Nurses' Knowledge on Medication Administration Best Practice.

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Background

- 5 medication errors made in December of 2016 on 7K and 7KS prompted this topic.
- Nurses surveyed showed they were not all familiar with or not following the best practices for medication administration.

PICO Question

- For RNs on 7K, 6KS and 7KS at LVHN, does the use of a medication administration tip sheet at the bedside computer improve the nurses knowledge of safe medication administration?
- P- RNs on 7K, 6KS and 7KS at LVHN
- I - A medication administration tip sheet at each bedside computer
- C - A tip sheet compared no tip sheet
- O - Increase nurses' knowledge of medication administration

Evidence

- 10 rights: drug, dosage, time, route, patient, refuse (patient and nurse), knowledge/education, questions, advice, outcome.[1]
- Common causes of med errors: interruptions during medication administration, stress or fatigue of nurses, documentation.[3]
- Sixty-eight (13.4%) errors occurred in the preparation process and 441 (88.6%) in the administration process.[2]
- Only 6.5% read the name of the patient from the wristband. Administering the medication at the correct time guideline was observed 41% of the time.[4]

Implementation

- Pre- test administered to 47 RNs on 7K, 6KS and 7KS to assess current medication administration practices and review of medication rights to determine initial knowledge base.
- Tip sheet (*figure 1)* placed at 64 bedside computers on 7K, 6KS, 7KS. Email sent to RNs to alert them to the new tip sheets
- Education provided on the rights of medication administration during unit safety huddles
- Post test administered to RNs on 7K, 6KS and 7KS

STOP

Before you administer…….check:

Right Medication
Right Dose
Right Time
Right Route
Right Patient
Right Education
Right Documentation
Right to Refuse
Right Assessment
Right Evaluation

(figure 1)

Outcomes

Questions	Pre-Test	Post-Test
Within the past 3 months, how many medication errors have you made?	1 RN medication error (right dose)	0 medication error
According to the medication policy, within what time frame are you allowed to safely administer medication?	6 RN answered incorrectly about the time frame.	8 RN answered incorrectly
Within the past 3 months, have you looked up the LVHN medication administration policy?	4 RN did not look up meds administration policy	2 RN did not look up meds administration.
How many times do you confirm the patient's identity prior to administering medication?	3 RN confirms 1x 5 RN confirms 2x 3 RN confirms 3x	2 RN confirms 1x 2 RN confirms 2x 4 RN confirms 3x
Where do you look to confirm correct dosing for the patient?	11 RN stated that they confirm correct dosing by comparing MAR and medication packet.	8 RN stated that they confirm correct dosing by comparing MAR and medication packet

Conclusions

- Limitations included staff turn-over. Many of the RNs who took the pre-test did not work on the units by the end of the project.
- Post-test revealed RNs still were unsure of the time frame for medication administration per policy, so follow-up should be done in that area

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