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Chapter 49.

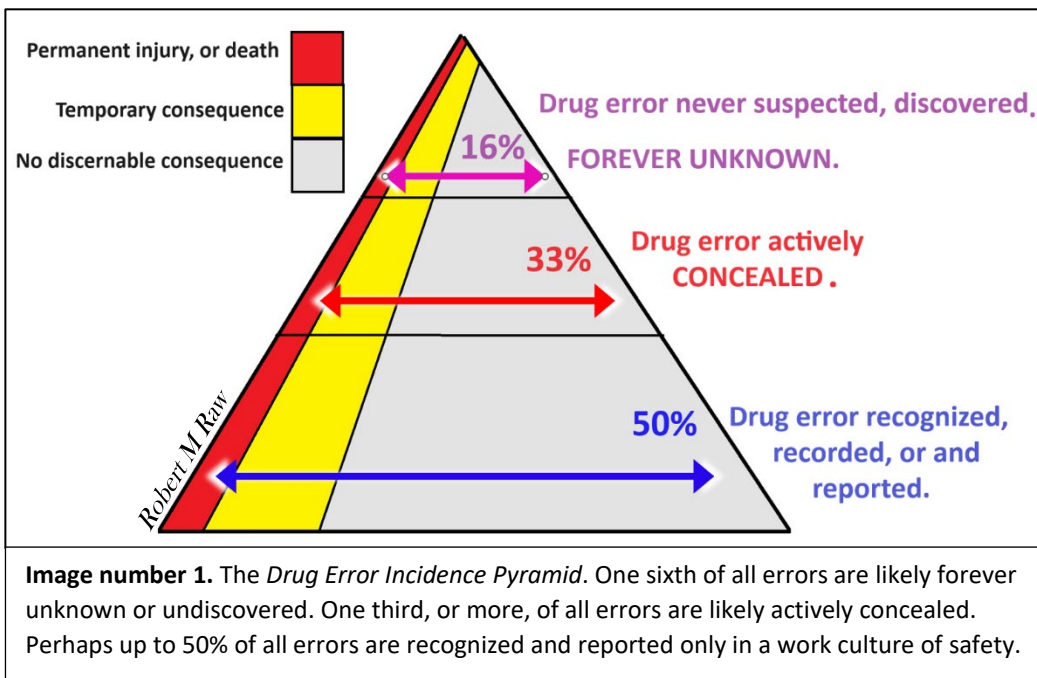
Anesthesia Drug Errors:
UNDISCOVERED or CONCEALED.

(Full chapter, as in
the book)

Anesthesia drug errors fall into three patency groups. Patency is the *visibility* and *discoverability* of the error. Anesthesia Administration Medication Process (AMAP) errors can be:

1. **Visible**, and **discovered** and **REPORTED**.
2. Visible, discovered by the anesthesiologist, and **ACTIVELY CONCEALED** and not reported.
3. **UNRECOGNIZED AND NEVER DISCOVERED** after the anesthetic.

See image number 1.



The Webster number states that, on average, up to 1 drug error can occur in 133 anesthetics. That number represents **REPORTED** errors, which likely represent half of the actual anesthesia drug administration process errors that happened. Fortunately, only a few errors cause death or permanent injury, but some do. See image number 1 for the visual representation of the proportion of serious consequences from anesthesia drug errors.

It is sometimes possible to retrospectively identify or strongly suspect occasional actively concealed drug errors. Considering anesthesiologists are well-intended but vulnerable second victims of errors, there is a **LARGE INCENTIVE** to actively conceal anesthesia drug errors that they discover they made.

It is rational to consider that drug errors also happen that produce adverse events that are inexplicable, as the anesthesia drug error was never recognized. Some regional anesthesia reported adverse events in Chapter 8, which initially seemed inexplicable, but drug swap errors are certain. Theories were proposed about the possible causes of the

nerve injuries. This author can identify drug-administration-error risk factors in case numbers 2.2 and no. 2.3 reported in Chapter 8. The original case report discussions that did not consider drug swaps lend weak support to other unrelated postulations of nerve injury mechanisms.

A working belief of this book author is that on a broad average, 3/6 (50%) of all anesthesia drug errors are uncovered and reported., 2/6 (33%) are recognized by the anesthesiologist but actively concealed, and 1/6 (16%) are never suspected, recognized or uncovered.

Any vial or ampule may contain a drug unknown to the anesthesiologist. Any drug syringe prepared by the anesthesiologist may have a different drug content than that labeled by the anesthesiologist. An anesthesiologist may inject a different syringe than the one planned.

As a principle for best anesthesia patient care, no used vile oval, ampoules, or drug syringe should ever be discarded until well after the patient is safely handed over to the next care provider after surgery. The Ondansetron—succinylcholine swap case on page 19, chapter 1. In a career, an anesthesiologist will experience a few bizarre, unexpected patient behaviors or outcomes. ALWAYS consider that the wrong drug was administered. Review the used vials, ampules, and syringes. Discovered evidence of a drug administration error is a therapeutic opportunity to optimize the patient's medical care to ensure the best outcomes. Caring for the patient is never not the biggest of all priorities. Save each patient's used vials, syringes, and ampules after their surgery in a plastic sandwich bag with the patient's hospital identity sticker or name on the bag. The bags can be finally discarded at the end of the day or the beginning of the next day.

In life, you never see what you do not look for. Many anesthesia drug errors will escape discovery if one does not consider them in cases with unexpected or inexplicable patient events. Read Section 2, Chapter 8 for examples.

Think of possible anesthesia drug errors when preparing for the anesthetic, think about them during the anesthetic, and keep thinking again about them after the surgery.

(This is the full chapter, as in the book)