Double Vision: Medication Duplication in the EMAR
Sinai Hospital of Baltimore

Program/Project Description.
The same medications are sometimes ordered with different doses, such as Percocet 1 tablet q 4 hours and Percocet 2 tablets q 4 hours. Each order is entered into computer separately which results in separate entries in electronic MAR (EMAR). If the entire EMAR is not viewed there is not evidence of a previous dose given. This was identified as several direct care nurses noted this as they were giving these medications on their shift. The goal was to determine a method to know when a last dose was given to prevent the child receiving the medication twice.

Process.
A nurse identified that when there are two orders for the same drug but with different doses it is difficult to determine when the last dose was given. A process was already in place in the EMAR to alert nurses when each ordered drug was given.

Solution.
A suggestion was made to include the last dose given regardless the dose/route of the same drug. A group of nurses, including direct care nurses, the Clinical Leader and the Advanced Practice Nurse worked with Information Systems (IS) to determine how this could be implemented in the EMAR. IS built the rule so that the last dose would appear and the nurse could ensure that the appropriate timeframe had elapsed.

Measurable Outcomes.
Medication errors related to incorrect weights have decreased to 0.

Sustainability.
This change was applied to the entire institution and will continue by ongoing use.

Role of Collaboration and Leadership.
Direct care nurses took this issue to the Clinical Leader. They pointed out the difficulty of verifying the when the last dose was given, which could lead to a medication error. The Clinical Leader reviewed the electronic documentation and involved the Advanced Practice Nurse, who presented the issue to Information Systems. Information Systems researched a method to alert the last dose given and implemented it throughout the institution.

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