

## Contingency Drugs

The Victorian Consultative Council on Anaesthetic Mortality and Morbidity continues to be concerned about the high number of reports of drug errors in anaesthetic practice, which has already been highlighted on the website. Also, there is ongoing concern about an increasing practice in some teaching hospitals of drawing up 'contingency drugs' to allow rapid treatment of emergency situations during anaesthesia and surgery.

The Council agrees that there are several situations where contingency drugs are advisable and should be readily available in appropriate doses, carefully labelled (for example, in emergency obstetrics, vascular and cardiac surgery and certain paediatric lists). However, the routine practice of having such drugs drawn up increases the risk of inappropriate administration and drug errors.

It is considered that the problem should be resolved at a departmental level with an education programme highlighting the risks and by instituting a well organised contingency plan.

The Council would make the following comments and suggestions:

- Many drug errors reported to the Council have involved inadvertent administration of vasoactive drugs instead of anaesthetic drugs, despite correct labelling, resulting in severe cardiovascular instability.
- There is a high risk of contamination and cross infection if such drugs are not discarded at the end of the case. In the misguided interests of economy, they may be transferred to the tray for the next patient.
- Opioids drawn up for the procedure should not be transferred to the Recovery Room unless the anaesthetist is planning to personally administer a bolus. Any further opioids administered in the Recovery area should be drawn up by the nurse concerned, be clearly labelled and have the patient identification attached. Any residual drug should then be discarded by the same nurse prior to discharging the patient.