Analysis of National Bariatric Surgery Related Clinical Incidents: Lessons Learned and a Proposed Safety Checklist for Bariatric Surgery

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Background:

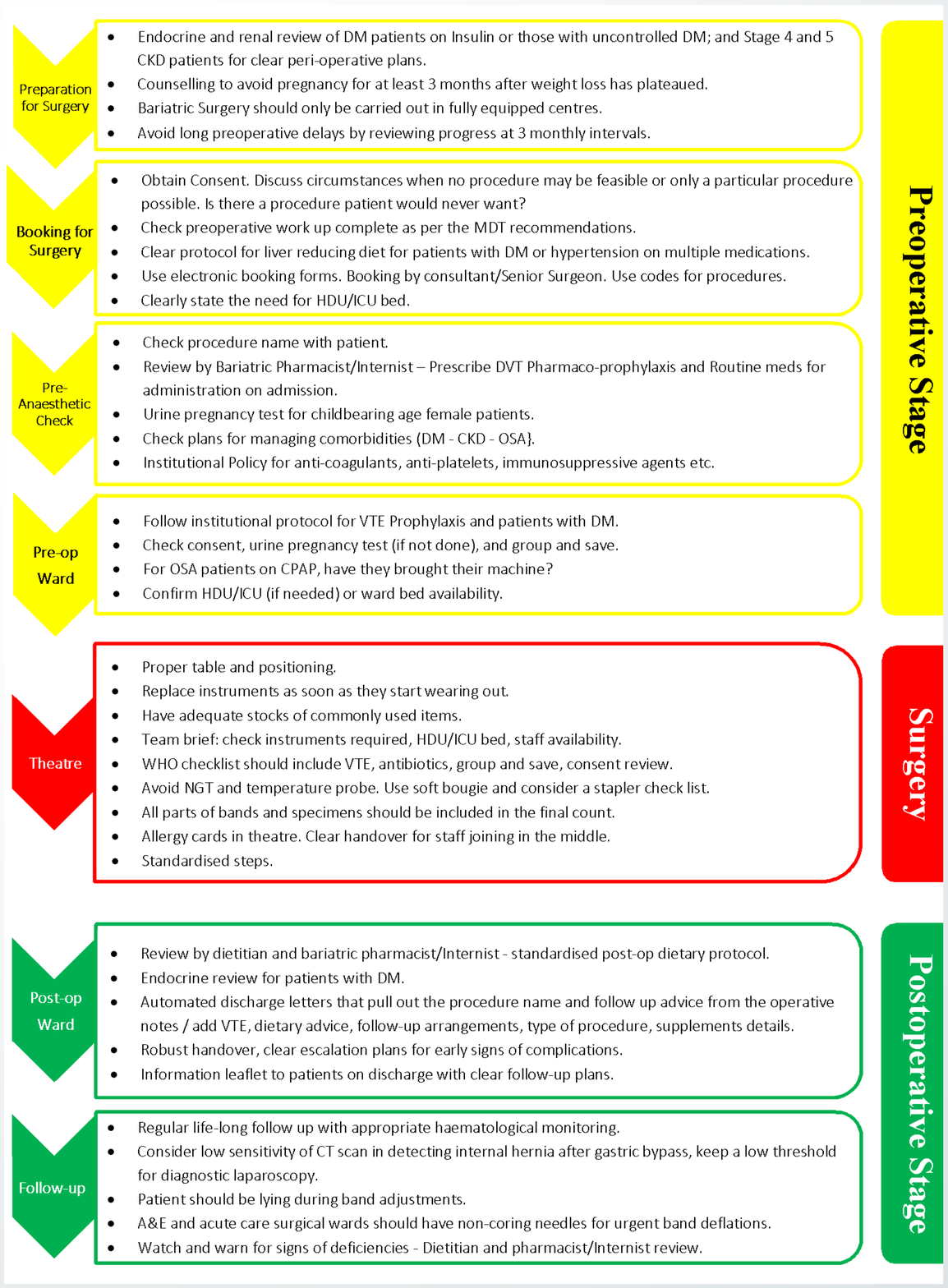
Hundreds of thousands of patient-safety clinical incidents are reported to the National Reporting and Learning System (NRLS) database in England and Wales every year. The purpose of this study was to identify bariatric surgery-related learning points from these incidents.

Methods:

We analysed bariatric surgery-related clinical incidents reported to the NRLS database between 01 April 2005 and 31st October 2020. The primary outcome measure of this study was to collate the incidents into specific themes. The secondary outcome measures were developing recommendations for the prevention of each theme a safety checklist for patients undergoing bariatric surgery.

Results:

- We identified 541 bariatric surgery-related clinical incidents in 58 different themes.
- 150 (27.7%), 244 (45.1%), and 147 (27.2%) incidents were attributed high, medium and low severity respectively.
- The most commonly reported high severity theme was the failure of thromboprophylaxis (50;9.2%).
- Intraoperative high severity incidents included 17 incidents of stapling of orogastric/nasogastric tubes or temperature probes, 8 missed needles, 8 broken graspers, and 6 incidents of band parts left behind.
- Postoperatively, the most commonly reported high severity theme was improper management of Diabetes Mellitus (DM) (35;6.5%). Medication errors represented a significant proportion of the medium severity incidents.



Bariatric Safety Checklist

Conclusion:

We identified 58 specific themes of bariatric surgery-related clinical incidents. We propose specific recommendations for the prevention of each theme and a safety checklist to help improve the safety of bariatric surgery worldwide.

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