In an effort to system to validate that the six rights of medication administration are being the patient’s armband, the clinician scans each medication prior to being or she first scans the patient’s armband bar-code to open that patient’s eMAR When a clinician is administering medications using the bar-code system, he medication contains information regarding the medication name, dose, and route (i.e., tablet or a unit-dose medication packager. The bar-code is unique to the medication. The bar-code on the All medications except for multi-dose medications have a bar-code applied in the pharmacy by errors, improve the quality and safety of medication administration, and generate online records of Background

Marriottsville, Maryland 21104

In June 2013, the Clinical Informatics Department of the Lady Baltimore Hospital, part of Bon Secours Kentucky Health System, Marriottsville, Maryland, set a goal that the unit-dose medications. This machine is maintained by the pharmacy staff. In January 2013, the performance for medication BCMA began significantly better.

...one tablet of every medication was packaged and labeled the print-heads on the medication packager. After doing so, the pharmacy asked the vendor to come and replace the bar-code scanner with one used by nursing and fixing the pharmacy could not read the bar-codes on the medications. When the pharmacy swapped out its old bar-code scanner for the same brand the bar-codes. The process broke down because the bar-code scanners on the nursing unit were failing to read the bar-codes on the medications. When multiple failures, many of the nurses reported using the system.

The nursing staff demonstrated that they knew how to use the bar-code system. The medications were all packaged with bar-codes and the patient’s armbands were also printed with bar-codes. The process broke down because the bar-code scanners on the nursing unit were failing to read the bar-codes on the medications. When multiple failures, many of the nurses reported using the system.

The vendor was asked to come and replace the bar-code scanner in the pharmacy. The pharmacy staff pulled some medications out and used their bar-code scanner on the medications, but the nurses’ scanners (sometimes) failed to read the bar-codes. The process broke down because the bar-code scanners on the medications. When multiple failures, many of the nurses reported using the system.

The Informatics staff tested the bar-code scanners in the pharmacy and on the nursing units and verified that the bar-code scanner did not successfully identify many of the medications. The nursing staff demonstrated that they knew how to use the bar-code system. The medications were all packaged with bar-codes and the patient’s armbands were also printed with bar-codes. The process broke down because the bar-code scanners on the nursing unit were failing to read the bar-codes on the medications. When multiple failures, many of the nurses reported using the system.

When scanning each medication with the new pharmacy scanner and the BCMA system, the nurses had essentially “thrown up their hands” at using the system. When scanning each medication with the new pharmacy scanner and the BCMA system, the nurses had essentially “thrown up their hands” at using the system. When scanning each medication with the new pharmacy scanner and the BCMA system, the nurses had essentially “thrown up their hands” at using the system.


The Clinical Informatics Department identified four possible root causes that could explain the poor performance in the implementation in the hospital and how they affected the six rights of medication administration: 1. Patient and medication were correctly bar-coded. 2. Patient was scanned, but medication was not. 3. Patient was scanned, but medication was not correctly bar-coded. 4. Patient was not scanned.

The informatics staff tested the bar-code scanner in the pharmacy and on the nursing units. The pharmacy was using a different brand of scanner than what is in use on the floors. It was discovered that the pharmacy scanner could not read the bar-codes on the medications. The nurses had correctly scanned the patient’s armband bar-codes but the nurse’s medication scanner could not read the bar-codes on the medications. The nurses had correctly scanned the patient’s armband bar-codes but the nurse’s medication scanner could not read the bar-codes on the medications. The nurses had correctly scanned the patient’s armband bar-codes but the nurse’s medication scanner could not read the bar-codes on the medications.

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The six rights of medication administration are being evaluated by The Clinical Informatics Department. The performance is compared against the goal of scanning all patient armbands in a timely manner. The goal was set by the hospital leadership. The performance is monitored on a monthly basis.

The Clinical Informatics Department also reassessed the three elements required for the Bar-Code Medication Administration System to work successfully: People, Process, and Technology.

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The six patient “rights” with respect to patient safety during administration of medications are: 1. Right Patient 2. Right Medication 3. Right Dose 4. Right Route 5. Right Time 6. Right Administration

According to the complaints, nurses who were giving medications claimed that the pharmacy was not giving medications that were compatible with the bar-code system. In June 2013, the bar-code scanning rates for patient armbands and medications were below 60%. It is to identify any potential source of problems which could be resolved.

The Clinical Informatics Department sponsored an investigation of the complaints.

A Case Study

In one especially egregious example, it’s our patient AB, a 71-year-old white female. A nurse at the hospital’s pharmacy department decided to test the system by using the same brand of badge and bar-code scanner used in the pharmacy. The nurse was able to successfully scan all of the medications with the badge and scanner.

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