The findings provide valuable information that can aid in the development of policy and procedures for safer, more effective postoperative administration of IV PCA” Lee et al (2019).

Abstract:

BACKGROUND: Intravenous patient-controlled analgesia (IV PCA), which typically involves opioids, has become widely used in clinical settings as an effective method of pain management. Identifying errors in the administration of these drugs is essential to improving patient outcomes. This study sought to describe and analyze the errors associated with postoperative IV PCA.

METHODS: Relevant data were collected from the medical records of all patients who received IV PCA at a large academic medical center in South Korea during a three-year period. The study sample comprised 45,104 patients who used one of four types of IV PCA delivery devices.

RESULTS: Errors occurred in 406 cases (0.9%). Operator error was the most common type of error (54.7%), followed by device malfunction (32.3%), prescription error (12.3%), and patient error (0.7%). Of the 222 operator errors, the most frequent type was failure to begin IV PCA drug administration (28.8%), followed by programming errors by non-anesthesia providers who weren’t authorized to program the device (24.8%) and wrong infusion rates set by anesthesia providers who were so authorized (24.8%).
CONCLUSIONS: The findings provide valuable information that can aid in the development of policy and procedures for safer, more effective postoperative administration of IV PCA. They also suggest that it’s necessary not only to improve the operation of acute pain services teams, but also to ensure ongoing provider and patient education specific to IV PCA use.

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