

Review Article Addressing anesthesia medication errors for improved quality care

Shrey Goel¹, Shramana Banerjee², Abhishek Harakbhavi Nagaraj⁰³, Safdhar Hasml Raveendran⁰⁴, Aarati Thakur⁰⁵, Akshaya Narayan Shetti^{06,*}

¹Dept. of Anesthesia, Neelam Hospital, Rajpura, Punjab, India

²Consultant Anesthesiologist, Health World Hospitals, Durgapur, West Bengal, India

³Dept. of Anesthesiology, Vydehi Institute of Medical Sciences and Research Centre, Bengaluru, Karnataka, India

⁴Dept. of Anesthesiology, King George's Medical University, Lucknow, Uttar Pradesh, India

⁵ Consultant Anesthesiologist, Gajendra Narayan Singh Hospital, Government of Nepal, Rajbiraj, Nepal

⁶Dept. of Anesthesiology and Critical Care, DBVPRMC, PIMS (DU), Loni, Maharashtra, India

ARTICLE INFO

Article history: Received 20-02-2023 Accepted 03-03-2023 Available online 09-03-2023

Keywords: Anesthesia Checklist Medication errors Nurses Patient safety Simulation training

A B S T R A C T

Medication errors in anesthesia can have serious consequences for patients, including morbidity and mortality. These errors can occur at any stage of the medication administration process, from prescribing and preparation to administration and monitoring. Learning from medication errors is essential to improving patient safety in anesthesia. To address medication errors in anesthesia, various strategies have been developed, including the use of checklists, protocols, and simulation training. The implementation of technology, such as barcode scanning and automated dispensing systems, has also been effective in reducing medication errors. Learning from medication errors involves identifying the root causes of the error, analyzing the factors that contributed to the error, and implementing strategies to prevent similar errors from occurring in the future. A culture of safety that encourages reporting and analysis of errors is crucial for learning from medication errors. Improving patient safety in anesthesia requires a collaborative effort among healthcare professionals, including anesthesiologists, nurses, and pharmacists, as well as a commitment to continuous improvement through learning from errors.

This is an Open Access (OA) journal, and articles are distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as appropriate credit is given and the new creations are licensed under the identical terms.

For reprints contact: reprint@ipinnovative.com

1. Introduction

Anesthesia is a critical component of medical care that requires careful attention to patient safety. Medication errors in anesthesia can result in significant harm to patients, including morbidity and mortality. Learning from adverse events is an essential aspect of improving patient outcomes in anesthesia. Medication errors can occur at any stage of the medication administration process, including prescribing, dispensing, preparing, and administering medications. Anesthesia medications are particularly potent and can have serious consequences if given inappropriately. Additionally, the fast-paced and high-stress environment of the operating room can contribute to medication errors.¹

Learning from medication errors involves identifying the root causes of the error, analyzing the factors that contributed to the error, and implementing strategies to prevent similar errors from occurring in the future. This process requires a culture of safety that encourages reporting and analysis of errors without fear of retribution. Various strategies have been developed to address medication errors in anesthesia, including the use of checklists, protocols, and simulation training. Checklists and protocols provide a structured approach to medication

https://doi.org/10.18231/j.ijpp.2023.006 2393-9079/© 2023 Innovative Publication, All rights reserved.

E-mail address: aksnsdr@gmail.com (A. N. Shetti).

* Corresponding author.

administration and can help prevent errors. Simulation training allows healthcare professionals to practice critical skills and decision-making in a safe environment.²

Technology, such as barcode scanning and automated dispensing systems, has also been effective in reducing medication errors. Barcode scanning can ensure that the right medication is given to the right patient at the right time. Automated dispensing systems can help reduce errors in medication preparation and administration.Root cause analysis is a key component of learning from medication errors. This process involves identifying the underlying causes of an error and implementing strategies to prevent similar errors from occurring in the future. Root cause analysis can be used to identify system-level issues, such as inadequate training or poor communication, that contribute to medication errors. This review article describes about anesthesia and medication error and possible improvement needed.³

Anesthesia medication errors can have serious consequences for patients, including morbidity and mortality. Learning from adverse events is an important strategy for improving patient safety and preventing future medication errors in anesthesia. Adverse event analysis involves reviewing patient cases in which medication errors occurred and identifying the factors that contributed to the error.⁴

One way that adverse event analysis can help to prevent medication errors in anesthesia is by identifying systemlevel factors that contributed to the error. For example, a medication error may have occurred due to a faulty medication delivery system or a lack of standardization in medication preparation procedures. By identifying these system-level factors, healthcare professionals can take steps to address them and prevent similar errors from occurring in the future.⁵

Another way that adverse event analysis can prevent medication errors in anesthesia is by identifying human factors that contributed to the error. These factors can include individual healthcare professional factors, such as fatigue or lack of experience, or team factors, such as poor communication or lack of supervision. By identifying these factors, healthcare professionals can develop interventions to address them and prevent similar errors from occurring in the future. Adverse event analysis can also help to identify patterns in medication errors. By analyzing multiple cases of medication errors, healthcare professionals can identify common factors that contribute to errors, such as medication dosing errors or lack of monitoring during medication administration. This can inform the development of targeted interventions to prevent these types of errors from occurring in the future.

In conclusion, learning from adverse events is an important strategy for preventing medication errors in anesthesia. By identifying system-level and human factors that contribute to medication errors and analyzing patterns in these errors, healthcare professionals can develop interventions to prevent similar errors from occurring in the future. Ultimately, this can lead to improved patient safety and outcomes. Adverse event analysis should be a standard practice in anesthesia practice to continuously improve patient safety.⁶

2. Top of Form

2.1. Recent advances to avoid medication errors

One recent advance in preventing medication errors in anesthesia is the use of smart infusion pumps. These devices are designed to reduce medication errors by using electronic drug libraries and dose-checking algorithms. The drug libraries contain pre-programmed medication dosages and rates of infusion, which can help reduce errors caused by manual data entry. The dose-checking algorithms can alert healthcare professionals to potential errors, such as incorrect dosages or infusion rates, and provide real-time feedback and decision support to help ensure that patients receive the right medication at the right dose and at the right time. Smart infusion pumps have been shown to reduce medication errors in anesthesia by up to 60%, making them an important tool in improving patient safety. Another recent advance in medication error prevention in anesthesia is the use of closed-loop anesthesia delivery systems. These systems use real-time monitoring and feedback to adjust medication dosages and rates of infusion automatically. By continuously monitoring the patient's vital signs and depth of anesthesia, the system can adjust the medication delivery to ensure that the patient is in the optimal state of anesthesia. This can help reduce the risk of under or over medication, which can result in serious complications, such as prolonged recovery time, respiratory depression, or cardiovascular instability. Closed-loop anesthesia delivery systems have been shown to reduce the risk of medication errors in anesthesia and improve patient outcomes by reducing the variability in anesthesia delivery.⁷

Technology, such as barcode scanning and automated dispensing systems, has also been effective in reducing medication errors in anesthesia. Barcode scanning can ensure that the right medication is given to the right patient at the right time, which can help reduce errors caused by incorrect patient identification or medication selection. Automated dispensing systems can help reduce errors in medication preparation and administration by ensuring that the right time. These technologies can also help improve medication tracking and documentation, which can improve the overall safety and quality of care in anesthesia.^{7,8}

2.2. Artificial intelligence and medication errors in anesthesia

Artificial Intelligence (AI) has shown promising potential in the healthcare industry, particularly in improving patient outcomes and reducing medication errors. One area of healthcare where AI has been implemented is anesthesia, a medical specialty that administers drugs to patients to induce unconsciousness during surgical procedures. Medication errors in anesthesia can have severe consequences, such as prolonged hospital stays, increased healthcare costs, and even patient mortality. Therefore, the integration of AI into anesthesia practice can help to reduce these errors and enhance patient safety. One of the primary ways that AI can prevent medication errors in anesthesia is through the use of predictive analytics. By analyzing patient data, AI algorithms can predict the likelihood of adverse drug reactions and suggest appropriate doses for anesthesia medications. Additionally, AI can detect drug interactions and allergies that might increase the risk of adverse drug reactions, allowing anesthesiologists to make informed decisions about the medications they administer.⁵⁻⁷

Another way AI can prevent medication errors in anesthesia is through the use of automated drug delivery systems. These systems use real-time patient data to calculate and deliver precise doses of medications, reducing the risk of human error. Additionally, these systems can provide alerts to anesthesiologists if a patient's condition changes or if there is a potential drug interaction.

Finally, AI can aid in the training of anesthesiologists and other healthcare professionals. By providing virtual simulations and training scenarios, AI can help to improve the skills of healthcare professionals and ensure that they are prepared for real-life situations that may arise during anesthesia administration. The medication errors in anesthesia can have severe consequences for patients, but AI has the potential to reduce these errors and improve patient safety. By leveraging predictive analytics, automated drug delivery systems, and virtual training simulations, AI can enhance the practice of anesthesia and help to prevent medication errors. As the healthcare industry continues to embrace AI technology, we can expect to see further advancements in anesthesia practice and improved patient outcomes.⁸

2.3. Simulation training and prevention of medication errors in anaesthesia

Simulation training is a valuable tool in preventing medication errors in anesthesia. Medication errors in anesthesia can have serious consequences, including patient morbidity and mortality. Simulation training provides a safe and controlled environment for healthcare professionals, including anesthesiologists, to practice their skills and decision-making abilities in realistic scenarios without putting patients at risk. By simulating various anesthesia scenarios, healthcare professionals can learn to identify potential medication errors and take steps to prevent them from occurring.

One way simulation can prevent medication errors in anesthesia is by allowing healthcare professionals to practice their medication administration skills. This can include the preparation, calculation, and administration of anesthesia medications. Anesthesiologists can practice various administration techniques and learn to recognize potential errors, such as dosing errors or incorrect medication administration routes. This practice can help to improve medication administration accuracy and reduce the risk of medication errors during real-life anesthesia administration.

Simulation training can also help anesthesiologists to recognize and respond to potential adverse drug reactions. Through simulation, anesthesiologists can learn to identify signs and symptoms of adverse drug reactions and take appropriate steps to prevent further harm to the patient. Additionally, simulations can be used to practice emergency response procedures, such as code blue scenarios, in which prompt and effective intervention is crucial in preventing further harm to the patient. Another way simulation can prevent medication errors in anesthesia is by improving communication and teamwork among healthcare professionals. During simulations, healthcare professionals can practice communicating with one another to ensure everyone is on the same page and working towards the same goal. This can help to reduce the risk of miscommunications and errors during real-life anesthesia administration.

The simulation training is a valuable and powerful tool in preventing medication errors in anesthesia. Through simulation, healthcare professionals can practice medication administration skills, recognize and respond to potential adverse drug reactions, and improve communication and teamwork. Ultimately, this can lead to improved patient safety and outcomes. As the healthcare industry continues to embrace simulation training, we can expect to see further advancements in anesthesia practice and improved patient care.⁹

2.4. Medication errors and legal implications in India

Medication errors in anesthesia are a serious concern in India, and can have significant legal implications for healthcare providers. Anesthesia medication errors can result in serious harm or even death to patients, and can lead to medical malpractice claims against healthcare providers. Anesthesia medication errors can occur at any stage of the anesthesia process, including during pre-operative medication administration, induction of anesthesia, maintenance of anesthesia, or emergence from anesthesia. Some common examples of anesthesia medication errors include administering the wrong drug, administering the wrong dose, administering the drug by the wrong route, or administering the drug to the wrong patient.^{9,10}

If an anesthesia medication error occurs, the healthcare provider may be held liable for medical malpractice. In India, medical malpractice is governed by the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, which outlines the duties and responsibilities of healthcare providers, including the duty to maintain the highest standards of professional conduct, and to ensure patient safety.

If a healthcare provider is found to be negligent in their duty of care, they may be required to compensate the patient for any harm or injury suffered as a result of the error. In addition, the healthcare provider may face disciplinary action from the Medical Council of India, including suspension or revocation of their medical license.

To prevent anesthesia medication errors, healthcare providers should follow established protocols and procedures for medication administration, including double-checking the medication and dose before administering it to the patient. They should also monitor the patient closely during anesthesia administration, and be prepared to respond to any adverse reactions or complications that may arise.¹⁰

3. Conclusion

Anesthesia medication errors can have serious consequences for patients and healthcare providers in India. By following established protocols and procedures, monitoring patients closely, and prioritizing ongoing education and training, healthcare providers can improve patient outcomes and minimize the risk of medication errors.

4. Source of Funding

None.

5. Conflict of Interest

None.

References

1. Leahy IC, Lavoie M, Zurakowski D, Baier AW, Brustowicz RM. Medication errors in a pediatric anesthesia setting: Incidence, etiologies, and error reduction strategies. J Clin Anesth. 2018;49:107–111. doi:10.1016/j.jclinane.2018.05.011.

- Grigg EB, Martin LD, Ross FJ. Assessing the Impact of the Anesthesia Medication Template on Medication Errors During Anesthesia: A Prospective Study. *Anesth Analg.* 2017;124(5):1617–25.
- Merry AF, Anderson BJ. Medication errors-new approaches to prevention. *Paediatr Anaesth*. 2011;21(7):743–53.
- Sakaguchi Y, Tokuda K, Yamaguchi K, Irita K. Incidence of anesthesia-related medication errors over a 15-year period in a university hospital. *Fukuoka Igaku Zasshi*. 2008;99(3):58–66.
- Dhawan I, Tewari A, Sehgal S, Sinha AC. Medication errors in anesthesia: unacceptable or unavoidable? *Braz J Anesthesiol*. 2017;67(2):184–92.
- Stipp MM, Deng H, Kong K, Moore S, Hickman RL, Nanji KC. Medication safety in the perioperative setting: A comparison of methods for detecting medication errors and adverse medication events. *Med (Baltimore)*. 2022;101(44):31432.
- Peterfreund RA. Intravenous administration of medications during an anesthetic: a deceptively simple process. J Clin Monit Comput. 2019;33(4):547–8.
- Wu S, Wang H. Medical Errors, Regrettable Mistakes in Public Health. Iran J Public Health. 2018;47(7):1052.
- Crigger NJ. Always having to say you're sorry: an ethical response to making mistakes in professional practice. *Nurs Ethics*. 2004;11(6):568–76.
- Orgeas MG, Soufir L, Tabah A. A multifaceted program for improving quality of care in intensive care units: IATROREF study. *Crit Care Med.* 2012;40(2):468–76.

Author biography

Shrey Goel, Consultant Anesthetiologist

Shramana Banerjee, Consultant Anesthetiologist

Abhishek	Harakbhavi	Nagaraj,	Assistant	Professor
https://orci	d.org/0000-0001-9	9035-8898		

Safdhar Hasml Raveendran, Senior Resident (5) https://orcid.org/0000-0002-7559-5702

Aarati Thakur, Consultant Anesthesiologist (b) https://orcid.org/0000-0003-1060-1152

Akshaya Narayan Shetti, Professor ^(b) https://orcid.org/0000-0002-4688-8071

Cite this article: Goel S, Banerjee S, Nagaraj AH, Raveendran SH, Thakur A, Shetti AN. Addressing anesthesia medication errors for improved quality care. *Indian J Pharm Pharmacol* 2023;10(1):20-23.