Nurses’ Knowledge on Medication Administration Best Practice.

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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.²
- 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**

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

**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.

**REFERENCES**