

**STATEMENT ON STANDARD PRACTICE FOR AVOIDANCE OF MEDICATION  
ERRORS IN NEURAXIAL ANESTHESIA**

**Committee of Origin: Committee on  
Quality Management and Departmental Administration (QMDA)**

**(Approved by the ASA House of Delegates on October 20, 2010)**

**Statement:** Labeling sterile syringes is not required when an anesthesiologist is performing a spinal or an epidural anesthetic under sterile conditions without any break in the process, the medications are immediately administered, and never out of the sight and control of the anesthesiologist.

**Rationale:** The possibility for administering the wrong medication or using the wrong syringe is immeasurably small\*, when an anesthesiologist is performing a continuous procedure where the medication is drawn up in a sterile fashion immediately prior to the injection of that medication into the patient. Labeling of such syringes could result in a break in the sterile field, contamination of the drugs or needles, and/or unduly delay the completion of the procedure in emergent situations. This is counterproductive to safe patient care.

\* A focused review of the ASA Closed Claim Database (data search of 8954 claims through December 2008), shows that there were no cases of wrong medication placed into a sterile syringe during a neuraxial block. The issue of sterility of the neuraxial field is important as it prevents a mix-up with a non-sterile substance.