Titration Guidelines as a Tool to Decrease Medication Errors

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Purpose

To assess nursing staff knowledge at a community hospital of The Joint Commission (TJC) policy regarding medication titration in the acute care setting. Areas in need of improvement were identified to increase nurses' knowledge of safe titration guidelines, to decrease medication errors.

Methods

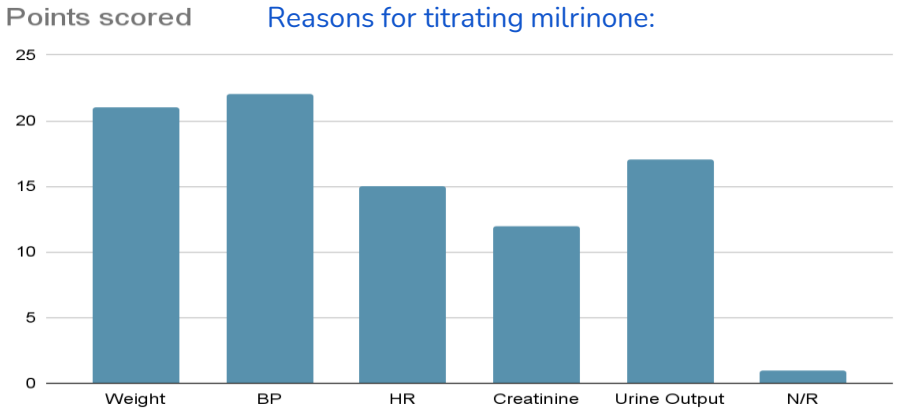
A voluntary survey of 25 nurses from different units was conducted to determine the practice of Milrinone, a vasodilator that treats life threatening heart failure across acute care settings, drip titration. The answers sparked an investigation into other medication orders to determine if titration instructions were included in the order. Multiple IV drip medication orders with examples of inconsistent practices and/or unclear parameters were discovered in the Electronic Medical Record (EMR) to support findings of the need to educate nurses and clarify orders.

Results

The results showed that the nurses' practices are inconsistent on whether or not to titrate Milrinone based on the patient's daily weight due to unclear medication orders. It was found that many medication orders do not provide specific titration instructions or simply read, "for ED use only."

Background

Upon investigation, the majority of IV drip medication orders did not provide specific titration instructions. This is inconsistent with TJC's goals for safe administration which requires that nurses are not placed in a "position of making dosing or administration decisions that may conflict with their scope of practice." In addition, not all nurses share the same view on titrating medications based on daily weights.



Implications for Practice

Based on investigation and findings, many medication orders do not provide specific titration orders, resulting in confusion among bedside nurses. It is crucial to address this problem because unclear titration orders can potentially lead to medication errors and patient harm. Next steps include sharing findings with hospital safety committee to initiate changes to improve patient safety.

References

Available upon request.