1. Are all medications prepared for routine use in anaesthesia, intensive care, emergency medicine and pain medicine clearly labelled?
   - Yes
   - No

2. Are pre-filled syringes used wherever possible, e.g. atropine, epinephrine, norepinephrine, insulin, morphine?
   - Yes
   - No

3. Is a supply of user-applied colour-coded syringe labels [ISO, 2008. ISO 26825 : 2008(E)] available in every necessary location?
   - Yes
   - No

4. Is there a policy for labelling drug-containing syringes and infusion lines?
   - Yes
   - No

5. Is there a policy to minimise the risk of drug contamination and transmission of infections between patients, e.g. the contents of any one ampoule should be administered to only one patient?
   - Yes
   - No

6. Are drugs stored in ways designed to facilitate their easy identification and minimise the risk of error or misidentification?
   - Yes
   - No

7. Are local anaesthetic agents stored separately from general anaesthetic drugs?
   - Yes
   - No
8. Is intravenous potassium stored securely?
   - Yes
   - No

9. Are bowls, gallipots or other open containers for drugs, antiseptics or saline no longer used on the sterile field?
   - Yes
   - No

10. Is there a policy for flushing cannulae to reduce the risk of inadvertent administration of anaesthetic drugs in recovery units or on the ward?
    - Yes
    - No

11. Do all drugs supplied meet current national standards and regulations?
    - Yes
    - No

12. Do all anaesthetists report medication incidents to a local and/or national incident reporting system which is regularly reviewed in departmental meetings so that lessons can be learned and passed on?
    - Yes
    - No

13. Is there a policy for managing and learning from adverse events when they occur?
    - Yes
    - No