Errors Happen in Clinical Education

Students in every health care discipline, including medicine, nursing and pharmacy, are required to complete mandatory hours in direct patient care in a variety of clinical settings. These rotations ensure that each student gains valuable real-world, hands-on experience that helps them attain the skills required to confidently and competently care for patients. Guided by instructors and preceptors, students perform a multitude of tasks while learning effective patient management. However, even under the watchful eye of their mentors, students are subject to similar errors that occur with veteran clinicians.

Student errors commonly reported include:

- Confusing medications due to look-alike labels and packaging.
- Mental mistakes due to distraction.
- Duplicated and/or omitted care when students are assigned to the same patient as hospital staff.
- Medications given twice or not given at all due to miscommunication.
    - Most common high-alert medications involved with student errors are insulin, opioids, and anticoagulants.

Earlier this year, the Canadian Institute for Medication Safe Practices analyzed its database of student-associated medication errors. The analysis revealed several strategies to improve training and reduce potential adverse events.

- Encourage students to recognize, resolve, and report medication errors.
- When pairing a student with a preceptor, ensure the workload is appropriate to allow adequate time for mentoring and training.
    - Avoid pairing the preceptor with multiple students.
    - Avoid precepting students in multiple locations.
    - Ensure the preceptor does not have additional clinical responsibilities.
- Provide adequate training to students and review hospital policies and procedures before they perform new tasks and skills.
- Avoid error-prone processes and short-cuts.
    - Teach students to avoid concurrent preparation of medications for several patients.
    - Instruct students to label all medications in syringes.

Often, inexperience is associated with higher rates of error however, students may provide fresh perspectives and their inquisitive nature can help foster a culture of safety in any health care environment. Healthcare leaders and organizations must do their part to provide training settings that promote safe medication practices that allow clinicians to use their knowledge to decrease potential errors.

References

1. Institute for Safe Medication Practices. (2018). *Nurse Advise-ERR.* Retrieved from Institute for Safe Medication Practices: http://www.ismp.org/newsletters/nursing/issues/NurseAdviseERR201809.pdf