

Medication Labeling

The Problem

The Joint Commission requires all medications to be labeled with the drug name, strength, and amount. In reviewing BIDMC's compliance with the Joint Commission requirement, Marne Shaves, RN determined that when medications were transferred from their original packaging to another container, there was not a clear and consistent process for ensuring that medications were appropriately relabeled prior to administration to the patient. Additionally, Nurses had found it difficult to hand write on the medication labels all of the medication information needed due to time constraints. Not labeling medications that were transferred from its original packaging to another container impacts patients and their safety.

Aim/Goal

The goal is to develop an efficient and effective process to ensure that all medications used on in-patient floors that are transferred from their original packaging to another container are properly labeled prior to administration to the patient.

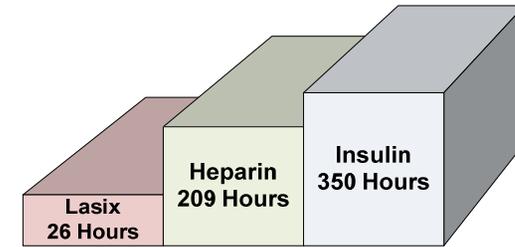
The Team

- Marnie Chaves, RN – Unit Based Educator
- David Drew – Practice Administrator
- Jaime Levash, MSW – Quality Improvement and Education Coordinator
- Kim Sulmonte, MHA, RN – Director, Operations, Quality & Safety

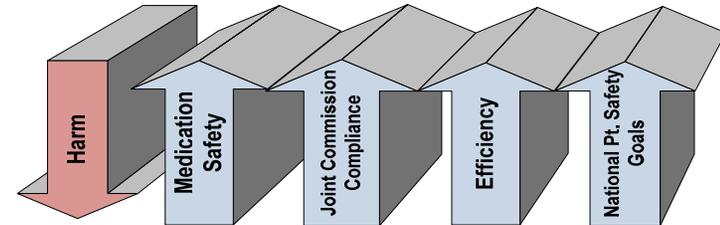
The Interventions

- Began pilot on Farr 6 with computer printed neon labels displayed on a sticky board in the Medication Room
 - Heparin 5000 Units
 - Lasix ___ mg
 - Insulin ___ mg
- Requested use by other units, thus implemented process on all units via printed neon labels by computer printer and placed in all inpatient unit's Medication Room
- Printed via printing company due to supply and demand
- Additional labels have been created due to hospital need and demand
 - Protonix ___ mg
 - Haldol ___ mg
 - Ativan ___ mg
 - Other labels for unit specific needs
- Continued Medication Labeling measurement on the Quality & Safety Audit

The Results/Progress to Date



Annual time saved from handwriting medication labels.
(Estimate based on medication orders for the year, 2009.)



Positive impacts from creating pre-written medication labels.

Lessons Learned

Before printing a large batch of Medication Labels, a few labels should have been tested on the vials. After the first print, it was determined that the labels were too big.

Before piloting the process, the ordering and printing processes should have been determined. Units continuously ran low while printing and distribution took place.

Before beginning a new process, have "buy in" from staff. At first there was resistance to the change of workflow, soon after the staff understood the importance.

Next Steps/What Should Happen Next

- Continue monitoring medication labeling via Quality and Safety Audit
- Verify what units would need a holder for labels in their Medication Room
- Create label awareness and how to create additional Medication Labels



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