THE STUDY VAULT

Clinical Chaos

Medication Rights

SKILL SNAPSHOT

Purpose
- Creates a structured safety check for medication administration while supporting clinical judgment and error prevention.

When to use
- Every medication preparation, administration, reassessment, omission, hold, waste, and documentation event.

Supplies needed
- Current MAR/order; medication; barcode system; drug reference; calculator; assessment/lab data; required monitoring equipment.

PREP + PATIENT SETUP

- Review indication, allergies, interactions, duplicate therapy, labs/vitals, last dose, and hold parameters.
- Clarify incomplete, illegible, unsafe, or conflicting orders before preparing.

VAULT TIP

- Ask two final questions: Why is this patient receiving it, and what result or harm must I assess afterward?

STEP-BY-STEP

1. Use two identifiers and match the right patient to the MAR and medication; never use room number.
2. Verify the right medication by comparing label with MAR/order at acquisition, preparation, and bedside.
3. Confirm the right dose: concentration, calculation, patient-specific range, maximum, and independent double-check when required.
4. Confirm the right route and that the formulation, access device, and site are appropriate.
5. Confirm the right time, frequency, last administration, meal relationship, and allowable window.
6. Check the right indication and expected goal; question medications that do not fit the patient.
7. Complete the right assessment: allergies, vitals, pain, labs, swallowing, access patency, and hold parameters.
8. Explain medication and honor the patient's right to education and right to refuse. Address concerns without coercion.
9. Use barcode scanning at bedside when available; investigate alerts rather than bypassing them.
10. Administer using correct technique. Stay with the patient until oral medication is swallowed when required.
11. Document the right medication information immediately after administration, never before.
12. Evaluate the right response: therapeutic effect, adverse effects, and need for further action.
13. If a dose is held, omitted, late, refused, or vomited, follow policy, notify as indicated, and document the reason and response.

SAFETY REMINDERS

- The rights are a final check, not a substitute for a safe system or clinical judgment.
- Never administer a medication you did not prepare unless policy supports a verified handoff.
- Do not bypass barcode alerts or independent double-checks.
- Report errors and near misses promptly; prioritize patient assessment and treatment.

COMMON MISTAKES

- Using one identifier or room number.
- Documenting before administration.
- Ignoring allergies, labs, or hold parameters.
- Assuming pharmacy verification means no further check is needed.

DOCUMENTATION

- Drug, dose, route, site, date/time.
- Required pre/post assessments.
- Therapeutic and adverse response.
- Teaching and patient refusal.
- Held/omitted doses, reason, notifications, error actions.