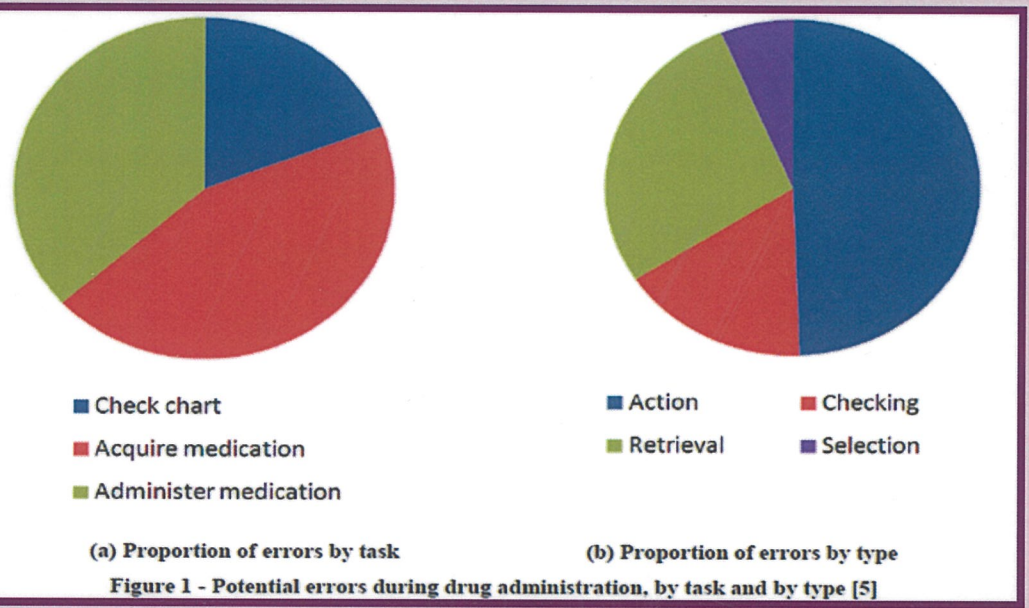
Are the 5 Rights used by nurses in medication administration enough to keep patients safe from drug errors?

By Kelly Bosscher

Introduction: During clinical placement I often noticed nurses not using the 5 Rights correctly or not at all in administering medication, this lead to researching literature to find if the 5 Rights are enough to prevent medication errors or are there other factors that culminate in errors being made?

Medication errors where the third leading cause of death or injury for patients admitted to hospital in the year 2012, these are just the cases that are reported many small errors go unreported or are not identified. In the document of Serious and Sentinel Events 2011/2012 issued from the Southern District Health Board (SDHB), medication errors rated at the top three after clinical management and falls, with 10% which is 3 critical drug errors that have been reported, this is just from reported from the SDHB, the remainder of hospitals nationwide have higher incidences at 17%.



(a) Proportion of errors by task (b) Proportion of errors by type

Figure 1 - Potential errors during drug administration, by task and by type [5]

Implications for Practice: Using the literature review the implications for practice are that the risk of medication errors are not solely one person's responsibility. Multidisciplinary teams need to work together when prescribing, dispensing and administrating medications. Patient safety is the nurse's responsibility so understanding and have medication knowledge is an important part in reducing the patient suffering harm or injury from a medication error. The literature suggests that adding to the 5 Rights so that they include right indication and right documentation, also that nurses have the right to have "legible orders, correct drug dispensing, timely access to information, procedures in place to support medication administration"(Macdonald, 2010, pg. 197).

Recommendations:

In the article by Parsotam & Clendon (2012) medication reconciliation is aimed at reducing medication errors and involves three steps which are Collecting, Comparing and Communicating. "The goal is to obtain, within 24hrs of admission, transfer or discharge, the most accurate list of all medicines a patient is currently taking (Parsotam & Clendon, 2012, pg.14). This then reduces the risk of errors and discrepancies. Electronic prescribing is also creating a reduction in errors as well. There is also greater encouragement for nurses to come forth when a error has occurred as this can then be used to gain greater insight as to why medication errors happen.

References:

Macdonald, M. (2010). Patient safety: examining the adequacy of the 5 rights of medication administration. *Clinical Nurse Specialist: The Journal For Advanced Nursing Practice, 24*(4), 196-201.

Parsotam, N., & Clendon, J. (2011). AIMING FOR GREATER ACCURACY IN PRESCRIBING, DISPENSING AND ADMIN ISTRTION. *Kai Tiaki Nursing New Zealand, 17*(11), 14-15.