Nurses and safe administration of Medicines

Nurses and safe administration of Medicines

We have moved into the 21st century but the healthcare crisis continues. Wrong administration of medicines is associated with high rates of morbidity, mortality and increase the length of stay at the hospital. The burden on patient’s family increases as they have to provide care to the patient and to deal with a complex regimen of the healthcare system. Increased access to high-quality care can help to manage this crisis. Although guidelines are present on a national level which aims at providing high-quality care to patient and the nursing profession is best suited to these efforts. It is a responsibility of nurses to administer medicines therefore, they should possess knowledge and skills to improve the safety of the patient. By this deaths associated with medicine error and complications can be reduced. If the medicine is administered wrong then it can lead to serious consequences, long stay at a hospital and even death. Nurses, because of their education and practice, promote patient safety by administering safe medicine. Safe medication administration aims to obtain the best quality of life by controlling disease symptoms and functional capacity restoration (Miladinia et al., 2016). The purpose of this paper is to define the responsibilities of nurses in providing safe medicine to patients. It is a responsibility of the nurses to recognize the symptoms of the patient and to administer safe medications to alleviate the symptoms. Following are some points that will discuss in this position paper.

* About 6-7% admission in hospital care due to error in the administration of medicine. Therefore the extent of problems related to medicines should be interpreted in the context of complex health care (Nanji, Patel, Shaikh, Seger, & Bates, 2016).
* Nurses play an important role in the safe administration of medicine, therefore, they should possess the required skills and knowledge
* Effective strategies that are needed for the safe administration of medicines should be implemented and proper protocol and policies regarding safe administration of the medicine should be present.

Safety of patient must be a priority for nurses, organizations, administrators, professional associations at all government levels. Politics procedures and protocols, working environment and workload all are associated with medication errors. Nurses create an environment which supports the safety of the patient. It is stated that most of the medication errors occur due to the miscommunication between nurses and physicians. There is a communication gap that is present between nurses and physicians. To safe medication administration, effective communication must be built between nurses and physicians. Lack of communication leads to the error in assessment and inadequate patient monitoring.

Many factors are associated with poor communication and teamwork. Some factors such as the transfer of a patient between facilities and shift change lead to poor communication between patients and nurses. If any error in medicine administration occurs, it should be reported but most of the nurses do not report to high authority because of threat to job. Strong leadership is very important to ensure safe administration of medicine. There should be first-line managers who should be always available to support nurses with their strong leadership abilities. Most of the nurses are usually not aware of the guidelines on the safe admiration of medicines. Different strategies can help improve medication safety including proper reporting, standardized medication time and documentation. Effective leadership with clear protocols and appropriateness of interventions can bring successful changes in improving administering medication errors. The converse is associated with increasing administering medication errors that are the unclear documentation, unclear aims, and poorly designed interventions. Nurses focusing too much on the collection of data and only involvement of stakeholders and time conflict demands can only increase poor administering medication errors (Hayes, Jackson, Davidson, & Power, 2015).

Patient safety is a human right and is equal to all patients. New advanced knowledge and advanced research methodologies should be used to provide care to patients to control confounding errors. There are many factors which prevent nurses to follow medicine administration guidelines properly such as lack of support, communication gap, unsupportive environment, lack of knowledge regarding patient allergies and difficulty in interpreting prescription order. Other factors such as being incompetent, patient negative attitude, decrease knowledge, criticism from seniors and physicians and lack of time also prevent nurses to adhere to guidelines of safe medication administration. Registered nurses should take actions and improvements at all levels to address this issue to enhance safe practices regarding the administration of medicine and increase patient safety. This shows that patient safety in healthcare is a major concern and nurses are directly linked with administering patients in medication and other methods. Patient safety should be the responsibility of nurses as well as an administrator.

 A blame-free society and culture can also reduce these errors and patient safety would be monitored. Full-time nurses and their employees can also help reducing medication errors. Support from heads and physicians towards nurses can improve patient safety regarding administering medication errors. Standardized methods of dispensing, separating and administrating can increase patient safety in hospitals. Reasons of distractions, risk factors, and medication errors need to be determined by carrying out different surveys. Successful implementation of process change and a good and communicating work environment is highly recommended that need to be available for all healthcare providers to reduce these errors and to improve patient safety.

 Some recommendations that can help to prevent medicine related error include education and training programs such as different workshops should be conducted to guide nurses on safe medication administration. Effective methods should be implemented to educate nurses regarding patient safety, workload, and effectiveness of checklists, procedures and policies. All nurses should be adhered to the 5 right of medicine (right dose, right time, right route, right patient, and right documentation) to avoid any error in medicine administration. To prevent errors in the administration of the drug in hospital settings, electronic system of medicine administration recording should be widely implemented by replacing the paper system. Proper accountability should be present.

**References**

Hayes, C., Jackson, D., Davidson, P. M., & Power, T. (2015). Medication errors in hospitals: a literature review of disruptions to nursing practice during medication administration. *Journal of clinical nursing, 24*(21-22), 3063-3076.

Miladinia, M., Zarea, K., Baraz, S., Mousavi Nouri, E., Pishgooie, A. H., & Gholamzadeh Baeis, M. (2016). Pediatric nurses’ medication error: the self-reporting of frequency, types and causes. *International Journal of Pediatrics, 4*(3), 1439-1444.

Nanji, K. C., Patel, A., Shaikh, S., Seger, D. L., & Bates, D. W. (2016). Evaluation of perioperative medication errors and adverse drug events. *The Journal of the American Society of Anesthesiologists, 124*(1), 25-34.