FREQUENTLY ASKED QUESTIONS (FAQS)

INDEPENDENT DOUBLE CHECKS

Is it considered a safe practice to administer multiple doses of medication from a single syringe?

In general, ISMP Canada does not support the use of a single syringe for multiple doses of the same medication. We are aware that it is not uncommon practice for nurses to withdraw morphine 10 mg/1 mL and dilute it to 10 mL and administer 1-2 mg doses over the course of a shift; however there are many safety concerns associated with this practice. These include: potential for administration of incorrect doses (e.g., through distraction at the time of administration), poor or no labelling leading to wrong drug errors or administration to the wrong patient, and problems associated with storage of the syringe (e.g., at the bedside or on top of a medication cart) which may increase the likelihood of narcotic diversion. Additional risk is introduced if the medication is being administered by a nurse who is not the same nurse who prepared the medication.

We recommend that the dosage forms provided by pharmacy for ward stock items such as opioids should support administration of usually prescribed doses. This can be supported through the use of order sets that encourage the use of available dosage forms of medication, e.g., morphine 2-4 mg vs. 2-5 mg. Further, each dose of opioid should be prepared, administered and documented at the time of use. As opioids are considered high-alert medications, an independent double check is recommended – this can also provide an opportunity to manage witnessing and documentation of wastage.

An additional concern is that specific records are required for narcotic and controlled drug administration. When multiple doses are administered from one ampoule the documentation can be difficult to track.