Yamamoto, M., Ishikawa, S. and Makita, K. (2008) Medication errors in anesthesia: an 8-year retrospective analysis at an urban university hospital. Journal of Anesthesia. 22(3), p.248-252.

Abstract:

Purpose: The Japanese Society of Anesthesiologists (JSA) has investigated critical events in several fields of anesthesiology. However, the types, frequency, and characteristics of medication errors related to anesthesia have not been investigated. By analyzing incident reports retrospectively, we investigated medication errors that occurred during anesthetic practice over the past 8 years at our institution.

Methods: Incident reports related to medication errors that occurred between May 1999 and March 2007 were analyzed retrospectively using a questionnaire published by the JSA in the â€œSurvey of medication errors related to anesthesia. During these 8 years, 233 incidents were reported, in a total of 27454 anesthesia cases conducted during this period. Of these incidents, 61 (26.2%) were anesthetic drug administration errors. In these 61 incidents, clerical error (e.g., erroneous prescription writing), and pre-error (defined as any incident with the potential to become an error) were excluded from the analysis. Consequently, 13 incidents were excluded and 48 incidents were analyzed.

Results: Medication errors due to overdose were the most frequent kind of error (25%), followed by substitution (23%), and omission (21%). Errors due to an incorrect route of

administration were rare. The drugs most frequently involved in these errors were antibiotics and muscle relaxants. Most of the patients involved in the incidents were, fortunately, not harmed seriously. The total frequency of medication errors in the survey period was 0.175% (48 incidents in 27 454 total anesthesia cases).

Conclusion: We found that overdose, substitution, and omission were the main causes of anesthesia-related medication errors in our department.

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