Practice sting 2025-04

Practice sting Administration registration is essential

This Practice String is particularly interesting for prescribers and nurses in hospitals and other intramural healthcare institutions

Nurses and caregivers administer medication based on the administration registration. It is therefore essential that the information on the administration record is complete, current and clear. In practice, this information is not always complete and up-to-date and the administration registration is not always read properly. This can have consequences for patients, as the following hospital notifications show.

Notifications

1. **Missing administration information**
   A patient taking the antithrombotic drug rivaroxaban is admitted to hospital due to severe rectal bleeding. The physician writes medication orders for all home medications - including rivaroxaban. In the Electronic Patient File (EPF), the physician states that rivaroxaban must be stopped until the patient has no more blood loss for 24 hours. The physician does not include this information on the medication order for rivaroxaban, which means that this information is not included in the administration registration. The result is that the rivaroxaban is not temporarily stopped.
2. **Missing medicine**
   A patient with COPD who is admitted to the lung department with serious lung complaints exhibits severe respiratory deterioration. The nurse calls the assistant physician. It turns out that no prednisolone was prescribed in the ER. However, it is noted in the EPF that this medicine must be started. The assistant physician in the lung department did not read this.
3. **Not reading properly**
   A patient with myasthenia gravis comes for pacemaker implantation. Normally patients receive diazepam for such a procedure. In this patient, the cardiologist deliberately refrained from doing so because diazepam can aggravate myasthenia gravis. The cardiologist has also mentioned this in the EPF. He did not write a medication order for diazepam. The nurse still gave diazepam to the patient without reading the administration registration and the report.

Recommendations

For the committee concerned with medication safety

- Bring the above discussed notifications to the attention of all departments within your institution where patients receive medicines.
- Ask to discuss the following in the department work meeting, to which the department physicians are also invited:
  - Do we recognize these incidents?
  - Could these incidents also happen in our department?
  - Have we already taken measures to prevent this kind of incidents? If so, what do we think of these measures?
  - What can we agree with each other to prevent these incidents from occurring in our department?
  - How are we going to evaluate the agreements made?
  - How are we going to monitor that these incidents no longer occur in our department?