Problem:
A 300 bed County Teaching Hospital Risk Management department had received patient complaints regarding the administration of Promethazine. The current practice of intravenous (IV) administration of Promethazine was to give up to 25mg IVP as ordered. An investigation into the administration led by the Professional Practice/Quality Shared Governance Council found no standard procedure for the safe administration of Promethazine.

Evidence:
A literature search revealed recommendations from the Federal Drug Administration (FDA) and the Institute for Safe Medication Practices (ISMP).

Strategy:
The FDA and ISMP recommendations were reviewed by members of the Professional Practice Shared Governance Council. The Council outlined recommendation and a multidisciplinary team consisting of front line nurses, physicians, education department, pharmacy, and nursing informatics identified barriers to a successful practice change and strategized how to overcome these barriers.

Practice Change:
Adoption and implementation of ISMP Promethazine Administration Guidelines to suggest alternative administration route or use of an 5-HT3 receptor Antagonist, administer slowly over 10 minutes, dilute the drug in 20ml normal saline, limiting the available concentration to 25mg/ml, limiting the dose to 6.25mg to 12.5mg starting IV dose and using large patent veins by avoiding hand or wrist veins when possible, verifying patency of site prior to administration, patient education to report burning or pain immediately, and to notify physician of adverse effects.

Evaluation:
Grol and Wensing Effective implementation model was followed. Outcomes measured were number of patient complaints, and nursing practice was monitored for emergence of work arounds.

Results:
No patient complaints related to Promethazine administration since practice change. No nursing work arounds have emerged

Recommendations:
Continuous evaluation of practice change and adaptation when necessary.

Lessons Learned:
Multidisciplinary team was key to a successful practice change. The group worked together to overcome unpredicted barriers to the implementation of the practice change.
Bibliography:

