Medication error by anaesthetist
(16HDC00882, 25 May 2015)

Anaesthetist ~ Private hospital ~ Surgery ~ Record-keeping system ~ Medication administration error ~ Right 4(1)

A woman was admitted to a private hospital to have decompression surgery on her back under general anaesthetic following diagnosis of spinal stenosis.

During the surgery, her anaesthetist administered an additional 6mg of morphine (to the prescribed 2.5mg of morphine) into the woman's epidural space in error. The syringe containing the 6mg of morphine had been prepared in advance for the next patient. The anaesthetist said that it was a "slip/lapse" by him in picking up the wrong syringe.

The anaesthetists at the private hospital used a record-keeping system to record, amongst other things, what types of drugs were administered during an operation. The anaesthetist said the system could have alerted him to the error but did not due to certain limitations with the system and how he used it during the operation.

The anaesthetist breached Right 4(1) by failing to administer the correct drugs, by failing to undertake appropriate safety checks to ensure that he was administering the correct drugs, and for storing syringes for two patients in close proximity. Criticism was also made about the anaesthetist for not ensuring that the record-keeping system's speaker was audible.

The private hospital did not breach the Code.