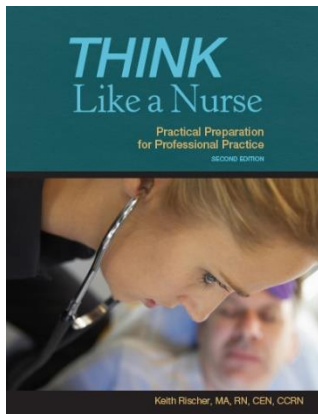


“Five Rights” of Clinical Reasoning



Though the numerous “rights” of safe medication administration are taught to students and then implemented in every med pass to be safe in practice, most educators are not aware of this relevant article that addresses the five “rights” of clinical reasoning. These five rights need to be applied to every patient students care for.

Be sure to download the article (see reference on next page) for additional information. When these “rights” are identified, then taught, students will have the foundational knowledge needed to be safe in practice by thinking more like a nurse by incorporating these aspects of clinical reasoning into their practice!

This excerpt is from chapter 9, “Why Clinical Reasoning is Nurse Thinking” from the student textbook *THINK Like a Nurse, Practical Preparation for Professional Practice*. If you would like a faculty preview eBook copy to consider as a resource in your program, email Keith@KeithRN.com.

As a nursing student, you have memorized the five to ten “rights” of safe medication administration in order to safely administer medications. But are you aware that there are “five rights” of clinical reasoning (Levett-Jones et al., 2010)? These five rights are as important as the rights of safe medication administration to promote patient safety.

Familiarize yourself with these five rights. Incorporate and recite them just as fluently as the medication rights that your program emphasizes! Knowledge of these five rights will deepen your understanding of applied clinical reasoning to practice. These five rights are another way to deeply understand the essence of clinical reasoning and are an easy acronym to guide nurse thinking in the clinical setting.

1. RIGHT Cues

This is the clinical data that is collected and clustered by the nurse. Recognizing the RELEVANCE and RELATIONSHIP of this data and contextualizing it to your specific patient is the essence of this “right.” EARLY cues that are missed or not identified and allow a complication to progress is a classic example of “failure to rescue” by the nurse when this “right” is not used in practice.

2. RIGHT Patient

This “right” is not about checking the name and date of birth of your patient, but the ability of the nurse to identify a patient who is high risk for developing a potential complication. The nurse must be able to recognize that an 18-year-old with an appendectomy is not as likely to develop a complication as a patient with the same problem who is 88! Patients who are susceptible hosts due to chemotherapy, radiation, or medications such as prednisone also fall under this “right” as patients at risk.

3. RIGHT Time

This refers to the timeliness of identifying a change of status. Recognizing EARLY signs of a complication and then initiating nursing interventions at the RIGHT time and in the RIGHT sequence is imperative to prevent a bad outcome. Remember that “failure to rescue” occurs not only by missing a

complication that develops but also when nursing/medical interventions are implemented too late.

4. RIGHT Action

Once a clinical judgment is made, the right action or intervention must be initiated. Clinical data that suggest a potential complication must be acted upon. The consequences of an incorrect clinical judgment can make the difference between life and death. In one study, one-half of patients who had cardiac arrests on the hospital floor had clinical signs of deterioration 24 hours before the arrest. These signs were NOT recognized and acted upon by the nurse (Thompson et al., 2008).

5. RIGHT Reason

The right reason is not just making the correct reasoning that leads to a correct nursing judgment, but understanding the RATIONALE or WHY of everything that is done in practice. In order to do this consistently, the nurse must be able to apply key aspects of clinical reasoning, which include grasping the essence of the current situation to put the clinical puzzle together.

Clinical Example

To see the relevance of these five rights to clinical practice, I will use the clinical scenario I used in the introduction. Ken was an elderly male patient who had a perforated appendix and was postoperative day #2. Ken was a RIGHT PATIENT who was at high risk for a possible change of status because he was elderly, had an invasive procedure, and his ruptured appendix spilled bacteria into a sterile peritoneum. Ken developed the RIGHT CUES. He became restless for no apparent reason, his initial BP was normal, but his HR was in the 100's.

Tachycardia with a normal BP is a classic presentation of EARLY shock as the body compensates for a low output state by increasing heart rate. If the nurse had correctly interpreted these clinical cues, she would have recognized the possibility of sepsis in the RIGHT TIME and contacted the primary care provider as a RIGHT ACTION to address this concern. Instead, Ken was given pain medication for restlessness, albuterol neb for tachypnea, and the RIGHT ACTION for the RIGHT REASON did not take place. Had these five rights been correctly acted upon in this scenario, Ken would likely still be alive today.

References:

- Levett-Jones, T., Hoffman, K., Dempsey, J., Yeun-Sim Jeong, S., Noble, D., Norton, C. Hickey, N. (2010). The 'five rights' of clinical reasoning: An educational model to enhance nursing students' ability to identify and manage clinically 'at risk' patients. *Nurse Education Today*, 30, 515–520.
- Thompson, C., Dagleish, L., Bucknall, T., Estabrooks, C., Hutchinson, A., Fraser, K., deVos, R., Binnekade, J., Barrett, G., Saunders, J. (2008). The effects of time pressure and experience on nurses' risk assessment decisions: A signal detection analysis. *Nursing Research*, 57(5), 302–311.