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

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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"[1(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"[1(p16660)]. Nurse supervisors should therefore have a set of skills that facilitate the learning process of supervisees, through constructive guidance[2]. 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[7] "in the permanent search for excellence in professional practice, the nurse contributes to maximum effectiveness in the organization of nursing care"[7(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[8]. 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"[9(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[9(p102)].

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

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promote the learning of the health teams with the errors associated with health care. The incident that occurred will be framed and justified 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 situation 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 student (in the third week of teaching clinic), performed the care planning 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 notes that on that day, the internal medicine doctor would come to re-evaluate the patient to decide whether to continue to administer enoxaparin or not.

The shift went on and at 10 am, the supervising nurse and student prepared the medication for patient A, taught the patient about the new medication and enoxaparin was administered at the scheduled time without incidents.
At 11 am, the internal medicine doctor came to observe patient B, having decided that it would be to continue administering enoxaparin for another 3 days, without changing the dosage or administration schedule, the supervising nurse and nursing student were with the doctor, when the communicated this information to patient B, and the electronic prescription was rectified.
Around 12:00, the supervising nurse was admitting another patient, in another room, so she asked the nursing student if she could go and prepare the medication for patient B and supervise the administration of the same by the patient, having the student accepted.
The shift continued and, at 1:00 pm, patient B rings the bell and calls the nurse to ask for enoxaparin, as the time for administration has already passed. It was with this call that the supervising nurse and the student herself realized that the enoxaparin that the student prepared at 12:00 was delivered and administered under supervision by patient A, instead of patient B. The nurse contacts internal medicine to inform about the error of medication, patient A was informed of the situation and monitoring/surveillance of possible adverse events related to drug overdose was carried out.

2. Identification of Risk Factors

In the situation described above, two of the biggest challenges for patient safety can be found: unequivocal patient identification and medication safety[10] and, in this case, the failure to correctly identify the patient led to an incident, a medication error.
Regarding the identification of risk factors for the patient associated with the situation described, it can be indicated that, for patient A, there was an overdose of a drug, which implied monitoring for possible adverse events and, until the day of discharge, no harm was found to the patient. In addition, it was necessary to invest in terms of health literacy, reinforcing all the teachings given to the patient, so that there is greater security in the provision of care, explaining, on the one hand, the importance of the patient being involved in the identification process. , clarifying how this measure contributes to ensuring their safety and, on the other hand, aspects related to the drugs they have prescribed (doses, routes of administration, frequency, care in administration and monitoring of warning signs). As for patient B, it involved a delay in the administration of a 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 practices 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 patient[11]. In this specific incident, the patient had an identification bracelet properly placed and there are internal procedures related to this topic, however they did not serve as a barrier. Because, in practice, the existing recommendations were not fulfilled, namely the positive identification of the patient and the lack of perception of the inherent risks of not using these safe practices, given the inexperience of the student and the clinical supervisor. On the other hand, the patient herself, probably due to low health literacy, was also unable to question the reason for repeating the administration of the drug, given that she had administered a similar drug 2 hours before.
The unequivocal identification of patients is one of the essential measures to ensure medication safety, in all its stages, considered as "one of the golden rules in the prevention of medication error"[12(p167)]. For this reason, it is always necessary to confirm the identification of patients, using at least two identification data, using positive identification, that is, asking patients about their data and validating it with the information available on the identification bracelet[10]. On the other hand, in the context of drug safety, in order to increase safety barriers, contributing to the literacy of patients, it is essential to involve them in the process, not only in the process of safe identification, but also in all related knowledge. with the medications you are given. Therefore, it is necessary to sensitize the entire team to the importance of creating these safety barriers, which will allow "the right medicine to be administered to the right person, by the right route, at the right time and dose"[13(p.251)].
Despite the fact that there are several constraints on safe practices/environments of care provision, as was observed in this situation, as a strategy for the prevention of incidents, the promotion of training of health professionals in the field of patient safety is highlighted in the literature, as well as the promotion of continuous learning

through the reporting/notification of incidents[9,12,13]. Therefore, it is suggested to include in the in-service training plan the theme of unequivocal identification of the patient, safety in medication administration and incident reporting.

This situation also requires looking at it from another perspective/dimension, given that a clinical supervisor nurse and a nursing student were involved, so I consider that, in macro terms, this situation was primarily 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 Beddoe[14] indicate, the main objective of supervision is to enable the provision of quality and safe health care. At the same time, the Ordem dos Enfermeiros[1] states that the clinical supervision process values "[…] the protection of the person, safety and quality of care."[1(p16657)].

A nursing student administered a medication without supervision by the clinical supervising nurse and this resulted in a patient safety incident, associated with safe identification and subsequent medication 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 priority for clinical supervision of undergraduate nursing students[10]. Authors such as Reid-Searl, Moxham and Happell[15] suggest that nursing students are at risk of making errors when administering medication to patients during clinical teaching and, in their study, in all real medication errors analyzed, inadequate supervision was present. Reid-Searl, Moxham and Happell[15] concluded that adequate supervision contributed to error prevention, clearly indicating that supervision is an essential component for the safe administration 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 effective health care[15].

As indicated by Davis and Beddoe[14], the clinical supervisor nurse must have competences in the scope of clinical supervision in nursing, being considered as an important prerequisite for those who assume the role of supervisor of students 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 the future will be that only nurses trained 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 these challenges"[16(p7)]. 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[7], promoting the learning of health teams with, in this case, the errors 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 medication.

To conclude this reflection, I could not fail to mention that it is essential to create favorable environments for reporting, sharing and subsequent learning of health teams with errors associated with health care. Given that the units/organizations where a safety culture is promoted, where learning from safety incidents and supporting professionals, patients and families is a constant premise, are better prepared to promote patient safety on an ongoing and provide quality care[17].

Bibliographic references

1. Ordem dos Enfermeiros. Regulamento nº366/2018. Regulamento da competência acrescida diferenciada e avançada em supervisão clínica [Internet]. 2018. [cited 2022 Apr 22]. Available from: https://www.ordemenfermeiros.pt/media/19821/reg.pdf

2. Tuomikoski, A., Ruotsalainen, H., Mikkenen, K., Miettunen, J., Juvonen, S., Sivonen, P., Kääriäinen, M. How mentoring education affects nurse mentors' competence in mentoring students during clinical practice: A quasi-experimental study'. Scand J Caring Sci [Internet]. 2020 Mar; 34(1):230-238. Available from: https://doi.org/10.1111/scs.12728

3. World Health Organization. Nurse educator core competencies. [Internet]. Geneva: World Health Organization, 2016. [cited 2022 Aug 13]. Available from: https://apps.who.int/iris/rest/bitstreams/1087713/retrieve

4. Beiranvand S., Kermanshahi S., Memarian R. Nursing instructors' clinical education competencies: an integrated review. J Pak Med Assoc, [Internet]. 2021 May; 71:5. Available from: https://doi.org/10.47391/JPMA.089

5. Amsrud K., Lyberg A., Severinsson E. The influence of clinical supervision and its potential for enhancing patient safety : Undergraduate nursing students' views. J. Nurs. Educ. Pract. [Internet]. 2015 Apr; 5(6); 87-95. Available from: http://dx.doi.org/10.5430/jnep.v5n6p87

6. Snowdon D., Leggat S., Taylor N. Does clinical supervision of healthcare professionals improve effectiveness of care and patient experience? A systematic review. BMC Health Serv Res. [Internet]. 2017 Nov; 17; 786. Available from: https://doi.org/10.1186/s12913-017-2739-5

7. Ordem dos Enfermeiros. Padrões de qualidade dos cuidados de enfermagem: enquadramento conceptual enunciados descritivos. [Internet]. Lisboa: Ordem dos Enfermeiros 2018. [cited 2022 Feb 22]. Available from: https://www.ordemenfermeiros.pt/media/8903/divulgar-padroes-de-qualidade-dos-cuidados.pdf

8. World Health Organization. Global patient safety action plan 2021–2030: towards eliminating avoidable harm in health care.

[Internet]. Geneva: World Health Organization, 2021. [cited 2022 Aug 13]. Available from: https://www.who.int/publications/i/item/9789240032705

9. Despacho n.º 9390/2021. Aprova o Plano Nacional para a Segurança dos Doentes 2021 -2026 (PNSD 2021 -2026). [Internet]. 2021. [cited 2022 Apr 22]. Available from: https://files.dre.pt/2s/2021/09/187000000/00096001O3.pdf

10. Barroso F, Sales L, Ramos S. Guia prático para a segurança do doente. Lisboa: Lidel- Edições Técnicas; 2021.

11. Sales L, Barroso F, Ramos S. Identificação inequívoca do doente. In: Barroso F, Sales L, Ramos S. Guia Prático para a Segurança do Doente. Lisboa: Lidel- Edições Técnicas; 2021. p. 209-216.

12. Ramos S, Perdigão P, Oliveira R P. Erros relacionados aos medicamentos. In: Sousa P, Mendes W., comps. Segurança do paciente: conhecendo os riscos nas organizações de saúde [Internet]. 2nd ed. rev. updt. Rio de Janeiro: Editora Fiocruz; 2019, [cited 2022 Apr 17]; pp. 161-188. Available from: https://doi.org/10.7476/9788575416419.0011.

13. Sales L, Coelho A, Graça A, Paulino E. Segurança na medicação. In: Barroso F, Sales L, Ramos S. Guia prático para a segurança do doente. Lisboa: Lidel - Edições Técnicas; 2021. p.249-264.

14. Davis A, Beddoe L. Best practice in professional supervision: a guide for the helping professions. 2nd ed. [Internet]. London and Philadelphia: Jessica Kingsley Publishers; 2021 [cited 2022 Apr 19]. Available from: https://ebin.pub/best-practice-in-professional-supervision-a-guide-for-the-helping-professions-2nbsped-9781784508579-1784508578.html

15. Reid-Searl K, Moxham L, Happell B. Enhancing patient safety: The importance of direct supervision for avoiding medication errors and near misses by undergraduate nursing students. Int. J. Nurs. Pract. [Internet]. 2010 May; 16(3):225-232. Available from: https://doi.org/10.1111/j.1440-172X.2010.01820.x

16. Leonardsen A, Brynhildsen S, Hansen M, Grøndahl V. Supervising students in a complex nursing practice - a focus group study in Norway. BMC Nursing, [Internet]. 2021 Sept; 20:168. Available from: https://doi.org/10.1186/s12912-021-00693-1

17. Pedroso E, Ramos S, Barroso F. Relato de incidentes. In: Barroso F, Sales L, Ramos S. Guia prático para a segurança do doente. Lisboa: Lidel – Edições Técnicas; 2021. p.135-146.