

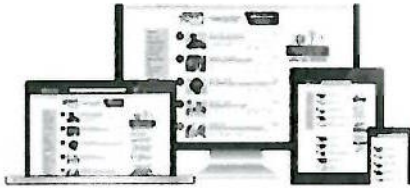


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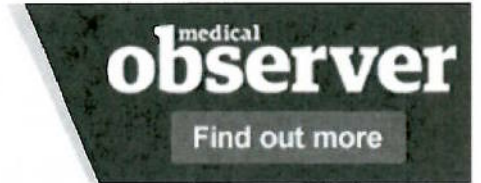
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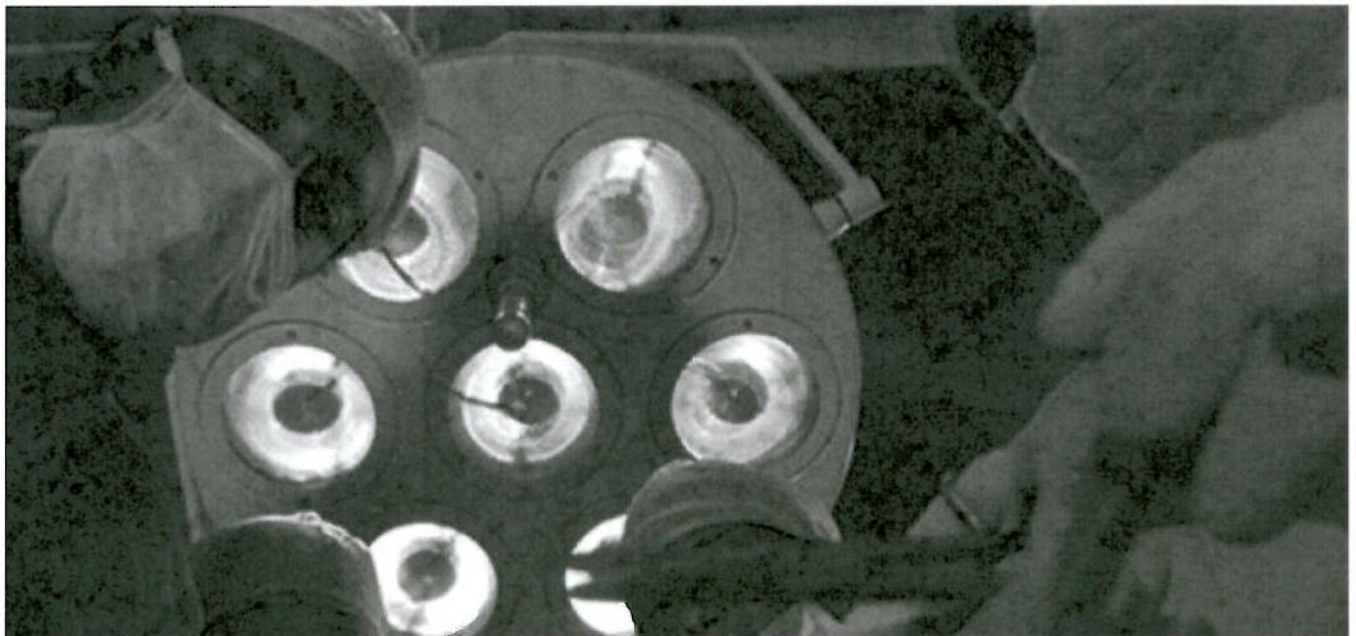
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# Hundreds of anaesthesia mishaps occur each week, report suggests

 [Rada Rouse \(http://www.medicalobserver.com.au/author/rada-rouse\)](http://www.medicalobserver.com.au/author/rada-rouse) 12 January 2017



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More than 200 anaesthesia mishaps are estimated to occur each week across Australia and New Zealand, a [report](http://www.aaic.net.au/Document/?D=20160686) (<http://www.aaic.net.au/Document/?D=20160686>) suggests.

Figures from the first report of de-identified anaesthesia incidents collected in an electronic database over seven years show that more than one quarter are associated with harm to the patient and a further 4% with death.

The reporting system, known as webAIRS, was set up in 2009 and allows anaesthetists to voluntarily and confidentially report incidents to a website.

"The data indicate that in a high proportion of anaesthesia incidents the outcome is not benign," write the authors, from a tripartite committee set up by peak Australian and NZ anaesthesia bodies to improve patient safety.

"Incidents appear to be an ever-present risk in anaesthetic practice, with extrapolated estimates exceeding 200 per week across Australia and New Zealand."

During one year some 1000 incidents were reported - representing about 20 incidents per week - from 134 hospitals.

However, this is likely to represent just 10% of the total number of anaesthesia incidents occurring in as there are 1300 hospitals in Australia and another 150 in New Zealand, the report notes.

Among the 4000 reports filed since the start of the program in 2009 to mid-2016 30% were associated with harm ranging from mild and temporary to permanent harm or death.

Meanwhile, incidents considered by those lodging the cases to be 'preventable' made up 52% of reports, with 36% being considered 'not preventable' and 12% not being specified.

Incidents occur across the gamut of ages, with 62% involving elective procedures. They occurred across a wide range of anaesthesia techniques and grade of provider, the report showed.

"This information alone is a sober reminder to all anaesthetists that anaesthesia incidents are unpredictable and can potentially occur in any patient at any time in any anaesthetising location," the authors said.



The most common category of incident was respiratory, followed by medication, cardiovascular and medical device/equipment.

It was concerning that medication was the second most common category of incident because this was more under the control of anaesthetists than airways or cardiovascular incidents which might be more influenced by patient factors, the authors said.

**More information:**

[Anaes \(http://www.aaic.net.au/Document/?D=20160686\)](http://www.aaic.net.au/Document/?D=20160686) Intensive Care 2017; online (<http://www.aaic.net.au/Document/?D=20160686>)

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