Best Practices for Missed Medications Report

1. The nurse should generate a Missed Medications report after each major medication pass and at the end of his or her shift.
   Rationale: If order changes occurred during the medication pass on a patient for whom the nurse has already administered medications, the nurse will see and be able to address that information immediately.

2. When generating a Missed Medications report early in the shift, the nurse should expand the start date and time to a period beginning two hours ***before*** the start of his or her tour. For example, John works 0730 – 1600. When John runs his first Missed Medications report he should set the start time of the report to 0530.
   Rationale: The majority of omitted doses occur during the change of shift. By back-timing the report a few hours before the start of his tour, he should be guaranteed to see anything the previous nurse may have missed and can properly address the issue.

3. The charge nurse should generate the Missed Medications report at the end of every tour after confirming with all nurses that they have completed their scheduled medication administrations.
   Rationale: Running the Missed Medications report without communicating with staff (including queuing the report to automatically print) serves little to no purpose. If a nurse is in the middle of his or her medication pass when the report is generated, the report will not be accurate and questioning him or her about medications from the inaccurate report will only serve to increase the nurse's anxiety and frustration.

4. The charge nurse should print the final Missed Medications report and physically hand-off the report to the charge nurse of the oncoming tour.
   Rationale: The physical piece of paper serves as a cognitive aid reminding the charge nurse of any outstanding medications that need to be addressed (for example, medications that may not have arrived from pharmacy in time to be administered).

5. In some (extreme) cases, if there are ongoing problems with lots of medications appearing on the report at the end of every shift, a second copy of the report may be printed and handed off to the Nurse Manager to be maintained. The nurse(s) should annotate this copy with reasons for not administering the medications.
   Rationale: These reports can be reviewed by the Clinical Bar Code Multidisciplinary Committee, Pharmacy and Therapeutics Committee, or other committee to determine if there are patterns to the omissions and what may be done to fix the issue(s).

6. There should be clear direction to nursing staff on how to handle the most common causes of (what appear to be) omitted doses.
   Rationale: Most medications that appear to have been omitted are not really omitted; they are simply missing the appropriate documentation. For example, if a nurse gives a 0900 medication at 0815 and the doctor re-writes the order at 0820, the new order will appear in BCMA to be given at 0900. When the nurse runs the Missed Medication report at the end of his or her med pass, he or she might simply ignore this because they know it was already given (or worse, they will give it again and overdose the patient). If there is clear direction that a nurse should mark the additional dose as **held** with a reason of

Duplicate order, the medication will have appropriate documentation and would not be considered missed. The facility should identify these common causes.

7. The status of **held** should be considered a final action, not as a stopgap measure. This should be written in policy and communicated to staff.
   Rationale: Many medication errors have been reported as a result of the inappropriate use of **held**. In an effort to clear-up documentation, sometimes nurses would mark a medication as **held** because of some temporary condition (patient off ward, etc.) while fully intending to administer the medication later. Marking the medication as **held** would take it off (clear-up) the Missed Medication report. However, if the nurse forgets to give it later, it becomes omitted. Therefore, the best-practice is to teach staff to use the option of **held** only when it there is no chance the medication will be given. For example, if there is a q1h medication and the patient is off the ward for three hours, there is no way a nurse could go back and give the first two doses. In this case, there is no chance those doses will be given and therefore it would be appropriate to mark those two doses as **held**.
8. When generating the Missed Medication report, the user should not include medications that have been discontinued or expired.
   Rationale: BCMA includes these options in the report by default. However, if the medication order expired or was discontinued, there would be reasonable expectation that the patient should not have received the medication.
9. When generating the final Missed Medication report of the day by the charge nurse, the statuses of **held** and **refused** should not be selected.
   Rationale: The final report at the end of the day should only be used as a reminder of items that need to be reconciled by the next shift and to identify that all medications have been documented on appropriately. If a medication is marked as **held** or **refused**, the medication has been documented on appropriately and there is no need to further reconcile these items.