
Guidelines for Drug Preparation and Blood Administration

“Right Drug, Right Dose, Right Route, Right Patient”

Version 6.0

N.B. To be used in conjunction with existing Policies and Procedures of St Vincent's Hospital and the Australian and New Zealand College of Anaesthetists (ANZCA) Professional Document PS51 - *Guidelines For The Safe Administration Of Injectable Drugs In Anaesthesia*, and the Australian Council for Safety and Quality in Healthcare (ACSQHC) *National Recommendations for User-applied Labelling of Injectable Medicines, Fluids and Lines*.

Drug preparation

1. Drug preparation is to be done without distraction and ideally without interruption. The individual preparing drugs is not to be unnecessarily disturbed by others and should not be conversing during this time.
2. Drug preparation for one patient should not occur in the same room as a different patient. Therefore drugs for the second or subsequent case in a given Operating Room should be drawn up in the Anaesthesia Room. Any drug ampoules required would then be taken to the Anaesthetic Room before being checked and drawn up wherever possible.
3. All syringes must be unambiguously identified with a user applied label (suitable for a closed practice environment) to indicate the name of the drug.
4. The concentration of any *diluted* drug must be indicated on the syringe or infusion bag.
5. Syringes for infusion must be labelled appropriately, and if the infusion will be leaving the OR with the patient (e.g. to the Intensive Care Unit (ICU) or Post Anaesthesia Care Unit (PACU)) then the infusion syringe must have a completed user applied label affixed which is suitable for an open practice environment i.e. including patient identification, drug and concentration, and date and time.
6. **Drugs for intrathecal or epidural use** must be double checked with a nurse or doctor; if more than one drug or fluid (ie saline) is present in a sterile field then the syringes must be labelled using a sterile label or sterile marking pen.
7. **Muscle relaxants:**
 - a. Must only be drawn up into a 5mL syringe with a red plunger.
 - b. Must only be drawn up and left in the patient's operating room
 - c. If the relaxant drawn up is not part of the primary induction plan, then an extra drug label should be used to 'bridge' the syringe barrel and needle cap to act as an active warning
8. A final check that the intended drug matches the drug name on the label must be done prior to intravenous injection.
9. Drugs drawn up into syringes for bolus administration to patients outside the patient's Operating Room (e.g. in the PACU) must only be used by the medical staff involved with the drug preparation. They are not to be left with nursing staff.

10. A registered nurse handing drugs to an anaesthetist will verbally identify each drug by name as part of that handover process.
11. **Empty ampoules** are to be retained (eg in a kidney dish) until the patient has left the Operating Room, as a further check on drugs drawn up.
12. Any opioid or other S8 or S9 drug drawn up but not given to the patient should be recorded as discarded on the anaesthesia record and the Drug Register.
13. Unused syringes with drugs drawn up for a given patient should not be transferred for use in another patient.
14. It is the responsibility of the anaesthetist administering any drugs to be satisfied that they are giving the correct drug and dose to the correct patient.

Blood Administration

Medical Practitioners are expected to have completed the on-line training module: *“Bloodsafe – Clinical Transfusion Practice”*.

1. There must be an accessible means of accurately identifying patients during anaesthesia. This could be an ID bracelet or a verified ID label sticker firmly attached elsewhere on the patient.
2. When requesting blood and/or blood products for administration in the OR from blood bank, the minimum amount needed should be asked for at any time eg typically 2 units of blood maximum. This is to avoid wastage.
3. Blood and blood products must be matched by patient name (ID bracelet or verified label compared to the name on the cross-match sheet) when they are brought into the operating room. The time taken to do this must be less than 2 minutes, and documented, if the products are then to be returned to the transport cooler (Esky).
4. All blood and blood products must be formally cross-checked with the cross-match record and patient’s identification using patient name, UR and birth date, prior to connection to an infusion line. Details are provided in the St Vincent’s Blood Transfusion Policy document. The only exception is in a critical situation when the Anaesthesia Consultant has approved the use of unmatched O-negative blood.
5. Autologous blood collected from the patient early in the procedure must be labelled with a patient sticker and have the date and time of collection marked. It must remain in the Operating Room with the patient and should be reinfused within 6 hours.
6. Used blood and blood product bags must be retained by theatre for 48 hours (compliant with hospital policy).
7. Unused blood may be returned to blood bank for restocking within 2 hours provided the blood has remained in the Esky for the whole time excluding the 2 minute checking period (Item 3 above).

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