Clinical Supervision of Nursing Students and Patient Safety – Reflection on an incident

Abstract
This article presents a reflection on the care situation that involves the clinical supervision of nursing students. Bearing in mind that the main objective of clinical supervision is to allow the provision of quality and safe health care, an analysis of a critical incident is carried out that involved a situation of clinical supervision of a nursing student (undergraduate), in which patient safety was compromised, associated with clinical error related to unequivocal patient identification and medication safety. In the development of this reflection, a description of the care situation is presented, identifying the risk factors associated with the patient, finally exposing the proposal for an improvement plan.

Key-words
Clinical Supervision, Nursing Student, Patient Safety

Introduction
Clinical supervision in nursing has as its central objective the “structuring of learning, the construction of knowledge and the development of professional, analytical and reflective skills” (p16657). In which communication plays a central role, as it allows the creation of a pedagogical relationship between supervisor and supervisee, providing confidence and motivation, essential aspects for the development of learning.

In the exercise of clinical supervision, the supervising nurse must develop “a dynamic, interpersonal and formal support process, in the course of monitoring and developing the supervisee's professional competences, which aims at the personal and professional development of the supervisee and himself” (p16660). Nurse supervisors should therefore have a set of skills that facilitate the learning process of supervisees, through constructive guidance.

In which conditions are expected to be created to analyze, to discuss, to clarify and to reflect on various aspects related to the different situations experienced/experienced (1,3,3,4).

The learning environment and clinical supervision in nursing are crucial for the development of professional identity and posture, as well as for ensuring the quality of care provided and patient safety (5,6). Quality in health and its improvement presents itself as a challenge for all health professionals and, according to the Quality Standards of the Ordem dos Enfermeiros “in the permanent search for excellence in professional practice, the nurse contributes to maximum effectiveness in the organization of nursing care” (p18).

At the same time, the Global Action Plan for Patient Safety 2021-2030 aims to eliminate avoidable damage to health care, making it possible to avoid damage or even stop the death of patients, as a result of unsafe health care (3). Being currently recognized that, during the provision of care, the occurrence of security incidents is a reality, it is known that the “implementation of policies and strategies that reduce these incidents, a part of which is avoidable, is recognized, internationally and nationally”, as leading to health gains and constitutes today an unequivocal bet on health (p96). Hence, in the National Plan for Patient Safety 2021-2026, the strategic objective “implementing and consolidating safe practices in a health care environment” is listed as a strategic objective.

Based on a patient safety incident that occurred during a process of clinical supervision of a nursing student of the degree course, it is essential to reflect on the situation, in order to...
promote the learning of the health teams with the errors associated with health care. The incident that occurred will be framed and jus-
tified within the scope of clinical supervision, with this reflection as objectives: 1) Describe the incident where patient safety was compromised; 2) Identify the risk factors for the patient associated with the situ-
ation described; 3) Present the improvement plan.

Development

1. Situation Description

One day, after the transition period of care from the night shift to the morning, a nurse, who was performing clinical supervision (their first clinical supervision experience) of a nursing degree stu-
dent (in the third week of teaching clinic), performed the care plan-
ning for the start of the shift. The patients assigned to him were all in the same room, allocated from bed 27 to bed 30. Two of them, patient A and patient B, who were next to each other (beds 27 and 28 respectively), were prescribed enoxaparin, with the following indications:

- Patient A would start enoxaparin 60mg sc at 10 am, and it would be necessary to teach the patient;
- Patient B autonomously administered enoxaparin 40mg sc, the time of administration being at 12:00. However, there was a note in the prescription noticing on that day, the internal medicine doctor would come to re-evaluate the patient to de-
cide whether to continue administering enoxaparin or not.

The shift went on at 10 am, the supervising nurse and students prepared the medication for patient B and supervised the administration of the medication. In the same room, allocated from bed 27 to bed 30. Two of them, patient A and patient B, who were next to each other (beds 27 and 28 respectively), were prescribed enoxaparin, with the following indications:

- Patient A would start enoxaparin 60mg sc at 10 am, and it would be necessary to teach the patient;
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cide whether to continue administering enoxaparin or not.

The shift went on at 10 am, the supervising nurse and students prepared the medication for patient B and supervised the administration of the medication. Around 12:00, the supervising nurse was admitting another pa-

tient, A, another patient, A, who was a patient that was admitted in the morning, with enoxaparin 40mg sc and a checkup to be done 3 days later.

The shift went on and at 10 am, the supervising nurse and student prepared the medication for patient A, taught the patient about the medication, without any damage being recorded until the day of discharge.

3. Improvement Plan

In the situation described, with regard to patient safety, there are two practices in which failures occurred, being the unequivocal identification of patients and medication safety, two of the practi-
ces evidenced there.

The unequivocal identification of the patient is identified as one of the safety goals of the health care provided, being a very important step towards patient safety. There is a diverse set of factors that can contribute to the occurrence of errors in this process, at the level of the health system, the professional, and the patient10,11. In this specific incident, the patient had an identification bracelet properly placed on his wrist, which helped the medication, as well as the care provided. Therefore, there was no problem in this aspect.

The situation described was initially related to issues associated with clinical supervision, the which in turn is closely related to the safety and quality of care provided. As Davis and Beddoe12 indicate, the main objective of clinical supervision is to enable the provision of quality and safe health care. At the same time, the Ordem dos Enfermeiros13 states that the clinical supervision process values “[…] the protection of the person, safety and quality of care”14. A nurse is considered a professional who mediates medication without supervision by the clinical supervision nurse and this resulted in a patient safety incident, associated with safe identification and subsequent medi-
cation error. As described above. With the nurse admitting a patient to another room, it would have been safer to have waited for the end of this procedure, which the student could have followed and then proceeded to administer the medication to patient B, in the process of effective clinical supervision. Therefore, ensuring that direct supervision is carried out at all times must be an urgent prior-

itv for clinical supervision of undergraduate nursing students14. Authors such as Reid-Seaf, Mosham and Happell15 suggest that nursing students are at risk of making errors when administering medication to patients during clinical teaching and, in their stu-
dy, in all real medication errors analyzed, inappropriate supervision was present. Reid-Seaf, Mosham and Happell15 concluded that administering medication to patients without proper supervision is a serious risk, considering that supervision is an essential component for the safe admi-
nistration of medication by nursing students. Effective supervision is thus important for quality learning experiences for students, but it also has significant implications for the provision of safe and effec-
tive health care15. As indicated by Davis and Beddoe12, the clinical supervision nurse must have competences in the scope of clinical supervision in nurs-
ing, having a competent perspective on the care provided. A nurse who assumes the role of supervisor and, in this specific case, it was the first supervisory experience of the nurse, not having any type of previous specific training in clinical supervision in nursing. I believe that the trend of that nurse will be that in the near future, emerging in clinical supervision in nursing will supervise nursing students. However, until then, it will be necessary to offer the best possible conditions to nurses who perform clinical supervision of nursing students, given the challenges that supervision represents, being evident “a need to support supervisors, to enable them to meet the challenges”10,11. Whether through in-service training on clinical supervision, through service meetings on the supervision processes that are taking place in the service, or through closer monitoring supervision by other more experienced nurses and/or team leaders present in the different shifts in which nursing students are present.

Conclusion

Reflection on professional practice is considered one of the ways to contribute to the quality of care provided, promoting the learning of health teams with, in this case, the error associated with health care. In the situation described, there were several risk factors for the patient that were associated with it, and an improvement plan was presented, which includes issues associated with the unequivocal identification of patients and safety in the administration of med-
cication.

To conclude this reflection, I could not fail to mention that it is es-
tenial to have favorable environments for reporting, sharing and subsequent learning of health teams with errors associated with health care. Given that the units/or organizations where a safety culture is promoted, where learning from safety incidents and supporting professionals, patients and families is a constant premise, are bet-
ter prepared to promote patient safety on an ongoing and provide quality care17.

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