Chapter 37.

How to Manage a Discovered WRONG-ROUTE INJECTION Drug Errors.

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A. INTRODUCTION.

It is common to see an impending drug error *before* initiating a drug injection. Well done, if that was you. You caught the problem before it could happen. Then, there is no clinical problem. It is only a near miss. Equally, many of the drug injection errors you ever made likely remained unknown, unsuspected, and undiscoverable forever because the drug error was not recorded as such. An unrecognized and never-discovered drug error might not cause a long-term adverse event. Alternatively, an unrecognized drug error can cause an inexplicable adverse event. **During anesthesia care, any surprise patient adverse event, whether minor or major, should always initiate a review of all drugs administered**[1]. All used ampules, vials, and syringes must be accessibly retained and stored until after the safe handover of all anesthesia patients in case a drug review is needed.

When any patient incident arises unexpectedly and for no immediate apparent reason associated with sedation, a regional anesthetic, or a general anesthetic, strong consideration must be given to there having been an Anesthesia Medication Administration Process (AMAP) error. Checking used syringes and retained used vials and ampules is a fast way to discover unnoticed, unintentional errors.

Connecting an adverse patient event with an unintentional drug error greatly aids in providing the best treatment, knowing which drug was injected, when, where, and in which dose. You can never connect an adverse patient event with an erroneous drug injection if all used ampules and syringes are trashed with those of other patients.

(This chapter in the book is 13 pages long with 24 references. It is a *rich case-based discussion* rooted in published reports and this book author's extensive personal experiences in handling the problems of own cases, and helping with peer's cases.)