STATEMENT ON STANDARD PRACTICE FOR AVOIDANCE OF MEDICATION ERRORS IN NEUROAXIAL ANESTHESIA

Committee of Origin: Committee on Quality Management and Departmental Administration (QMDA)

(Approved by the ASA House of Delegates on October 20, 2010, and last amended on October 28, 2015)

Statement: Labeling sterile syringes is not required when an anesthesiologist is performing a spinal or an epidural anesthetic under sterile conditions without any break in the process, the medications are immediately administered, and never out of the sight and control of the anesthesiologist.

Rationale: The possibility for administering an unintended medication by using an unlabeled syringe is immeasurably small*, when an anesthesiologist is performing a continuous procedure where the medication is drawn up in a sterile fashion immediately prior to the injection of that medication into the patient. Labeling of such syringes could result in a break in the sterile field, contamination of the drugs or needles, and/or unduly delay the completion of the procedure in emergent situations. This is counterproductive to safe patient care.

* The National Anesthesia Clinical Outcomes Registry (Four million cases with reported clinical outcomes), the Anesthesia Closed Claims Project (10,000 cases over 30 years) and the Anesthesia Incident Reporting System (1,500 incident reports since 2011) have not recorded a medication error due to syringe mislabeling occurring during epidural or spinal anesthesia performed by an anesthesia provider.