Drug Errors in Obstetric Anaesthesia: A National Survey

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Introduction: Drug errors are of particular interest in obstetric anaesthesia owing to time pressured situations with multiple distractions leading to significant potential for error. We aim to determine any change in national practice with regards to reporting incidence and preventive measures compared to previous surveys 1,2.

Methods: An OAA approved email survey was sent to all lead obstetric anaesthetists in the UK. Questions asked about; incidence/outcome of drug errors and measures used to reduce them.

Results: A 71% response rate was achieved. All drugs are drawn up in advance in 0.5% of units, none in 7%. In last 5 years 22% of units reported no errors, 51% reported 1-5 errors and 21% didn't know. There was a major outcome to patient in 15% of errors. The likelihood of error being repeated was certainly in 4.5%, likely in 6.4%, possible in 38.1% and unlikely in 31%. All drugs are drawn up in advance in 0.5% of units, none in 7%, only GA drugs in 53%, phenylepherine in 29% and antibiotics in 0.5%. The main reason for not using pre filled syringes is expense. The commonest error in the last 5 years of wrong drug given is Thiopentone instead of antibiotics and vice versa.

Conclusion: There is little change for the better since 2003 regarding drug errors. The white paper "building a safer NHS for patients" recommends that all intravenous drugs should be checked by two qualified practitioners thus reducing error by up to 58%. Less respondents do this now than in 2003 OAA survey. The use of pre filled syringes has increased since 2003. They minimise potential for drug error, are sterile and reduce wastage. We recommend a prospective data collection of obstetric drug errors under the auspices of the Obstetric anaesthetist association as the NPSA has failed to provide us with an accurate incidence of drug errors.

References: