Editorial II

CRITICAL INCIDENT REPORTING

Anaesthesia related deaths are so infrequent that analysis of them alone would not allow us to learn of problems that would occur. Therefore it is important that we study and analyse incidents and near misses in order to establish patterns of common errors and for improvement of patient safety. This process is critical incident reporting and analysis.

Critical incident investigations were first used in the 1940's to improve safety and performance of military pilots.

A critical incident is an event that leads to harm or could have led to harm if it had been allowed to progress. It should be preventable by a change in practice. This harm is usually to the patient but could involve the anaesthetist or any other staff member. The common causes are human error, equipment failure and errors in organizational environment.

It is now common all over the world in their individual units or departments of anaesthesia to record and discuss these adverse events and near misses with a view to learning and prevention of recurrence. The tools used are a recording form, on line recording system or an interview with the discussion at a Morbidity and Mortality conference.

In the 1990's, during our training period we reported on critical incidents on a recording form which was collected in a box kept at the telephone exchange of the National Hospital of Sri Lanka, our 'centre'. The interest was due to the Australian Incident Monitoring Study (AIMS) which started as an anaesthetic venture in late 1980's. Since of late this practice has not been adhered to.

It is time that we rejuvenated this process, not only at a local level but nationally.

Many are the advantages of a critical incident reporting system. Individually we would change our practice for the better and for patient safety. At a department level, we could use the data for lobbying for new monitoring equipment, withdrawal of undesirable drugs, and for establishing improvement into team work, communication and organizational structure. It would also be a means of continuous quality improvement to which the entire department contributes.

Nationally, it has the potential for learning from an incident, identification of new problems and incidents, wider dissemination, and to have a role on establishing standards, patient safety and quality of care, and for research.

There would be drawbacks as well. The reporting is voluntary. This would be certainly done by conscientious doctors who are keen on improving their practice but there is room for no reporting or under reporting. Under reporting could be due to lack of anonymity, ambiguous reporting systems and lack of ownership.

As I see it, a single system should be established for our specialty nationally, through the training body and the college. It is important to make it user friendly and unambiguous and in current day context 'on-line'. There should not be 'blame' or 'disciplinary action' for reporting. As in aviation reporting it should be a routine occurrence and encouraged, and failure to report be considered a disciplinary matter.

It is essential that the governing body appoints professionals and independent experts to handle the reports. Incidents of a 'severe' nature should have expedited analysis and reporting and the others could be analysed on a more regular basis. The appointed experts should also identify learning points, regularly provide feed back and disseminate the information with recommendations for development of guidelines, to plan audits and for changes in curriculum and training.

Lets strive to improve our practice and the safety for the patient.

References

1. Smith AF, Mahajan RP: National critical incident reporting: improving patient safety. British Journal of Anaesthesia; November 2009; Vol 103;No.5 623-625
2. Hutton P, Cooper G. Fundamental principals and practice of anaesthesia. Chapter 13.

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