**Lessons Learned from a Medical Error: A Student's Perspective**

Student’s Name

Institution’s Affiliation

Course Number and Name

Professor Name

Date

**Lessons Learned from a Medical Error: A Student's Perspective**

**Introduction**

As a nursing student, I vividly recall an incident that stressed the significance of quality and safety measures in healthcare. This assignment describes a time when I witnessed a medical error, its circumstances, and the implicit tools and methods that could have prevented it. The incident underscored the critical part of effective communication, proper documentation, and patient-centred care.

**Description of the incident**

A medical mistake happened while administering medication during my clinical rotation at a crowded hospital. Glucose was issued to Mr. Smith, a diabetic patient, to control his blood sugar levels. Unfortunately, a series of misunderstandings and detours caused the nurse to administer the incorrect dosage of glucose inadvertently. This oversight remained unreported until Mr Smith started to experience hypoglycemic symptoms, such as disorientation and perspiration (Janett & Yeracaris, 2020). The nursing team's quick action prevented more significant damage, but the episode had a long-lasting effect on the patient and the healthcare professionals involved.

**Quality and safety methods and tools**

Quality and safety methods and tools play a crucial role in preventing medical errors, and in this case, several strategies could have been employed to forestall the incident. First, effective communication is paramount. The error was partly a result of breakdowns in communication, emphasising the significance of standardised communication tools. One similar tool is the Situation- Background- Assessment- Recommendation (SBAR) framework, which facilitates accurate and concise information exchange between healthcare professionals. However, the nurse responsible for administering the insulin could have entered vital details regarding the dosage from the nurse who prepared it if the nurses had employed SBAR (Lawrence et al., 2020). This exchange would have reduced the liability of confusion or misinterpretation, eventually preventing the error from being.

In addition to effective communication, enforcing a structured double-checking process is crucial, particularly for high-threat specifics like insulin. This process involves two healthcare professionals independently vindicating the drug, dosage, and patient identification before administration. Had the nurse followed this protocol, the error could have been detected before any detriment changed the patient (Meder et al., 2019). Double-checking procedures act as an additional safeguard to ensure the delicacy of drug administration and help prevent errors from slipping through the cracks.

Technological advancements have paved the way for innovative tools to enhance patient safety. One similar tool is the Barcode Medication Administration (BCMA) system, which has proven effective in reducing medication errors. This system operates by surveying barcodes on specifics and cross-referencing them with patient identification. By enforcing BCMA, the nurse would have entered an alert regarding the incorrect insulin dosage, thereby preventing its administration (Musharyanti et al., 2019). Using technology in medication administration adds an extra layer of safety by ensuring delicacy and minimising the threat of human error.

Likewise, Electronic Health Records (EHRs) applications can significantly contribute to precluding medication errors. EHRs give real-time access to comprehensive patient information, including medication orders and allergy cautions. By using electronic systems that offer decision support, healthcare professionals can minimise attestation errors, similar to deficient or inaccurate medication orders. In the case of Mr. Smith, having clear and easily accessible information within the EHR would have empowered the nurse to confirm the correct insulin dosage before administering it (Janett & Yeracaris, 2020). Real-time access to patient data through EHRs aids healthcare professionals in making informed opinions and reduces the likelihood of errors.

**Conclusion**

During my clinical rotation, I saw a medical error, which brought home the value of quality and safety procedures in healthcare. Preventing drug mistakes and maintaining patient safety depends heavily on effective communication, double-checking processes, BCMA systems, and EHRs. To decrease the likelihood of errors, healthcare organisations must prioritise the adoption and ongoing improvement of these tools and techniques (Lawrence et al., 2020). By doing this, one can promote a safety culture, improve patient outcomes, and inspire trust in patients and healthcare professionals.

**References**

Janett, R. S., & Yeracaris, P. P. (2020). Electronic Medical Records in the American Health System: challenges and lessons learned. *Ciencia & saude coletiva*, *25*, 1293-1304. <https://doi.org/10.1590/1413-81232020254.28922019>

Lawrence, K., Hanley, K., Adams, J., Sartori, D. J., Greene, R., & Zabar, S. (2020). Building telemedicine capacity for trainees during the novel coronavirus outbreak: a case study and lessons learned. *Journal of General Internal Medicine*, *35*, 2675-2679. <https://doi.org/10.1007/s11606-020-05979-9>

Meder, D., Herz, D. M., Rowe, J. B., Lehéricy, S., & Siebner, H. R. (2019). The role of dopamine in the brain lessons learned from Parkinson's disease. *Neuroimage*, *190*, 79-93. <https://doi.org/10.1016/j.neuroimage.2018.11.021>

Musharyanti, L., Claramita, M., Haryanti, F., & Dwiprahasto, I. (2019). Why do nursing students make medication errors? A qualitative study in Indonesia. *Journal of Taibah University Medical Sciences*, *14*(3), 282-288. <https://doi.org/10.1016/j.jtumed.2019.04.002>