Learning Together Matters: Interprofessional Education to Avoid Medication Errors

Dear Editor,

Medication error occurs while committing mistakes in the steps from prescribing the medications to administering it, resulting in an adverse drug event.[1] Is the physician, the pharmacist, or the nurse being solely liable? No, it is an entire process involving the clinician who prescribes it, the pharmacist who delivers it, and the nurse who administers it. It is time to emphasize the importance of having a multiprofessional approach by embedding Interprofessional Education (IPE) models in the respective curriculums.[2]

Bringing together aspiring clinicians, pharmacists and nurses are essential, as training them in three different colleges may not give the students their role clarity in achieving medication safety. Redesigning curriculum with common learning platforms may help. Creating collaborative simulated environments with scenarios will help to instill self-awareness about their responsibilities and improve interdependence on each other.[2] Currently, scenarios are run by the same group of students assuming different roles but the impact would be higher if different health care professional students unite to learn together. IPE is better than single profession education.[3] To bridge the gap of feasibility issues in different curriculums, creating common learning courses with self-paced videos may benefit multiprofessional students in updating themselves. Organizing interprofessionally linked scholarly activities can help students be equally aware of *Prescribing Principles* including medical reconciliation. *Transcribing* specifically by computer entry to avoid handwriting errors. *Dispensing* by thorough checking by pharmacists and *Administration* by nurses adhering to medications rights.

Slightly riskier responsibility is being vested with the nurse who is directly involved in medication administration. Emphasis on strategies like *Patient Identification* with 3 V's: Verbalization, Visualization, and Verification, *3 checks* of drug before administration with the second nurse, *barcode checking* in administration usage, watching out for signs of *adverse drug reaction*, patient and family *education on drug safety*. Nursing students should be trained for medication safety and administration under direct supervision of the clinical instructor. Working in collaboration, recognizing, and realizing one's own roles and responsibilities as healthcare team leads to lesser errors, improves teamwork thus safer for both patients and health care providers.[4]

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Conflicts of interest

Nothing to declare.

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