77 - PREVENTING MEDICATION ERRORS (Partner Check-Off)

I acknowledge I have physically practiced and successfully learned the following skill(s):

Student: _____Date: _____

	P1	P2	P3	Comments
1. Checked the medication administration record against the provider's order.				
2. Ensured the six rights of safe medication administration.				
3. Reviewed the medication order.				
4. Consulted the prescriber about any illegible handwriting, an unusually large or small dose, or an order that seemed incomplete, incorrect, or inappropriate for the patient.				
5. Did not let anything interrupt the process.				
6. EIGHT Rights error prevention: **1) Right medication:** a) When administering the drug, compared the label on the drug container with the MAR three times. b) When the patient questioned the medication, withheld it until possible to recheck the preparation against the order. c) Referred to drug reference material if the medication name was different from that which appeared on the order.				
2) Right Reason a) When the drug ever seemed inappropriate with the patient's condition, checked with the prescriber				
3) Right dose: a) Double-checked calculations. Verified them with another RN, especially if it was a high-alert medication. b) Used standard measurement devices. c) Avoided splitting medication that had not been scored by the manufacturer. If possible, sent the pill to the pharmacy to be split and repackaged with an accurate label or encouraged the provider to order medications that did not require splitting. d) When crushing a tablet, pulverized it and mixed it with a small amount of food or liquid. If mixing with food, ensured there was no incompatibility.				

4) Right patient: a) Used at least two patient identifiers. Compared this information with the MAR. If the patient's ID band was illegible or missing, obtained a new one. b) When patient was confused or unresponsive, compared the information in the MAR with that printed on the patient's ID band.				
5) Right to Refuse a) Made sure the patient consented to taking the medication. Did not give medication if patient refused. Contacted provider if refusal occurred.				
6) Right route: a) Used oral syringes for oral and enteral medications. Used parenteral syringes for injectable medications. Labeled all syringes at the point of preparation with the drug, dose, and route. b) Contacted the prescriber immediately if the specified route was missing or if the route was not recommended or contraindicated for the patient's condition.				
7) Right time: a) Did not give PRN medications automatically. Checked the documentation to see when the medication was last given, and allowed an appropriate time interval to elapse. b) Administered time-critical medications within the 30-minute window before or after the scheduled time or according to agency policy. c) Gave non-time-critical drugs within 1 to 2 hours of the scheduled time or according to agency policy.				
8) Right documentation: a) Documented preparation for medication administration, and documented all medications. b) Followed agency policy for documenting held or refused medications. c) Documented the name of the drug and the dose, route, and time of administration in the MAR. Included the site when giving an injection. d) Documented the patient's response to all PRN medications.				
7. When a medication error occurred despite best efforts, followed up by reporting it. Followed agency policy for appropriate interventions for the patient.				

S = Satisfactory **U** = Unsatisfactory **NP** = Not Performed ***** =Must Perform to Pass

By signing below I acknowledge that I witnessed the skill performed and the student successfully passed the skill.

Practice 1: Evaluator:_____ Signature:_____

Practice 2: Evaluator:_____ Signature:_____

FINAL Student Evaluator:_____ Signature:_____