

Recommended Incident Report/QM Indicators

1. Mortality (within 48 hours of anesthetic care)
2. Mortality within 30 days of surgery
3. Operation cancelled while receiving anesthetic care
4. Discharge/PACU Issues
 - a. > 2 unplanned hours spent in PACU
 - b. Unplanned hospital admission within 72 hours of surgery and for > 24 hours
 - c. Unplanned admission to higher level of care (i.e.-ICU)
5. Airway Problems
 - a. Failed tracheal intubation and unable to ventilate with mask
 - b. Dental trauma
6. Cardiovascular Problems
 - a. Cardiac arrest (during procedure or within 48 hours of anesthetic care)
 - b. MI (within 48 hours of anesthetic care)
7. Respiratory Problems
 - a. Re-intubation (within 48 hours of anesthetic care)
 - b. Respiratory arrest (within 48 hours of anesthetic care)
 - c. Non-cardiogenic pulmonary edema (within 48 hours of anesthetic care)
 - d. Aspiration pneumonitis while receiving anesthetic care
8. Renal Problems
 - a. Renal insufficiency (within 48 hours of anesthetic care)
 - b. Renal failure (within 48 hours of anesthetic care)
9. Neurologic Problems
 - a. CVA (within 48 hours of anesthetic care)
 - b. Peripheral nerve deficit (within 48 hours of anesthetic care)
10. Regional Anesthesia Problems
 - a. Failed regional anesthesia
 - b. Postdural puncture headache
11. Medication Problems
 - a. Medication error (wrong medication given)
 - b. Medication dose error
 - c. Adverse drug reaction other than anaphylaxis
 - d. Anaphylaxis
12. Transfusion Reaction
13. Any serious or life threatening event
14. Results of Patient Satisfaction Surveys
15. Administrative Indicators (e.g., case delays, room turnover etc..)
16. Misuse of equipment or operator error
 - a. Neglecting to perform the prescribed equipment check results in equipment failure that contributes to patient death (Human factors)
 - b. Equipment malfunction results in death despite proper maintenance and checks (System factors)
17. Improper technique

- a. A short catheter placed in an internal jugular vein dislodges and results in hematoma formation
- 18. Communication error
 - a. Failing to make preoperative recommendations for medical optimization available to primary physicians results in case cancellation (Human factors)
 - b. Medical consultant's report is delayed when following the usual channels of communication (System factors)
- 19. Disregard of available data
 - a. Failure to avoid a known drug allergen results in unplanned hospital admission
- 20. Failure to seek adequate data
 - a. Failure to check appropriate extubation criteria results in premature extubation, subsequent respiratory failure and need for reintubation
- 21. Inadequate knowledge
 - a. Incorrect interpretation of hemodynamic variables results in pulmonary edema
- 22. Improper supervision
- 23. Technical accident
 - a. Postdural puncture headache follows a properly performed spinal anesthetic
- 24. Limitation of therapeutic standards
 - a. Appropriate resuscitative efforts result in death of multiple trauma victim
- 25. Limitation of diagnostic standards
 - a. Preoperative assessment fails to predict difficult airway management
- 26. Limitation of available resources
 - a. Lack of available blood products results in death due to massive bleeding