Saolta
Grúpa Ollscoile Cúram Sláinte
University Health Care Group

An Audit of Syringe Labelling in the Operating Theatre

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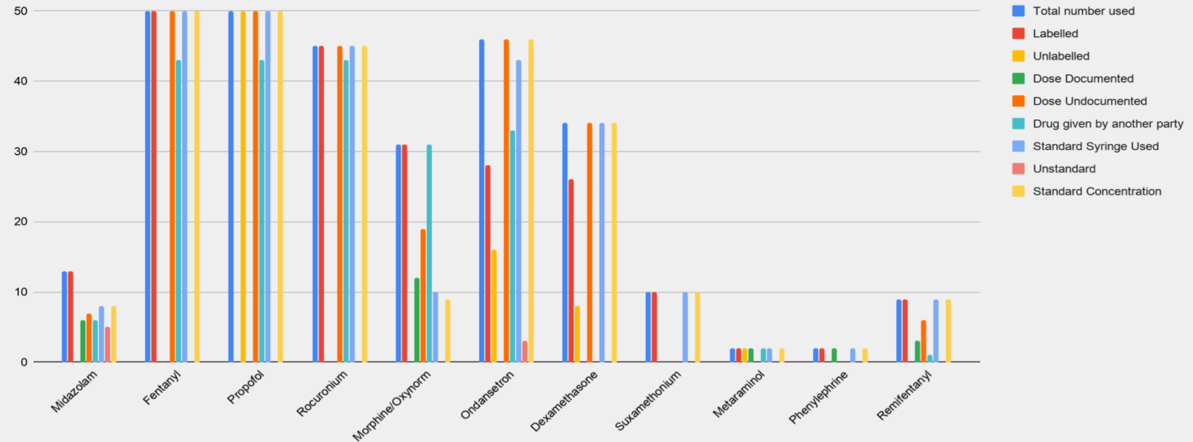
Introduction

- In 2017 the British Journal of Anaesthesia published clear guidance on medication safety in the operating room [1].
- All medicines given intravenously should be labelled with the name, date and concentration.



Methods

- Prospective Audit Evaluating:
  - What Drugs were given in the operating theatre.
  - If they were labelled.
  - What Information was recorded on any label applied.

Results

- Propofol was never labelled.
- Ondansetron and dexamethasone are intermittently labeled.
- Only morphine/oxycodone, Midazolam & remifentanil had dose labelled.
- All other drugs were labelled with drug sticker alone.
- Date of preparation was never labelled.

Conclusion

- Medication errors occur in about 5.3% of surgeries [2].
- Standard vial sizes and manufacturer prepared syringes may allow anaesthetic staff to know the contents of a given, drug labeled syringe.

References

1. Wahr JA, Abernathy III JH, Lazarra EH, Keebler JR, Wall MH, Lynch I, Wolfe R, Cooper RL. Medication safety in the operating room: literature and expert-based recommendations. BJA: British Journal of Anaesthesia. 2017 Jan 1;118(1):32-43.
2. Nanji KC, Patel A, Shaikh S, Seger DL, Bates DW. Evaluation of perioperative medication errors and adverse drug events. The Journal of the American Society of Anesthesiologists. 2016 Jan 1;124(1):25-34.