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One of the most commonly committed errors in the health care endeavor is medication errors. The term ‘ medication errors’ was defined by Mayo and Duncan (2004) as “ deviations from a physician’s order” (Mayo & Duncan, 2004, p. 209). Aronson (2009) provided the meaning of medication errors, to encompass “ a failure in the treatment process that leads to, or has the potential to lead to, harm to the patient” (Ferner and Aronson, 2006; cited in Aronson, 2009, p. 601). The definition provided by the National Coordinating Council for Medication Error Reporting and Prevention (2007) was more comprehensively stated as:

“ A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use" (National Coordinating Council for Medication Error Reporting and Prevention, 2012, p. 1).

From the definitions, these errors are an action that are apparently committed and are divergent from the intended act; and, as a consequence fails to adhere to the principles of safety and conformity to the delivery of the highest quality of patient care, as expected from the health care profession.

The Institute of Medicine (IOM) appropriately provided definitions of patient

safety and quality of care as presented from the paper written by Mitchell. Accordingly, the IOM was reported to have provided the definition of quality as “ the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (Lohr, 1990; cited in Mitchell, 2008, p. 1). As such, quality of care incorporates elements that ensures patient safety and the delivery of highy quality of health services. Concurrently, patient safety was defined by the IOM as “ the prevention of harm to patients” (Aspden, Corrigan, Wolcott, & al., 2004; cited in Mitchell, 2008, p. 2). The nursing theory that espouses both patient safety and quality of care is adherence to the principles of beneficence and least harm: to do good and to possibly inflict the minimum possible harm, if not at all preventable.

In this regard, several studies have already tried to identify the root causes of these medication errors to stem from system factors (nurse staffing, workloads, organizational climate, health care procedures and policies); process factors (distractions and interruptions, communication, documentation of the process on medication administration, complexity issues on medication safety, equipment failure during administration, monitoring and assessing); and human factors (fatique and sleep loss) (Hughes & Blegen, 2008).

The strategies and recommended courses of action to ensure application of safety precautions while delivering medications to patients therefore include addressing the root causes of the errors through continued training and educational pursuits for nurses and health care practitioners regarding safety in the health care setting and in the administration of medication; a

re-evaluation of system factors to address weaknesses and causes of errors; a proposed system change in conjunction with technological applications, as deemed appropriate in the health care setting; and being more vigilant in regularly reviewing processes, procedures, protocols and performances of health care practitioners within the complex system of medication administration. By focusing more on preventing medication errors, nurses would have effectively adhered to the principles of patient safety and quality of care, as expected of the profession.

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