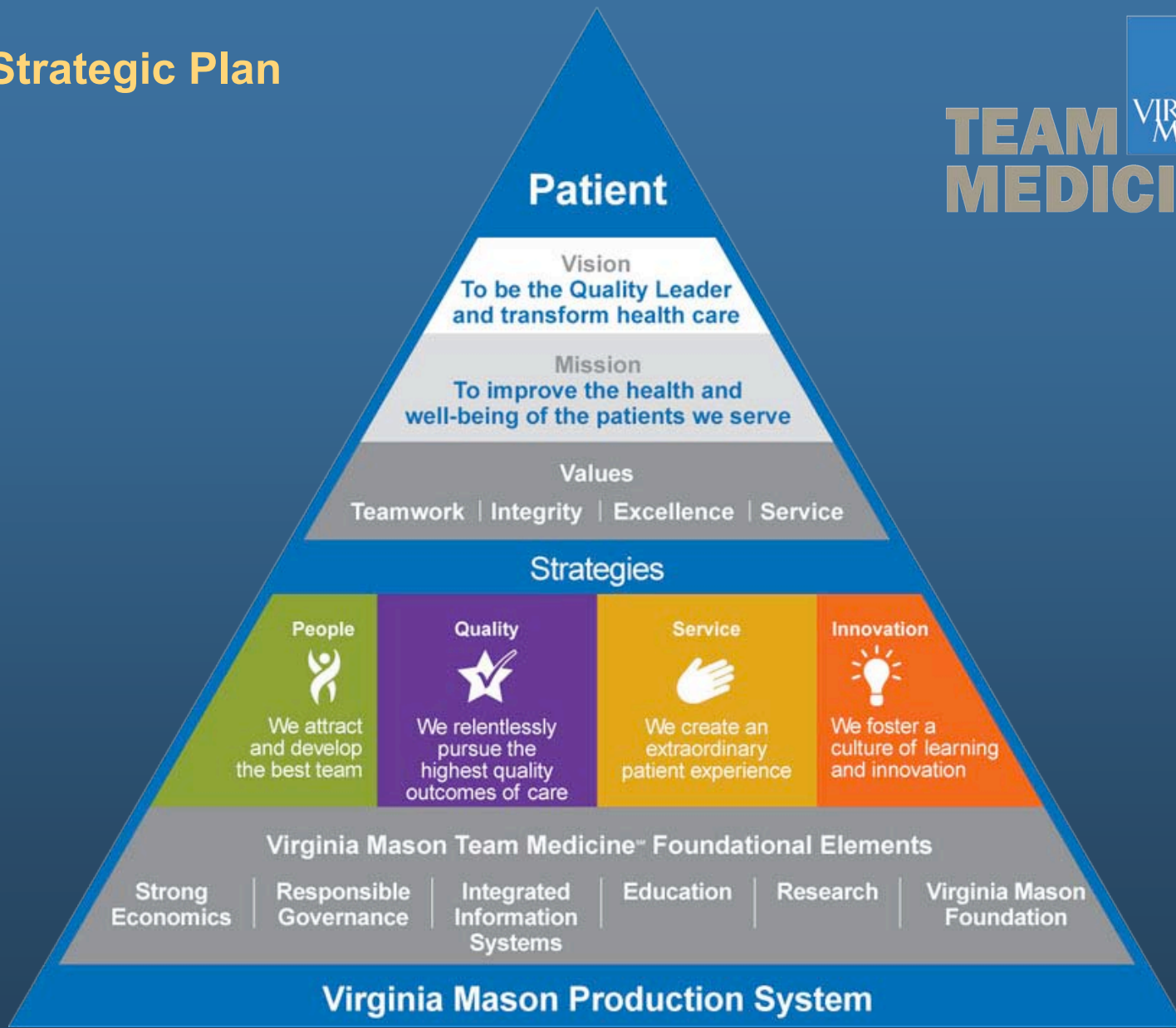




Labeling of Medications On and Off the Sterile Field

By Tracey V. Jones

Our Strategic Plan



Medication Labeling at Virginia Mason Medical Center

- Describe an incident that heightened our awareness to labeling medications.
- Present our policy and procedures surrounding medication labeling in all areas of our hospital.
- Present the A.O.R.N. Standards and Guidelines for medication labeling.
- Present the J.C.A.H.O. Requirements for labeling medication.



Mary McClinton - 2004



- Mrs. Mary L. McClinton died in our care in 2004 due to an error we made. We injected Chlorahexidine, a chemical antiseptic used for skin preparation, instead of a local injection. Both liquids were colorless and clear and the receptacles containing these liquids, were unlabeled.



Operating Room Policy

- Any medication to be delivered to the sterile field will be identified verbally by the circulator Registered Nurse (RN) with the label shown to the scrubbed person for confirmation.
- Verifying medications includes:
 - Name of medication
 - Strength or dosage
 - Expiration date
 - Expiration time, if expires in < 24 hours



O.R. Policy continued

Once the medication is delivered to the surgical field:

- Both the scrubbed person and the circulating nurse will verify the pre-printed label against the original source label.
- The scrubbed person will label containers.
- The scrubbed person will immediately draw the injectable solution into the syringe and label the syringe.
- The scrubbed person and circulating nurse will re-verify the label on the container and syringe against the original container.



O.R. Policy continued

- When passing the medication/syringe:
 - The scrubbed person will verbally and visually verify the contents of the syringe/container with the recipient each time the syringe/ container is passed.
 - A running tally of the amounts of medications should be maintained on the field and given to the Circulating RN for documentation on the intraoperative record.



O.R. Policy continued

- Similar looking solutions will be placed in dissimilar looking containers with a pre-printed label.
- Only one medication can be added to the field at a time.
- The circulator RN will document in the Intraoperative Nursing Record.
- This information should be verified with relief shifts as they arrive and take over.
- Normal saline and Ringers on the sterile field are required to be labeled.



Association of Perioperative Registered Nurses (A.O.R.N.)

- Confirm with Surgeon's preference list.
- Deliver one medication to the field at a time.
- Verbally and visually confirm medication for name, strength, concentration, & expiry date (where applicable).
- No abbreviations.
- Label container with the above information.
- Verbally and visually identify the medication while passing it to the surgeon.
- Confirm medication for accuracy during hand-offs.
- Discard all unlabeled medication.



Outside the Sterile Field

- The same practices are adopted throughout the hospital/clinics, procedural based departments and anesthesia.
- Monthly audits are done within each department either by peer-to-peer or internal persons.



J.C.A.H.O. Standards

- Medications and solutions both on and off the sterile field are labeled even if there is only one medication being used.
- Labeling occurs when any medication or solution is transferred from the original packaging to another container.
- Medication or solution labels include the medication name, strength, amount (if not apparent from the container), expiration date when not used within 24 hours, and expiration time when expiration occurs in less than 24 hours.
- All medication or solution labels are verified both verbally and visually by two qualified individuals whenever the person preparing the medication or solution is not the person who will be administering it.
- No more than one medication or solution is labeled at one time.
- Any medications or solutions found unlabeled are immediately discarded.
- All original containers from medications or solutions remain available for reference in the perioperative or procedural area until the conclusion of the procedure.
- All labeled containers on the sterile field are discarded at the conclusion of the procedure.
- At shift change or break relief, all medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting personnel.





TEAM
MEDICINESM

VIRGINIA
MASON

Questions?

LABELING ON AND OFF THE STERILE FIELD



THE BEGINNING

- IN 1995, WE BUILT A 3 O.R. “DAY ONLY” SURGERY CENTER ATTACHED TO A MULTI- SPECIALTY CLINIC.

WE STARTED WITH 4 CUSTOM STERILE PACKS.



GROWING FAST AND FURIOUS!!

- **BEGAN WITH HANDFUL OF SURGICAL PROCEDURES AND HANDFUL OF SURGEONS.**
 - **ONE OF OUR EARLY DOCS USED EPINEPHRINE FREQUENTLY & C/O ABOUT IT'S EFFECTIVENESS. BEGAN KEEPING MEDICATION VIAL FOR PROOF.**
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OPHTHALMIC PROCEDURES

- IN 1997, BEGAN DOING CATARACT EXTRACTIONS AND OTHER OPHTHALMIC PROCEDURES = LOTS OF MEDICATIONS THAT ALL LOOK THE SAME!!
 - LUCKILY, ONE MEDICATION MANUFACTURER PUT SYRINGE LABELS IN THE BOX WITH THE MED VIAL, SO STAFF BEGAN USING FOR EYE CASES.
-

“I’VE ALWAYS DONE IT THIS WAY!”

- **BUT IN THE OTHER SURGICAL PROCEDURES, WE SIMPLY DEVELOPED CONSISTENCY = MOST OUR M.D.’S USE TWO LOCALS MIXED → SCRUB PUT LOCAL IN SMALL, BLUE DISP BASIN.**
 - **FOLKS WHO SCRUBBED EYES BEGAN WANTING MEDS IN OTHER CASES LABELED AS WELL.**
-

OTHER PROCEDURES



- **SCRUBS BEGAN
OPENING A WRITING
PEN & WRITING MED
NAMES ON BACK
TABLE IN FRONT OF
BASIN / CUP**



INTERESTING FALL-OUT!!

- STAFF BEGAN FEELING LIKE THEY WERE “MISSING” SOMETHING WHEN THEY DIDN’T LABEL MEDICATIONS
 - STAFF BEGAN REFUSING TO RELIEVE THOSE MEMBERS WHO DID NOT LABEL THEIR MEDS!!
-

ADDITION TO CUSTOM PACKS

- **IN 2002, WE ADDED WHITE BLANK LABELS AND WRITING PENS TO EVERY CUSTOM STERILE PACK WE HAD, WHICH BY NOW HAD DOUBLED IN NUMBER.**



“ADD-IT” TO I.V. SOLUTIONS

- **ALWAYS USED LARGE FLUORESCENT ORANGE “MEDICATION ADDED TO I.V.” STICKERS.**
 - **ANESTHESIA PERSONNEL LABEL ALL THEIR SYRINGES AND ALSO USE “ADD-IT” LABELS WHEN ADDING MEDICATION TO I.V. SOLUTION**
 - **ANESTHESIA USED STANDARDIZED COLORS FOR SYRINGE LABELS**
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SURGICAL “TIME-OUT”

- **IN 2004, WE BEGAN THE VERBAL “TIME-OUT” PRIOR TO EACH SURGICAL PROCEDURE TO VERIFY CORRECT PATIENT, CORRECT PROCEDURE, AND CORRECT SIDE.**
- **THIS ALSO COVERS PATIENT ALLERGIES AND A REVIEW OF MEDS ON STERILE FIELD.**

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NEW POLICY WRITTEN

- **IN 2005, EXTENDED LABELING OF MEDICATIONS AND I.V. SOLUTIONS TO ALL AREAS WHERE PROCEDURES ARE TAKING PLACE.**
 - **HIGHLIGHTS OF POLICY:**
 - **1. ALL MEDICATIONS ARE LABELED, EVEN I.V. SOLUTIONS, IN WHATEVER CONTAINER**
 - **2. IF UNLABELED MED IS FOUND → DISCARDED**
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NEW POLICY WRITTEN

- **3. ALL PERSONNEL VISUALLY AND VERBALLY VERIFY MEDICATION, PATIENT'S IDENTITY & ALLERGIES DURING "TIME OUT"**
 - **4. REVIEW ALL MEDS DURING SHIFT CHANGE OR BREAK RELIEF**
 - **5. DO NOT REMOVE ORIGINAL MED/I.V. CONTAINER FROM ROOM, BUT DO DISCARD BEFORE NEXT PT ARRIVES**
-

NEW POLICY WRITTEN

- **VERBALLY STATE MED NAME WHEN PASSING TO PROCEDURALIST**
- **ANY CALCULATIONS SHOULD BE VERIFIED BY ANOTHER QUALIFIED INDIVIDUAL.**



PRE-PRINTED LABELS FINALLY!

- **ALSO IN 2005, O.R. PERSONNEL TIRED OF WRITING ON WHITE LABELS IN CUSTOM PACKS, SO WE BEGAN BUYING PREPRINTED COLORED LABELS SEPARATELY! OH HAPPY DAY!**

 - **AND THIS IS WHERE WE ARE TODAY!**
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