The College of Nurses of Ontario presents the Medication Learning Module: Enhancing Client Safety.

Nurses work with other members of the health care team and their employers to prevent and resolve medication issues. This includes having a quality practice setting with the appropriate staff and safe medication practice systems in place to track, address and learn from medication errors that occur in the practice environment. 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.

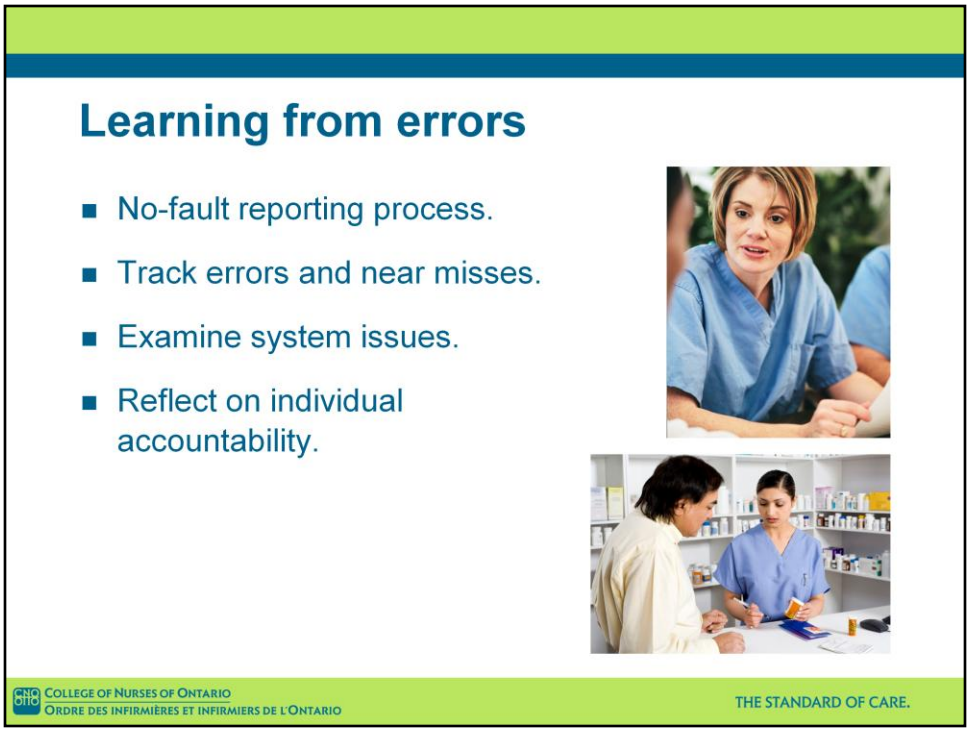
A medication error is any preventable event that may cause or lead to the inappropriate use of medication or the harm of a client while the medication is in the control of the health care professional, client or consumer.

There are two types of errors: commission and omission.

An error of commission is something that happens in the administration of the medication; for example, giving the wrong medication.

An error of omission occurs when the administration process is not completed; for example, not administering an ordered medication.

Medication errors can result in adverse drug reactions leading to harm, injury or death. An error can also result in a “near miss.” In this situation, an error does not reach the client, but if it had, it could have resulted in harm. For example, you are going through a routine medication check when you notice that the medication sent from the pharmacy is the wrong dose. You inform the pharmacy and obtain the correct dose.



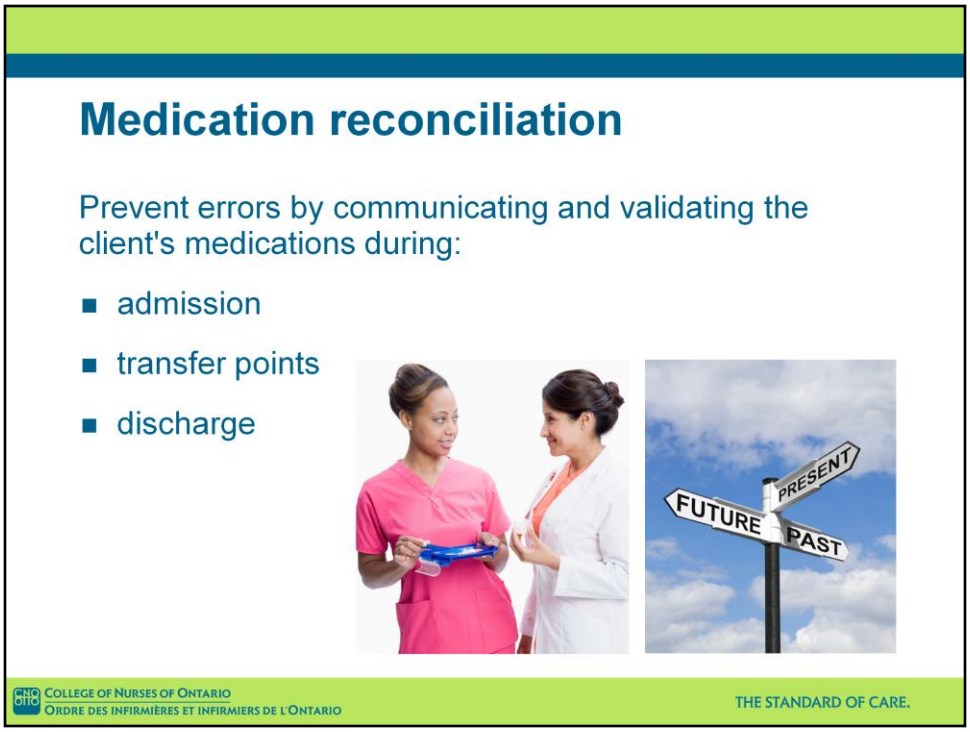
By using the continual process of medication administration, nurses can often identify and stop potential errors before they actually occur. However, if they do occur, it is important to have a process in place to report errors and to track near misses. By tracking near misses, you can identify the root cause of the issue and take corrective action.

Medication errors are often multifaceted. There may be many different features, qualities or events that lead to the medication error. It is important to examine system issues at your workplace using a framework to determine the root causes of an issue, as well as recognize any individual accountability when an error occurs. An error offers an opportunity to engage in practice reflection.

Nurses can support safe medication practices in their workplace by using their knowledge, skill and judgment. For example, if you are asked to administer a medication you're not familiar with, it is crucial that you assess the client and look for evidence about the medication prior to administering it to the client.

Other safe medication practices include: having knowledge of high alert medications in your practice setting; only using agency approved abbreviations; having access to current medication information, such as drug formularies; and using your workplace's independent double checks system.

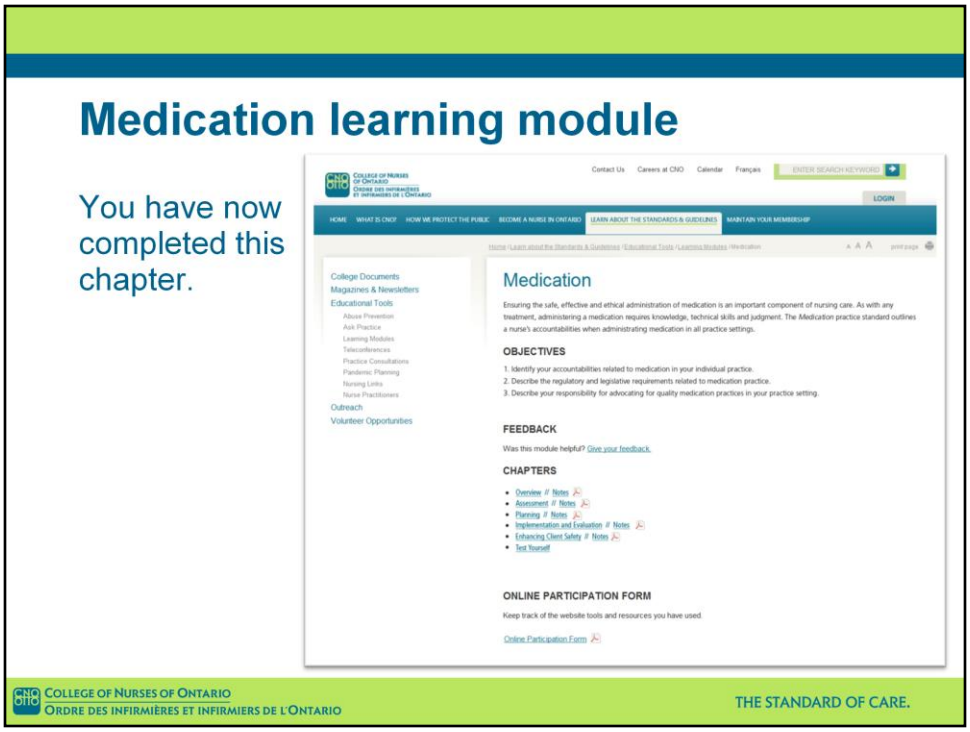
For more information on safe medication practice, go to the Institute for Safe Medication Practice of Canada's website.



Medication reconciliation is intended to prevent medication errors when a client's care is transferred. It is an important step in preventing potential adverse events and is key for client safety.

The process, which may include all members of the health care team, involves communicating and validating the most current list of a client's medications to the client and the caregivers during admission, at critical points of transfer or at discharge to ensure appropriate ongoing pharmacotherapy.

For more information on medication reconciliation, go to the Intervention section of the Safer Health Care Now's website.



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.