**Standardization of Medication Handling Processes by Anesthesia Providers Decreases Medication Errors**

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**Background**

Medication errors are dangerous and often preventable. Anesthesiologists have a unique role in developing error prevention strategies as the only physicians who prescribe, prepare, administer and record medications autonomously. Anesthesiologists are at particularly high risk due to fast paced demands of the OR, absence of common safety mechanisms, and handling of high risk medications.1,2

**Phase 1**

Multidisciplinary team, 120 hours OR Observation
3-day team CPI event: "Failure Mode and Effects Analysis"
1. Systematically deconstruct & evaluate medication steps
2. Identify highest risk targets
3. Design countermeasures

**Phase 2**

1. Medication Trays
2. Cart Top Template
3. Labels
4. Infusion Check
5. Practice Guidelines
6. Online Reporting System

**Objectives**

1. Systematically evaluate medication handing processes by anesthesia providers in the operating room, identify areas of risk, and generate countermeasures
2. Decrease medication errors and improve medication error reporting through system changes and heightened provider awareness

**Conclusions**

1. Medication error reporting improved, likely due to increased provider awareness and improved reporting mechanisms
2. Implementation of this countermeasure bundle was associated with a subsequent decrease in medication error rates
3. Targeted medication practice changes may improve medication safety in the operating room