitting and to the best of their ability guaranteeing the report.

Contact email: _____

Please indicate:

☐ Yes, the name of my department can be listed on the ESA/EBA Taskforce Patient safety website with the names of all other departments that have sent in a report to contribute to the annual analysis.

Sample report for example

Safety Initiative 1

Safety Hazard Recognised: medication hazards including syringe swaps were reported. A variety of labelling techniques were used varying from none to illegible writing with marker pens.

Action Taken: risk explained to the hospital management and a supply of printed user applied syringe labels was obtained with the standard international colours. After a departmental meeting explaining the issue outline plan they were distributed to all theatre areas on the same date.

Improvement Outcome: a random spot check audit carried out showed 96% of all syringes drawn by anaesthetists now correctly labelled.

Safety Initiative 2

Safety Hazard Recognised: following a critical incident involving a difficult intubation it was reported that not all necessary equipment had been quickly available.

Action Taken: all the difficult intubation trays in theatre and the difficult intubation trolley were inspected to make sure all equipment is present. The intubation trays, the intubation trolleys and the defebrillators are now checked once a day and audited once a month.

Improvement Outcome: since introducing this there have been no further reports of delay in obtaining the necessary difficult intubation equipment.

Safety Initiative 3

Safety Hazard/Risk Recognised: insulin is a high-risk medicine and critical incidents have occurred in our hospital including one death last year. Syringes for insulin infusions in theatre and intensive care are currently made at the bedside from multidose vials with the risk of error and infection

Action Taken: a commercial supply of prefilled 50 ml syringes containing one unit of insulin per millilitre obtained and stored in convenient central refrigerator

Improvement Outcome: 70 percent of patients requiring insulin infusions in these areas are now given these syringes. Demand sometimes exceeds supply. Risk of error , infection and poor labelling is now reduced and an additional benefit is a saving in doctor nursing time preparing the infusions

Safety Hazard / Risk Recognised Awaiting Attention

1. After an ENT operation a throat pack was removed in recovery when the patient appeared partially obstructed. Plan to continue to raise awareness and introduce NPSA throat pack guideline

2. Continuous Capnography is not used routinely on the intensive care unit plan to address this in the next 12 months

3. WHO Safe Surgery Save Lives checklist is not being used routinely before paying treatment procedures in the pain clinic. Plan addresses the next 12 months.