



AB235. An audit and analysis of 1 year's anonymised anaesthetic incident reports in a National Specialised Children's Hospital

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Background: This is an audit of critical events that occurred from 1st January to 31st December 2018 in the Dept of Anaesthesia in Our Lady's Children's Hospital Crumlin. In addition to a critical analysis of this data, we will undertake a brief comparison to international data.

Methods: Critical events in the department are prospectively, voluntarily recorded in an anonymised record. The age, weight, the American Society of Anaesthesiologists (ASA) clinical rating scale, location, classification and consequence of each event, timing and training status of the

reporters were recorded. Critical events were categorised and signals which would indicate a higher risk of a critical event were sought—"off-site" location of anaesthesia and emergency versus elective surgery.

Results: Critical events were reported in 52 of 10,899 (0.5%) anaesthetic procedures in 2018. Communication issues, equipment error and drug errors accounted for 62% of all events. A significant majority of the reports were submitted by registrars (P value 0.02). High risk groups for critical events were emergency patients (0.7%) and Cath lab patients (1%). Magnetic resonance imaging (MRI) patients were a low risk group (0.3%). The overall frequency of events matches international norms.

Conclusions: Adequate quality assessment performance for the department of anaesthesia in Our Lady's Children's Hospital Crumlin in 2018 is evidenced by the 0.5% incidence of critical events that were prospectively documented. Emergency and Cath lab patients were at highest risk; identification of the category of event allowed interventions to occur to minimize chance of recurrence.

Keywords: Audit; anaesthetic; incidence; children; hospital

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