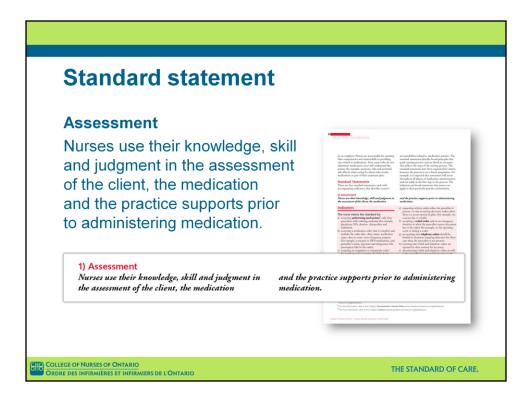


The College of Nurses of Ontario presents the Medication Learning Module: Assessment.



The standard statement for assessment states:

Nurses use their knowledge, skill and judgment to assess the client, the medication, and the practice supports prior to administering medication.

Links to College practice documents and other resources, including related websites, referred to in this chapter can be found on the home page of the learning module.

Assessment

Nurses assess clients:

- before medication has been administered
- during medication administration
- after medication has been administered



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THE STANDARD OF CARE.

Assessment, the first and ongoing component in the process of medication administration, is critical in determining the client's needs before, during and after medication has been administered. This chapter outlines the expectations and accountabilities for nurses regarding assessment and medication administration.

Continuing medication competence

The administration of medication is an entry-to-practice competency that continues for all nurses throughout their careers.

Nurses are accountable for:

- assessing their competence
- having the knowledge skill, and judgment required to provide care related to medication



All nurses are expected to know the medication process.

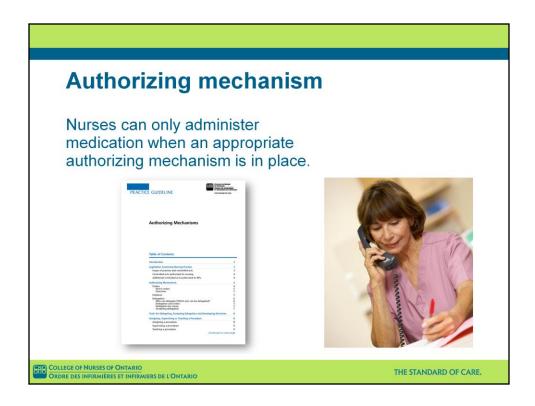


THE STANDARD OF CARE.

The appropriate use and administration of medication is an entry-to-practice competency that continues for all nurses throughout their careers. Nurses are accountable for assessing their competencies, which include their knowledge, skill and judgment in providing care related to medication. For more information, review the College's entry-to-practice competencies.

Even nurses who do not administer medication are expected to know the medication process when caring for clients who receive medications as part of their treatment plan. This includes understanding the purpose, risks and potential side effects of a medication.

For example, if a respiratory therapist has administered Salbutimol to your client, you are accountable for knowing about the medication and its potential effects on the client.



Nurses can only administer medication when an appropriate authorizing mechanism is in place. An authorizing mechanism gives nurses the authority to perform a procedure such as medication administration. For more information on authorizing mechanisms, review the College's *Authorizing Mechanisms* practice guideline.

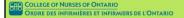
Medication orders

A complete order includes:

- order date
- client's name
- medication name
- dose in units
- route
- frequency
- purpose
- prescriber's name, signature and designation







THE STANDARD OF CARE.

Nurses must only accept orders that are appropriate to the client, clear and complete. For an order to be complete, it should include the following information:

- order date
- client's name
- medication name
- dose in units
- route
- frequency
- purpose and
- prescriber's name, signature and designation

When reviewing a medication order that is unclear or does not include this information, the nurse must withhold the medication and follow up with the prescriber in a timely manner.

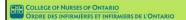


Medication must only be administered for the purpose for which it is ordered.









THE STANDARD OF CARE.

Medication must only be administered for the purpose for which it is ordered. For example, a client may have a medication ordered for pain control. In the course of treatment, the client tells you that he is also using this medication as a sleep aid. In this situation, you should assess the client and contact the prescriber to advocate for an appropriate medication order for a sleep aid.



Written medication orders provide the safest means of communicating an order. Examples include computerized prescriber order-entry and hand-written medication orders.

The requirements for electronic prescriptions are the same as for hand-written orders. When working in an electronic environment the principles of confidentiality still apply, and you must be confident that your workplace has implemented confidentiality and security measures.

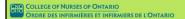
Verbal and telephone orders

Should:

- Repeat
- Document
- Include prescriber's name and designation





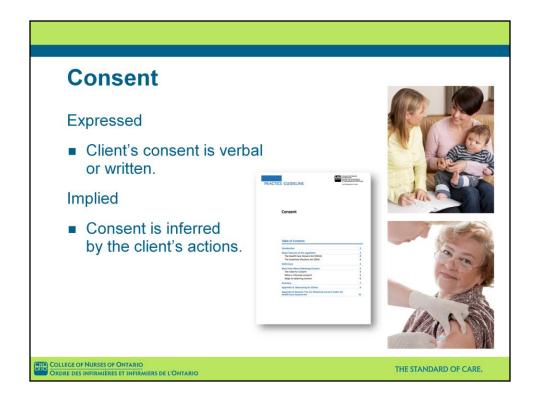


THE STANDARD OF CARE.

Sometimes it is not possible to obtain a written medication order; in certain situations, verbal orders are acceptable. For example, when an NP is attending to a client during a crisis situation and is unable to provide a written order, you may accept a verbal order.

Telephone orders should only be used when the prescriber is not present. Verbal and telephone orders should be repeated to the prescriber in their entirety to ensure accuracy. You must document all verbal or telephone orders you receive, including the prescriber's name and designation. You are not responsible for ensuring the prescriber signs the order.

Refer to your workplace policy about accepting verbal and telephone orders.



A key part of assessing the client is to ensure that he or she has given informed consent. Consent can be expressed or implied. Expressed consent is when a client gives his consent verbally or in written form. Implied consent is inferred from a client's actions. For example, if you say to a client that you need to give him a subcutaneous heparin injection and he willingly exposes his abdomen, you can reasonably conclude that the client is giving you implied consent. If the client has questions regarding the medication, you should give him more information or refer him back to the prescriber.

For more information on consent, review the College's Consent practice guideline.

During assessment

Nurses are accountable for:

- ensuring medication is appropriate
- knowing the factors that influence administration
- withholding the medication if it is inappropriate



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THE STANDARD OF CARE.

During your assessment, you are accountable for determining that the medication prescribed is appropriate for the client. You must be knowledgeable about the factors that influence the administration of a particular drug, such as: a client's age a client's weight laboratory results or the need for a medication to be taken with food.

For example, you should know of a client's allergies or other sensitivities that contraindicate the administration of a medication.

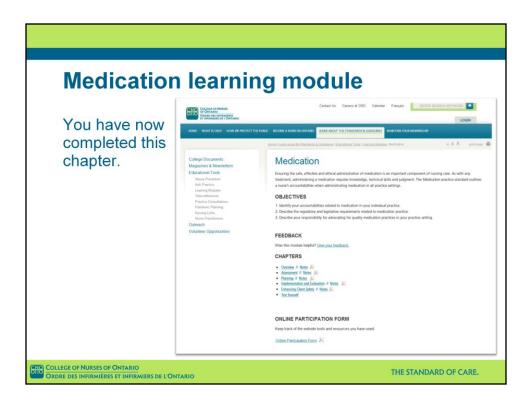
If you determine the medication is inappropriate, you must withhold it and talk with the prescriber in a timely manner.



Defining clear roles and responsibilities helps to ensure client safety.

One nurse should perform all the steps of medication administration to reduce the risk of error, clarify accountability and ensure client safety. For example, you should not prepour medication for another nurse to administer. In some situations, such as preparing for mass immunization, you need to exercise your professional judgment to decide whether to involve other people in the medication administration process.

You need to ensure that your accountability is clearly outlined during medication administration, and you must be aware of your workplace policies that support your practice.



You have now completed this chapter. To continue the learning module, close this presentation, return to the Learning Centre and select the chapter of your choice.

If you have a question for a Practice Consultant, click on the link in the upper right-hand corner.