Background and importance Operating rooms (OR) are an area with a significant proportion of high risk, high alert medications. A new law was passed in 2016 in Spain with the objective of improving safety regarding drug identification in the OR and describing the correct labelling of reconstituted medication.

Aim and objectives The aim of this study was to describe the actions developed to adapt our environment to the new legislation and to analyse intravenous drug labelling in daily clinical practice.

Material and methods A committee was created composed by anaesthetists, surgeons, and nursing and pharmacy departments. Seven brainstorming sessions were carried out to apply the new law to our OR in clinical practice. A transversal observational study was conducted over 2 days in a tertiary hospital in October 2019. Variables were collected by nurses from reconstituted medication in bags and syringes.

Results It was decided that the following variables should be described in our drug labels and were consequently collected for the study: patient identification (name and ID), drug, dose or concentration, total volume and administration route. For the syringes, we collected drug name and dose.

We decided that autolfill ID patient labels and white labels to identify drugs should be pre-printed before the operation. In addition, pre-printed syringe labels were purchased complying with the colour code used in the international system. The information was disseminated to the departments in September 2019.

The total number of bags analysed was 91, and 55 (60.4%) were correctly identified according to all standards: 66 (72.53%) with patient information, 88 (96.7%) with drug identification, 81 (89%) with dose or concentration, 77 (84.6%) with total volume and 72 (79.1%) with administration route. The median total number of bags per patient was 2.7±0.8. The total number of syringes analysed was 113, and 60 (53.1%) were correctly identified: 93 (82.3%) with the drug identification label and 60 (53.1%) with dose identification. The median total number of syringes per patient was 2.5±1.

Conclusion and relevance Reconstituted medication labelling in our OR adequately followed the standards but there is room for improvement. New measures will be discussed in training sessions on the importance of patient identification, administration route and syringe doses, and new pre-printed syringe labels will be purchased. A new study will be conducted in November 2019.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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