

In response: neuraxial and peripheral misconnection events leading to wrong-route medication errors

To the Editor

We thank Dr Patel for calling attention to his very thoughtful and insightful reviews of neuraxial and potassium chloride administration errors.^{1–3} We are pleased that his work complements and amplifies the results of our study.⁴ Our literature search was performed using PubMed and Embase, which served as the primary sources for published references on misconnection events. To supplement this, we conducted an internet search strictly for related public access documents from regulatory bodies such as the Food and Drug Administration.

The reviews authored by Dr Patel and colleagues include multiple types of human errors, while our narrative review focused on one specific error: the misconnection of intravenous tubes and syringes. To that end, we specifically omitted wrong-route cases attributed to causes other than misconnection (eg, mislabeled medication containers) and included only reports of confirmed misconnection events that noted the name of the drug administered and the patient's health outcomes. It is of interest that in the case series of neuraxial potassium chloride administrations, approximately 50% of errors were the consequence of misconnections.¹ Administration errors that were not due strictly to misconnection events, even errors occurring during the perioperative period, were beyond the scope of our current review.

We agree with Dr Patel's assertion that there is a need for better scales to categorize incident harm in this context. Our goal in using the National Reporting and Learning System criteria⁵ was not to specify which reports were representative of each level of severity, but rather to collectively describe which drugs have the most severe outcomes when administered incorrectly. With regard to classifying harm, we focused on mortality because this is an unambiguous outcome and represents a 'never event'.

When assessing the efficacy of different safety preventions, forcing functions are at the top of the pyramid. The use of non-Luer neuraxial devices to prevent the misconnection of tubing and syringes falls into this most effective safety prevention category and cannot be defeated by human error. Although non-Luer devices

will not prevent all administration errors, if universally adopted, these devices could have a substantial impact. Why do clinicians and health systems tolerate these events when there is a 'foolproof' solution that could reduce mortality due to intravenous medication administration errors by 50%?

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