Royal Devon and Exeter NHS Foundation Trust

Guideline for:
Preparation of Drugs for use by Anaesthetists

SUMMARY AND KEY POINTS

This guide is intended for use by anaesthetic assistants (ODP or Nurse) in the preparation of drugs required by an anaesthetist during induction, maintenance and recovery of anaesthesia and includes both general and practical considerations

Please note that Controlled Drugs are subject to a specific procedure.
See: Medicines Management Policy (2016) *(Section 11)*

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1. GENERAL CONSIDERATIONS

1.1 Anaesthesia requires drugs to be administered in variable, titrated doses. Some drugs will need to be prepared in advance of anaesthetic induction for use in case of unexpected complication.

1.2 All drugs used in anaesthesia may be assumed to be dangerous if misused and have potential for diversion.

1.3 The anaesthetic assistant should be competent to prepare drugs for use by the anaesthetist.

1.4 All drugs administered to a patient during the course of a procedure should be recorded on a recognised prescription chart (either the anaesthetic chart or trust prescription chart).

1.5 The anaesthetist is responsible for the drugs administered as part of the anaesthetic procedure. The anaesthetist may derogate the duty of preparation of drugs to the anaesthetic assistant but is still responsible for the final check.

2. PRACTICAL CONSIDERATION

2.1 In general, drugs should not be prepared long in advance of intended use. Many are stored in a cold environment, need reconstitution for use and may not be bactericidal or static, leading to potential drug instability and/or infection.

2.2 Drugs that need to be drawn in advance (e.g. obstetric emergency drugs) need to be drawn in an aseptic manner, capped and stored in an appropriate lockable refrigerator. The time and date of preparation should be clearly recorded and the storage tray “sealed”. They should not be kept more than 24 hours. Propofol is not suitable for preparation long in advance because of its action as a culture medium. Thiopentone is strongly bactericidal.

2.3 Drugs for intravenous use should be drawn into appropriate sized syringe using appropriate sized preparation needles.

2.4 All syringes should be labelled accurately. Any drug that needs dilution prior to administration should have a label with drug and strength clearly visible.

2.5 All ampoules (both active drug and diluents) used during drug preparation should be kept until the procedure is complete and the patient is safely in recovery. In the event of complication or unexpected reaction, all should be kept in a sealed, labelled container for inspection, if necessary.

2.6 Many drugs need specific diluents and may precipitate if mixed with others. A handy reference chart with diluents and potential reactions may be useful. A saline flush should be prepared for use between drugs in every anaesthetic induction.

2.7 No drugs should be left unattended. If it is necessary to leave the room, then they should be placed in a lockable cupboard or refrigerator. Drugs prepared for a patient should accompany the patient in to the operating room.

2.8 It is inadvisable to prepare drugs such as anti-emetics, NSAIDs and other adjuncts prior to induction, unless they are to be used as part on the induction process. This is to prevent clutter and potential wrong drug administration. They can usually be easily prepared and administered in theatre.

Note:

These notes are for guidance only. Individual circumstances may differ and clinical need may necessitate variation. Variation is the responsibility of the clinician in charge of the anaesthetic care of the patient. Any variation requested by a responsible clinician must be adhered to but should be recorded.

For example – It is acceptable for an anaesthetic assistant to draw up and administer suxamethonium under direction of an anaesthetist in the event of airway compromise and the anaesthetist needing to use both hands for an airway manoeuvre.

This list is not exhaustive.