



Victorian Consultative Council on Anaesthetic Mortality and Morbidity

Incorrect administration of anaesthesia and/or regional anaesthesia technique

Council has recently been referred several cases from the DHS Sentinel Event Program that have involved the incorrect administration of anaesthesia or wrong side for a regional block. The common theme has been the failure of the responsible anaesthetist to correctly identify all the aspects of the "Time Out" including correct patient, correct consent and correct site. Council recognises that many institutions have adopted a policy to perform the surgical time out after induction of anaesthesia. However, in these circumstances it is mandatory that there is a specific anaesthesia time out or pre-anaesthesia check to include all these components. Such a process should involve the responsible anaesthetist, the patient and the allocated anaesthesia nurse or technician. It should also be documented in the medical record. Attention is also drawn to the recently published article in the NEJM on WHO Safe Surgery Guidelines.

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Correct Side and Correct Site Surgery Guidelines:

http://www.health.vic.gov.au/_data/assets/pdf_file/0007/266569/correct_side.pdf

Information on the WHO Safe Surgery Saves Lives initiative can be found on the following Website:

www.who.int/safesurgery.

Link to 'A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population

<http://content.nejm.org/cgi/reprint/360/5/491.pdf>