

## Resident Rights to Medication Administration Avoiding Transcription Errors

### Background

The 10 Rights to Medication Administration is a tool utilized by various healthcare professionals to ensure the correct medication is being administered to the correct resident at the right dose, route, and frequency. Understanding how to apply these rights promotes safe administration habits, reduces the risk of medication errors, and improves overall resident care.

### 10 Rights to Medication Administration

Sometimes referred to as the "5 Rights to Administration," this checklist ensures that the correct resident is receiving the correct drug, at the right time, dose, and through the right route. These rights have since been expanded to include other steps of care including right documentation and right to refuse treatment. The most commonly used and recognized 10 Rights to Medication Administration have been provided below for reference.

- |                     |                        |
|---------------------|------------------------|
| 1. Right Resident   | 6. Right Assessment    |
| 2. Right Medication | 7. Right Education     |
| 3. Right Dose       | 8. Right to Refuse     |
| 4. Right Route      | 9. Right Documentation |
| 5. Right Time       | 10. Right Evaluation   |

### Transcription Errors

Transcription errors occur when a prescription is incorrectly transcribed between documents or electronic health records. Such errors can result in unwanted side effects or, in severe cases, be life-threatening. One can utilize their knowledge on the 10 Rights to Medication Administration to assist in identifying common transcription errors.

#### Example transcription errors include:

- 1. Wrong Resident:** *Lisinopril for Resident A in room 401 was ordered for Resident B in 301.*
- 2. Wrong Drug:** *A prescription order for clonazepam was incorrectly entered for clonidine instead.*
- 3. Wrong Dose:** *An order for trazodone 25mg ½ tablet before bed was transcribed as one 25mg tablet before bed.*
- 4. Wrong Dosage Form:** *A B12 injection was ordered, but B12 tablets were entered instead.*

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- 5. Wrong Frequency of Use:** *Methotrexate to be given once weekly was transcribed into the EHR for daily administration.*
- 6. Missing Duration of Use:** *Missing end date on a prescription resulted in apixaban being continued beyond the intended 6 months of treatment for deep vein thrombosis.*
- 7. Missing Indication for Use:** *Diphenhydramine 25mg is to be given as needed once nightly, but no indication is noted on the order.*
- 8. Missing Medications:** *The resident's alendronate was not continued once weekly upon admission into the facility after recent discharge from the hospital.*

### Best Practices to Prevent Transcription Errors

Consider these best practice tips to assist in identifying transcription errors and thereby prevent significant adverse reactions and re-hospitalizations.

- ✓ **Apply the 10 Rights to Medication Administration when reviewing prescription orders.**
  - Right Resident: Verify the resident's identity with at least two identifiers.
  - Right Drug: Be aware of [look-alike and sound-alike medications](#).
  - Right Dose: Does the dose make sense?
  - Right Frequency: Avoid using [error-prone abbreviations](#).
  - Right Formulation: Verify the correct dosing form (oral, injection, etc.).
- ✓ **Review the prior day's medication administration record (MAR).**
  - Check for any missed medications that need to be addressed.
- ✓ **Implement a plan for order review and follow up.**
  - Consider discussing new medication orders during morning meetings.
  - Have a three-way check system in place: upon entry, after entry by peer, and then at stand up/stand down.
- ✓ **Review diagnoses on discharge summaries for omissions.**
  - Check for missing medication orders, especially for chronic conditions that may require multiple medications.
- ✓ **Reconcile medication lists on readmissions.**
  - Hospitals often rely on past medication orders for reconciling medication lists. Double check that all medications were reinitiated correctly.
- ✓ **Review and add indications for all medications.**
  - PRN or "as needed" medications should have a specified indication for use.

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- ✓ **Verify that medication orders have a stop date.**
  - Antibiotics, anticoagulants, and proton pump inhibitors are common drug classes that are often missing stop dates on medication orders.
- ✓ **Utilize electronic health record (EHR) systems for order verification.**
  - Leverage your EHR system to flag incorrect or incomplete medication orders. Some systems have multiple checkpoints to maintain accuracy (orders entered vs. orders approved).
  - Utilize order sets or templates as allowed.
  - Review order alert messages. Know who has the authority to override these alerts.