Standards for Medication Management - Quiz

1. There are four principles in the *Standards for Medication Management*. Which of the following is not one of the principles?
    a. Safety
    b. Competence
    c. Collaboration
    d. **Administration**

    Rationale: The principles are: Authorization, Competence, Safety, and Collaboration.

2. A client develops a fever but has no orders for an antipyretic. When the nurse calls the physician for an order, he replies: "just give him some Tylenol and keep an eye on him." What should the nurse do?
    a. Ask the client how much Tylenol he used to take at home.
    b. Read the Tylenol package and decide the appropriate dose.
    c. **Clarify the order with the physician.**

    Rationale: According to indicator 1.2 of the *Standards for Medication Management*, nurses only accept orders that are clear, comprehensive, and complete. And as per indicator 1.3 and Appendix A, nurses consult with the authorized prescriber and/or pharmacist on medication orders that are unclear and require clarification.

3. A nurse is caring for a palliative client who has become agitated. The client has an order for *Nozinan 5-10mg IM q4-6hrs PRN* for sedation. The nurse is not familiar with this medication. What should she do?
    a. Call the prescriber to discuss the order.
    b. **Look up the medication to ensure proper knowledge.**
    c. Administer the medication as ordered even though the nurse is unfamiliar with it.

    Rationale: As per indicators 2.3 and 2.5 of the *Standards for Medication Management*, nurses should know the limits of their knowledge and ensure their competency before they perform any practices of medication management. In this case, the nurse needs to gain knowledge about the medication before administering it.

4. A nurse in a community clinic is required to administer an intradermal injection. She has never performed this type of injection. What should the nurse do?
    a. Watch a quick video on the injection and attempt it on the client.
    b. **Ask for training on this skill and review relevant employer policies.**
    c. Attempt the skill because they do not want to appear incompetent in their new workplace.

    Rationale: As per indicator 2.5 of the *Standards for Medication Management*, nurses should not perform any medication management practices that they are not competent to perform. Because the nurse has never performed this type of injection, she should receive training prior to performing this skill on a client and be knowledgeable of any relevant employer policy.

5. A client is being discharged from the hospital with several new medications. Before the client leaves, it is most important for the nurse to:
    a. Ask the client which pharmacy they go to
    b. Check what medication the client already has at home
    c. **Provide education to the client regarding medication**

    Rationale: Indicator 3.2 of the *Standards for Medication Management* requires nurses to provide education to the client regarding their medication. It is important that the client understands how to take their medications and the importance of taking them.

6. A nurse is providing post-operative care to a client who just had a knee replacement. This client had a successful recovery from a same surgery last year. The nurse is trying to decide what pain medication to give the client. What should she do?
    a. Perform a thorough pain assessment on the client including what pain management medication has been administered.
    b. Consult the client about what medication has been efficient to relieve pain in the past.
    c. Check the current medication orders.
    d. **All of the above**

    Rationale: The nurse should assess whether it is appropriate to administer the medication by considering the client, the medication, and the environment (indicator 2.2 of the *Standards for Medication Management*). In this case, it is appropriate for the nurse to conduct a pain assessment to guide her decision. Further, the nurse can only administer medications that are ordered from an authorized prescriber (indicator 1.1 of the *Standards for Medication Management*). According to indicator 4.1 of the *Standards for Medication Management*, clients should be engaged in the management of their medications; consulting the client is an important piece in deciding which medication to administer.

7. A nurse notices a discrepancy in the insulin administration practice on her new unit. The current policy requires a double check and signature of both nurses. However, most times, nurses administer the insulin without the second check, because they claim they are too busy to wait for the second check. This practice makes the nurse nervous, and she fears that client safety is being compromised. What should she do?
    a. Follow the double-check rule herself but ignore that other nurses are not following it.
    b. Say nothing about this practice as she does not want to criticize her new colleagues.
    c. **Collaborate with the nurse manager and nursing staff to implement the double check practice as per policy.**

    Rationale: Client safety is key for medication management. Indicator 3.5 of the *Standards for Medication Management* states that "nurses promote and implement safety precautions as they handle, prepare, administer, store, transport, and dispose of medication". Indicator 4.3 of the *Standards for Medication Management* explains that nurses must collaborate in developing, implementing, and evaluating system approaches that support safe medication practices. In this situation, the nurse needs to address the unsafe practice and collaborate to implement the double-check policy to ensure client safety.

8. The nurse is preparing morning medications for his four clients. When administering medications to Mr. Martin, he says, “those aren’t my pills, I only take a blue one and a red one.” The nurse realizes he gave Mr. Martin’s medications to his roommate, Mr. Clark. What should he do?
    a. Call the physician
    b. Complete an assessment on Mr. Clark to check for an adverse reaction
    c. Report the medication error in a timely manner and according to employer policy
    d. **All of the above**

    Rationale: Indicator 3.7 of the *Standards for Medication Management* indicates that the nurse must take action to minimize the risk of harm to the client when a medication error occurs. Completing an assessment and calling the physician are important steps in fulfilling this requirement. Additionally, indicator 3.8 of the *Standards for Medication Management* says that nurses must report medication errors in a timely manner.

9. What is important to consider in reducing the risk of errors, when taking a verbal medication order?
    a. Transcribe directly into the medical record
    b. Read back the order
    c. Understand the indication
    d. Accept abbreviations

    ☒ a, b, c
    ☐ a, b, d
    ☐ a, c, d
    ☐ b, c, d

    Rationale: Recommendations for prescription receivers are the following: transcribe directly into the medical record; read back the order; understand the indication; discourage misuse; do not accept abbreviations. Reference: Institute for Safe Medication Practices (2017). *Despite Technology, Verbal Orders Persists, Read Back is Not Widespread, and Errors Continue*. https://www.ismp.org/sites/default/files/attachments/2018-03/NurseAdviseERR201706.pdf

10. According to the *Food and Drug Act*, which of the following authorized prescribers can provide drug samples to clients?
    a. Physicians
    b. Pharmacists
    c. Nurse practitioners
    d. **All of the above**

    Rationale: According to the *Food and Drug Act*, drug samples can be distributed to physicians, nurse practitioners, pharmacists, dentists and veterinarians under certain conditions. On March 13, 2020, Bill C-4 (the *Canada–United States–Mexico Agreement Implementation Act*) received Royal Assent (approval) and includes nurse practitioners as a “practitioner” to whom drug samples may be distributed.

11. Medication Case Study

A client was transferred from the hospital to a long-term care (LTC) facility. The receiving nurse reviewed the transfer information. The transfer form, discharge summary, and medication administration record (MAR) did not specify the insulin doses. Only the concentration of insulin (100 units/mL) was listed on the MAR after the drug name. When the nurse referred to the MAR, she mistakenly copied the insulin dose as 100 units in her list of current medications. The nurse contacted the LTC physician who had followed the client's course of hospitalization, who instructed the nurse to "continue the same orders." The nurse transcribed the list of medications onto an order form and sent it to the pharmacy. The order was filled despite the unusually high insulin dose. The next morning, the nurse administering the medication gave an insulin dose of 100 units to the client, who experienced severe hypoglycemia and required transfer back to the hospital.

What could have been done to prevent this error?

a. The nurse that transcribed the order should have clarified the dosage with the prescriber.
b. The nurse who administered the medication should have questioned the abnormally high dose of insulin.
c. Implement a medication reconciliation system as per best practices.
d. **All of the above**

Rationale: There are several errors that allowed this incident to occur. According to the *Standards for Medication Management*, the transcribing nurse should not have accepted the medication order as it was unclear and incomplete (indicator 1.2) and should have clarified the dosage with the prescriber (indicator 1.3). Both nurses should have assessed the appropriateness of the dosage (as per indicator 2.2) given the abnormally high dosage. As per indicator 3.7: nurses are expected to take action to minimize harm from a medication error, and as per indicator 4.3: nurses collaborate in the development, implementation an evaluation of system approaches that support safe mediation management. In this case, a medication reconciliation system could have prevented this error from occurring.

The Institute for Safe Medication Practices (ISMP) granted permission to NANB to adapt their case study in the following article: From the Hospital to Long-Term Care: Protecting Vulnerable Patients During Handoff