Medication Safety Process Check

If the wrong medication reached this point, what would stop it?

Unit / service

Review date / shift

Medication / process being followed (no patient identifiers)

Use with pharmacy, nursing and quality; include the clinician performing the process. Follow one medication from selection through administration, observe routine work and discuss an exception. Do not introduce errors into patient care to test safeguards.

Status: Observed = safeguard demonstrated in this review; Gap = weakness found; Not verified = evidence still needed; N/A = explain why. A policy or verbal assurance alone does not demonstrate performance.

1 Selection and storage

Select status

Inspect the actual drawer, cabinet or tray. Could similar names, strengths or packaging cause a mix-up? Can staff read the full label before selection? What separates products whose confusion could cause serious harm?

Safeguard + evidence observed (or explain N/A)

Gap / next action

Owner / due date

2 Preparation and labeling

Select status

Follow a medication from its original container to a syringe, cup or bag. How are identity, concentration and route preserved? What happens if preparation is interrupted or a prepared medication is handed to another person?

Safeguard + evidence observed (or explain N/A)

Gap / next action

Owner / due date

3 Verification before use

Select status

Ask staff to demonstrate how the order, patient, allergies, drug, dose and route are checked. Where an independent double check is required, what is checked separately? Who resolves a discrepancy before administration?

Safeguard + evidence observed (or explain N/A)

Gap / next action

Owner / due date

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If the wrong medication reached this point, what would stop it?

4 Administration and monitoring

Select status

Observe patient and medication scanning where used; look for scanning away from the patient or other workarounds. For infusions, trace the line to the patient and review pump guardrail use. Who monitors the patient response and acts on concerns?

Safeguard + evidence observed (or explain N/A)

Gap / next action

Owner / due date

5 Exceptions and interruptions

Select status

Walk through a scanning failure, cabinet override, urgent dose or downtime scenario with staff. What safe alternative and escalation route exist? Ask: "When is the safe process difficult to follow, and what do people do then?"

Safeguard + evidence observed (or explain N/A)

Gap / next action

Owner / due date

6 Learning and action

Select status

Review a recent near miss, override or workaround with the team. What condition made it possible? What changed in the process, and what evidence shows the change works? Include staff feedback and check whether the risk exists elsewhere.

Safeguard + evidence observed (or explain N/A)

Gap / next action

Owner / due date

Focused discussion aid; not a comprehensive medication audit or compliance score.

ISMP hospital best practices (2026) ISMP: persistent medication hazards (2024)

Before the team leaves

If an immediate hazard is found, use the local safety escalation process now. Assign follow-up to every Gap or Not verified item. An Observed result reflects this review only; it is not proof of sustained safety.

Priority action / interim safeguard / accountable lead

Recheck date / who verifies / evidence of improvement