ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 6 (June 2026)

Common Clinical Errors among Beginning Nurse Practitioners

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Date Submitted:
May 10, 2026

Date Accepted:
May 15, 2026

Date Published:
June 02, 2026

DOI:
10.5281/zenodo.20509570

ABSTRACT

This quantitative-qualitative descriptive study investigated the nature and contributing factors of clinical errors among 144 novice nurse practitioners with less than two years of experience across four hospitals in Cotabato City. The findings revealed alarming high-frequency slip-ups: 94% of participants infused excessive intravenous fluids, 78% administered intravenous drugs in under one minute, and 76% provided incomplete information during patient handovers. Overall, data showed errors occurred "rarely" (one to five times), with medication and charting/recording errors yielding the highest weighted means (1.82), followed closely by reporting and referral (1.72) and procedural errors (1.68). Systemic issues heavily drove these outcomes, with managerial/system factors and intense workloads ranking as the top contributors ahead of personal factors. Notably, a MANOVA analysis indicated that single status heightened medication and procedural errors, while regular employment and 0–12 months of experience increased reporting and referral errors. Crucially, managing more than 20 patients daily significantly increased errors across all four categories, whereas age, gender, assignment area, and training history remained insignificant. To mitigate these risks, personal corrective measures included implementing the "10 Rs" of medication administration and double-checking orders, while institutional strategies relied on incident reports and unit meetings. In conclusion, placing novice nurses into regular roles with high patient loads severely compromises patient safety. The study strongly recommends bolstering patient safety management, establishing a mandatory self-reporting culture, and enhancing undergraduate nursing course syllabi specifically within nursing process, pharmacology, mathematics, and chemistry.

Keywords: *Clinical errors, medication errors, procedural errors, reporting errors, recording/ documentation errors*

INTRODUCTION

Clinical errors remain a sensitive issue as these give a common notion of a mistake that poses a threat to patient safety; however, little do we know about how critical it is for nurses' reputation. Nurses have a prominent role in preserving the patient's safety and creating, keeping and promoting the caring quality. However, to err is human. In particular, beginning nurses may have a greater risk for errors. Morrow (2009) concluded that less experienced nurses are associated with increased rates of complications. They are also perceived to be inadequately prepared to enter practice. Minda News (2011) quoted Dr Vega's statement that nurses fresh out of school need a year or two of training before entering the profession to

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 6 (June 2026)

reduce clinical error. It is also stated, in the study of Kenward and Zhong as cited by Knowles (2013), that 50% of the newly graduated nurses feel that they are adequately trained before entering the workplace.

Local and foreign studies claim there is an ongoing clinical error. It has been said in the Study of Saintsing, Gibson, and Pennington (2011) found that 49-53% of nurses made errors in terms of nursing care. There may be no study that focuses on beginning nurse practitioners, collectively, conclusions over the length of experience and that of the commission of errors are evident in the findings of Thompson (2009) and Dumo (2012).

This issue is gaining significance; thus, this study attempts to determine the nature of clinical errors in the hospitals in Cotabato City and draw parallels to their corrective measures, as It hopes to look at initiatives and relevant measures by the nurses and the hospitals to prevent and correct clinical errors. The researcher believes that when the common errors are well understood and awareness is raised, changes can be made on several levels to improve the quality of care and reduce the number of errors in the locale of the study or in the country.

Clinical errors are increasingly important aspects of nursing practice. There is concern that the risk of acquiring a disabling illness due to medical or inappropriate nursing intervention during hospitalization is contributing to the cost of care, adding to the burden of the patient and is likewise causes demoralization of a professional life of a nurse.

To cite cases, Cheragi, Manoocheri, Mohammadnejad, and Eshani (2013) found out in Iran reported that a great number of nurses, accounting to 65.55%, had experienced medication errors, 31.37% of them reported being on the verge of a medication error. According to Shishani, Al-Faouri, as cited by Eshani (2013), in Jordan, 42.1% of nurses had committed one medication error within 3 months, 58 % of the errors were related to medication administration. The second most common type of errors was procedural errors of 18.4 percent followed by charting errors with 11.9 percent.

In line with fatalities, Eslami, Taheri, Bahrami and Mojdeh (2010) highlighted that in 2009, more than 10000 in-hospital errors were reported, among which 1100 cases led to death. Additionally, according to the global statistics, one in 300 errors leads to death. The movement toward patient safety has snowballed after several reports on the fatality of clinical errors.

Safety during patient hospitalization consists one of the patients' rights and also the priority of health professionals. Clinical errors have drawn health researchers' attention over the last decade. Considering this concern, corrective measures from both individual health professionals and health facilities or institutions will be highlighted.

Theoretical Support

The study was anchored on two nursing theories: the Nursing Expertise Model of Patricia Benner, and The Donabedian Model of Care by Avedis Donabedian. Dr. Patricia Benner (2013) points to the five levels of nursing experience as: Novice (1 year), Advanced beginner (1-2 years), Competent (3-4years), Proficient (4-5years) and Expert (5years up), which reflect movement from reliance on past experiences to changing current perception. This model also proposes that, as a person advances in skill level, there is a corresponding change in the performance of a given skill (Bautista, 2008). Beginning nurse practitioners in the study were likened to novices who need monitoring, either by self-observation or instructional feedback. In both configurations, it is, therefore, necessary for beginning nurse practitioners to learn through experience, as this will allow them to gain mastery of a given skill, which will develop their competency.

The patient, of course, offers another key perspective as the nursing profession explores and applies a specific framework for the purpose of delivering exquisite nursing care. It looked at the perspective of Avedis Donabedian Model of care, which provides a framework for examining health services and evaluating quality of care. The model says that improvements in the structure of care should lead to improvements in clinical processes that should, in turn, improve patient outcomes, where quality of care can be drawn from three categories: "structure," "process," and "outcomes". Patient satisfaction is the

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 6 (June 2026)

outcome of any health care facility, which is derived from a well-grounded structure with a goal-directed system and a process with clear communication, which is reflected through good care coordination by nurses, doctors and patients themselves. Putting these theories in perspective of the study is relevant in the sense that they address excellence in nursing practice.

Problem

The following Research Questions guided this study:

1.) What is the demographic profile of the respondents in terms of :
   a.) age;
   b.) gender;
   c.) civil status;
   d.) status of employment;
   e.) length of work experience;
   f.) area of assignment;
   g.) average number of patients in a day; and
   h.) updates, seminars, and trainings attended?

2.) What are the common clinical errors committed by beginning nurse practitioners in terms of:
   a.) medication;
   b.) procedural;
   c.) reporting/referral; and
   d.) charting/recording?

3.) How frequently do they commit these errors?

4.) What are the personal efforts made by the beginning nurse practitioners to correct the errors committed?

5.) What are the institutional efforts made to correct the errors committed?

6.) Is there a significant difference in the clinical errors committed by the beginning nurse practitioners when grouped according to:
   a.) age;
   b.) gender;
   c.) civil status;
   d.) status of employment;
   e.) length of work experience;
   f.) area of assignment;
   g.) average number of patients in a day; and
   h.) updates, seminars, and trainings attended?

7.) What are the learning/training needs of the beginning nurse practitioners to prevent the commission of a clinical error?

METHODOLOGY

Research Design

The study used a quantitative-qualitative descriptive design. It described the profile of the participants and investigated the clinical errors they commonly commit. A qualitative approach for an in-depth analysis of the data has been utilized using Focus Group Discussion (FGD) and Key Informant Interviews (KII).

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 6 (June 2026)

Study Context

It was conducted in four hospitals in Cotabato City, namely the Cotabato Regional and Medical Centre (CRMC), Notre Dame Hospital and School of Midwifery (NDHSM), Cotabato Medical Specialist Hospital (CMSH), Cotabato Peuriculture Centre, and General Hospital Children's Foundation Incorporated.

Population and Sampling

The participants of the study who answered the survey questionnaire and participated in FGD were screened according to the inclusion criteria set. The criteria include the following: (a) 19- 40 years old, (b) deployed nurses from other health care institutions, volunteers, trainees, job order, regular or contractual nurses, (c) no more than two years of work experience at the current hospital, and (d) has been assigned to direct patient care.

The total population of beginning nurse practitioners in four hospitals was 174; they were selected purposively given the criteria; however, only 144 questionnaires were retrieved and processed for analysis.

Data Collection

First, quantitative data were collected on different dates as approved by each hospital. Distribution and retrieval of the questionnaires were made with the help of the unit heads. The questionnaires were taken home by the participants to ensure that they could answer the questionnaire at their most convenient time.

Qualitative data were gathered using in-depth interviews with an open-ended semi-structured questionnaire to probe personal experiences on clinical errors and corrective measures employed. There were nine participants for FGD, each representing an area of assignment from different hospitals. There were eight key informants (six nurses and two doctors) from four hospitals who were considered to have potentially rich insights germane to the study aims.

Instrument

The study used a literature-based, self-made questionnaire consisting of the four types of clinical errors. It was divided into three parts. The first part included eight items on the demographic profile. The second part explored the beginning nurse practitioners' common clinical errors committed, which were classified as: medication, procedural, reporting/referral and charting/documentation. Each classification has ten-item Likert-type questions with a five-point Likert frequency scale. The third part focused on personal efforts of the participants and institutional efforts made to correct errors, which were done in narrative form.

The qualitative side of the study used a four-item semi-structured interview guide for FGD and KII. Discussion revolved around the most common type of clinical error and root causes, corrective measures for beginning nurses and the institution, system on prevention and monitoring, and perceived training/learning needs.

Data Analysis

Quantitative data were analysed using descriptive statistics such as frequency and percentage, mean and standard deviation and MANOVA. Qualitative data were audio taped, transcribed and checked for completeness with written notes to reinforce and substantiate the data gathered.

Validity

The contents of the questionnaire for the survey and the guide questions for the interview were validated by experts from nursing education, nursing practice and research and were found to be very good. The contents were validated in terms of clarity of language, presentation, and organisation of topics, suitability of items, adequateness of purpose, attainment of purpose, objectivity, and appropriateness of measurement and scaling.

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 6 (June 2026)

Ethical Considerations

The study had an approved ethical clearance from the CRMC Research Ethics Board Committee which has adopted the National Ethical Guidelines for Health Research 2011 of the Philippine Health Research System. All 144 participants were provided with written consent, and a consent process was adopted emphasizing the privacy/confidentiality provisions of the study.

RESULTS

Demographic profile

Participants were mostly in the between the range of 24 – 27 years old (56.9% n=42), female (70.8% n 102), single (84.7% n=122), regular status (76.4% n 110), have been in the current hospital for 0 -12 months (60.4% n=87), assigned in general ward (37.4% n =54), attended to more than 20 patients in a day (34% n=49) followed by more than 40 patients (21.5% n=31), have attended Intravenous Therapy Training (IVT) (n=75). Table 1 displays demographic data.

Table 1. *Demographic Characteristics of Participants (N=144)*

Variables	Frequency	Percentage
Age		
20 – 23 years old	42	29.2
24 – 27 years old	82	56.9
28 – 31 years old	16	11.1
32 – 35 years old	3	2.1
36 – 39 years old	1	.7
Gender		
Male	42	29.2
Female	102	70.8
Variables	Frequency	Percentage
Civil Status		
Single	122	84.7
Married	21	14.6
Separated	1	.7
Status of Employment		
Regular	110	76.4
Contractual	27	18.8
Trainee	7	4.9
Length of Work Experience	87	60.4
0 – 12 months		
13 – 24 months	57	39.6
Area of Assignment		
General Ward (Floors, ONA Wing, Pay)	54	37.5
Surgery Ward	2	1.4
OB-GYN Ward	6	4.2
Medicine Ward	9	6.3
Orthopedic Ward	4	2.8
Oncology Ward	4	2.8
Pedia Ward	11	7.6
ICU (NICU, PICU, OBCU, SICU)	12	8.3
Operating Room	16	11.1
Delivery Room	6	4.2
Emergency Room	12	8.3

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 6 (June 2026)

Mental Health Unit	5	3.5
Out-Patient Department	3	2.1
Average Number of Patients		
Less than 10	15	10.4
More than 10	24	16.7
More than 20	49	34.0
More than 30	25	17.4
More than 40	31	21.5

Common Clinical Errors of the Participants

The most common errors for medication were giving an intravenous therapy drug shorter than 1 minute (78%), followed by giving a drug without informing patients of its contraindication (71%), failing to evaluate the patient's response to medication, and giving the drug at an unscheduled time, both at 67%.

As for procedural errors, 94% of them infused intravenous fluid more than the expected amount in a shift, 74% violated aseptic principles, and 69% failed to observe infection control practices and inserted venous access after three attempts.

With respect to reporting and referral errors, 76% have endorsed incomplete information on patient care to incoming duty, 73% have failed to report non-functional equipment or unavailable devices, and 65% have left the telephone or verbal orders unsigned.

About charting and recording, 75% have missed recording nursing actions done and incompletely filled-in information on the patient's record, 71% of them have a charting that were not in sequence to time and event, 70% of them were writing interventions in advance of the event.

Overall, the top three were infusing intravenous fluid more than the expected amount in a shift (94%), followed by giving intravenous therapy drugs for shorter than 1 minute (78%) and endorsing incomplete information on patient care to incoming duty (76%). Full details are presented in Table 2.

Table 2. *Common Clinical Errors of the Participants (N=144)*

Medication Errors	Frequency	Percentage	Rank
1. I gave an un-prescribed drug.	32	22	9
2. I administered a drug using an improper route.	35	24	8
3. I gave a drug at an unscheduled time.	97	67	3
4. I gave an inappropriate dose of the drug.	63	44	6
5. I gave an intravenous therapy drug shorter than 1minute.	112	78	1
6. I gave a drug without checking for drug allergies.	59	41	7
7. I gave more than three oral drugs at one time.	77	54	4
8. I gave a drug without informing of its contraindication.	102	71	2
9. I failed to evaluate the patient's response to medicine.	96	67	3
10. I omitted an available scheduled drug.	66	46	5
Others: Double dose			
Not signing the medication sheet.			
Wrong drug			
Procedural Errors	**Frequency**	**Percentage**	**Rank**
1. I performed a procedure that was not indicated.	34	24	8
2. I failed to monitor the patient's vital signs.	90	63	4
3. I failed to match the patient's cross matching the sheet against available blood before transfusion.	8	6	9

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 6 (June 2026)

4. I inserted intravenous access to a visible vein after three attempts.	100	69	3
5. I infused an intravenous fluid in an amount more than expected in a shift.	135	94	1
6. I placed the uro bag at the patient's bladder level during transport.	72	50	5
7. I failed to carry out preparations before diagnostic tests.	68	47	6
8. I failed to examine patients with mobility problems for bedsore.	101	33	7
9. I violated the aseptic principle.	106	74	2
10. I failed to observe infection control protocols.	100	69	3

Reporting & Referral Errors	Frequency	Percentage	Rank
1. I miscommunicated a diagnostic finding to the doctor.	66	46	7
2. I failed to relay significant diagnostic results to doctors promptly.	85	59	5
3. I referred the untoward changes in patients' condition to doctors too late.	73	51	6
4. I left the telephone/verbal orders unsigned by doctors.	94	65	3
5. I failed to notify the unit before referral or transfer of a patient.	70	49	7
6. I failed to inform the dietary department of admissions and dietary changes.	89	62	4
7. I missed reporting a non-functional hospital equipment or unavailable device.	105	73	2
8. I endorsed incomplete information on the patient's care to incoming duty nurse/s.	110	76	1
9. I failed to report inadvertent events in my assigned area.	85	59	5
10. I gave unclear instructions about a procedure to patients/significant others resulting in a misunderstanding.	73	51	6

Charting & Recording Errors	Frequency	Percentage	Rank
1. My charting was not reflective of the nursing process.	100	69	4
2. My charting was not in sequence with time and event.	102	71	2
3. I wrote in an illegible way.	79	55	6
4. I wrote interventions in advance of the event.	101	70	3
5. I failed to include the education given about the consequences of refusal to treatment.	90	63	5
6. I missed recording the nursing actions done.	108	75	1
7. I deleted the erroneous entry improperly.	91	63	5
8. I recorded on the wrong chart.	61	42	8
9. I incompletely filled in information on the patient's record.	108	75	1
10. I improperly transcribed the doctor's order.	69	48	7

Frequency of Commission of Clinical Errors

It can be seen in Table 3 that participants rarely made the following errors under medication errors: giving intravenous drugs shorter than 1 minute (2.42), giving drugs without informing patients of their contraindication (2.28) and failing to evaluate patients' response to medication (2.10). However, they never gave an inappropriate dose, used an improper route, nor gave an un-prescribed drug.

Whereas for the procedural errors, they rarely infused an intravenous fluid more than the expected amount in a shift (2.01), failed to observe infection control protocols (2.10), and violated aseptic principles

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 6 (June 2026)

(1.91). However, they never performed procedures that were not indicated (1.27) and failed to match the patient's cross-matching sheet against available blood before transfusion (1.06).

Data also presents reporting and referral errors, where they rarely missed reporting a non-functional hospital equipment or unavailable device (1.92) and endorsed incomplete information on patient's care to incoming duty nurse/s(1.92), left the telephone/verbal orders unsigned by doctors (1.85), failed to inform the dietary department of admissions and dietary changes(1.83) and miscommunicated diagnostic findings (1.55).

In terms of charting/ recording errors, they rarely (1.97) made a charting that was not in sequence to time and event, wrote interventions in advance of the event and failed to record nursing actions done (1.96) and did charting that was not reflective of the nursing process (1.94).

All four categories of clinical errors had an average mean description of rarely, which is interpreted as the participants committed the errors approximately one to five times. Out of the four categories, medication errors as well as charting & recording errors both have the highest weighted mean (1.82), followed by reporting & referral errors (1.72), and lastly the procedural error (1.68). Table 3 displays their data in full.

Table 3.*The equivalent interpretation represented the participants' data on the frequency of commission of clinical errors under four categories for the whole duration of work in their current workplace.*

Medication Errors	Mean	SD	Interpretation
1. I gave an un-prescribed drug.	1.28	.480	Never
2. I administered a drug using an improper route.	1.31	.480	Never
3. I gave a drug at an unscheduled time.	2.03	.752	Rarely
4. I gave an inappropriate dose of the drug.	1.49	.555	Never
5. I gave an intravenous therapy drug for less than 1 minute.	2.42	.943	Rarely
6. I gave a drug without checking for drug allergies.	1.63	.842	Rarely
7. I gave more than three oral drugs at one time.	2.08	.997	Rarely
8. I gave a drug without informing of its contraindication.	2.28	.978	Rarely
9. I failed to evaluate the patient's response to medication.	2.10	.895	Rarely
10. I omitted an available scheduled drug.	1.62	.657	Rarely
Others: Double dose	0	0	
Not signing the medication sheet	0	0	
Wrong drug	0	0	
Mean of Means	1.82		Rarely

Procedural Errors	Mea Mean	SD	Interpretation
1. I performed a procedure that was not indicated.	1.27	.518	Never
2. I failed to monitor the patient's vital signs.	1.76	.692	Rarely
3. I failed to match the patient's cross-matching sheet against available blood before transfusion.	1.06	.230	Never
4. I inserted intravenous access to a visible vein after three attempts.	1.87	.722	Rarely
5. I infused an intravenous fluid in an amount more than expected in a shift.	2.01	.719	Rarely
6. I placed the urobag at the patient's bladder level during transport.	1.65	.743	Rarely

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 6 (June 2026)

7. I failed to carry out preparations before diagnostic tests.	1.58	.675	Rarely
8. I failed to examine patients with mobility problems for bedsore.	1.85	.672	Rarely
9. I violated the aseptic principle.	1.91	.678	Rarely
10. I failed to observe infection control protocols.	1.88	.714	Rarely
Mean of Means	1.68		Rarely

Reporting & Referral Errors	Mean	SD	Interpretation
1. I miscommunicated a diagnostic finding to the doctor.	1.55	.678	Rarely
2. I failed to relay significant diagnostic results to doctors promptly.	1.72	.696	Rarely
3. I referred the untoward changes of patients' condition to doctors too late.	1.60	.702	Rarely
4. I left the telephone/verbal orders unsigned by doctors.	1.85	.802	Rarely
5. I failed to notify the unit before referral or transfer of a patient.	1.55	.624	Rarely
6. I failed to inform the dietary department of admissions and dietary changes.	1.83	.805	Rarely
7. I missed reporting a non-functional hospital piece of equipment or an unavailable device.	1.92	.695	Rarely
8. I endorsed incomplete information on the patient's care to incoming duty nurse/s.	1.92	.642	Rarely
9. I failed to report inadvertent events in my assigned area.	1.69	.653	Rarely
10. I gave unclear instructions about a procedure to patients/significant others, resulting in a misunderstanding.	1.60	.672	Rarely
Mean of Means	1.72		Rarely

Charting & Recording Errors	Mean	SD	Interpretation
1. My charting was not reflective of the nursing process.	1.94	.826	Rarely
2. My charting was not in sequence to time and event.	1.97	.848	Rarely
3. I wrote in an illegible way.	1.81	.879	Rarely
4. I wrote interventions in advance of the event.	1.96	.827	Rarely
5. I failed to include the education given about the consequences of refusal to treatment.	1.81	.757	Rarely
6. I failed to record nursing actions done.	1.96	.708	Rarely
7. I deleted the erroneous entry improperly.	1.77	.707	Rarely
8. I recorded on the wrong chart.	1.47	.591	Never
9. I incompletely filled in information on the patient's record.	1.92	.674	Rarely
10. I improperly transcribed the doctor's order.	1.58	.685	Rarely
Mean of Means	1.82		Rarely

Personal Corrective Measures Instituted by the Participants

Data show that in giving medication, the participants check the following: 10Rs/12Rs, medication ticket and drug handbooks (MIMS). While for procedural errors, they double-check the doctor's orders, review the nursing procedure and do a correct assessment of the patient. They also control reporting & referral errors through complete and proper endorsement, accurate assessment, and immediate reports of significant details, as well as double-checking or clarifying the doctor's orders. They minimise charting & recording errors by doing detailed documentation, double-checking what they recorded, and informing the senior or head nurse should they encounter errors.

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 6 (June 2026)

Table 4. *Participants Corrective Measures Instituted (N=144)*

Personal Corrective Measures Instituted	Frequency
A. Medication Errors	
Read drug handbooks, familiarisation with medicine	3
Assessment	2
Presence of mind	1
Double-checking or checking ticket 3 times	6
10Rights/12Rights	7
Read the label and the doctor's orders	2
Skin test all antibiotics	1
Develop system	1
Time management	2
Check route	1
Chart review	1
B. Procedural Errors	
Informed Senior Nurse	2
Double-checking doctors' orders	6
Reported wrong procedures	1
Presence of mind	2
Improve techniques/skills	2
Review the nursing procedure	4
Correct assessment	3
Ask about an unfamiliar procedure	1
Familiarizing procedure	1
Time management	1
Observe hospital protocol	1
Develop system	1
C. Reporting & Referral Errors	
Inform Head Nurse	1
Assess properly and report ASAP	3
Complete and proper endorsement	7
Review patient history	1
Double-check or clarify the doctors' orders	2
Gather complete data before making a referral	1
Presence of mind	1
Always relay important information	1
D. Charting & Recording Errors	
Informed Senior Nurse/Head Nurse	3
Detailed documentation	5
Customize charting	1
Proper reading of orders	1
Presence of mind	1
Doing it properly next time	2
Self-correct	1
Double check	3
Develop system	1

Institutional Corrective Measures Made to Correct Errors Committed

Participants were mostly asked about incidental reports; they were being reminded by the senior

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 6 (June 2026)

or head nurse of their errors, and unit meetings were held. A progressive step of discipline set by DOH and its institutions was said to have been followed in treating error.

Table 5. *Institutional Corrective Measures*

Institutional Corrective Measures Made	Frequency
A. Medication Errors	
Incident Reports	5
Reporting about proper drug administration	1
Inform Seniors and Doctors	1
Discussion	1
Unit meeting	3
Reminded by Senior Nurse	4
B. Procedural Errors	
Reporting & discussion on the failed procedure done	1
Incident Reports	3
Staff evaluation	1
Trainings	1
Unit meeting	3
Clarification with Senior Nurse	3
Oral reprimand	4
Bedside teaching	1
Updates, seminar	1
C. Reporting & Referral Errors	
Incident Reports	3
Unit Meetings	3
Discussion	1
Orientation on Proper Referral	1
Oral reprimand	1
D. Charting & Recording Errors	
Discussion	1
Review nursing process & documentation	1
Incident Reports	3
Unit meetings	2
Senior Nurses teach us/ Coaching	1
Reminded by the Head Nurse	2
Oral reprimand	1

Significant Difference in the Clinical Errors Committed by the Participants when Grouped According to Profile

There were four demographic data points found significant, which imply an increased propensity to commit errors in a specific category of clinical errors, for civil status (single), to medication and procedural errors, status of employment (regular), reporting/referral errors, length of work experience (0-12months) to reporting/referral errors, & number of patients (more than 20 patients a day) in all clinical errors.

Table 6. *Significant Difference in the Clinical Errors Committed by the Beginning Nurse Practitioners When Grouped According to Profile*

Profile	Medication Errors	Procedural Errors	Reporting & Referral Errors	Charting & Recording Errors	Significance
	p – value				
Age	.661	.125	.707	.610	Not Significant

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 6 (June 2026)

Gender	.612	.336	.941	.516	Not Significant
Civil Status	.038	.001	.805	.496	Significant
Status of Employment	.308	.829	.035	.709	Significant
Length of Work Experience	.255	.450	.016	.235	Significant
Area of Assignment	.659	.684	.708	.682	Not Significant
Average Number of Patients in a Day	.050	.014	.019	.003	Significant
Updates, Seminars & Training Attended	.429	.752	.065	.298	Not Significant

Learning and Training Needs

Participants need IVT, review the administration of IV drugs, and be updated about new drugs; they should learn not to disturb the medicating nurse while preparing and during administration.

In terms of enhancing nurse acuity on procedures, it will be helpful to update skills on new procedures through seminars and training, follow basic hospital procedure, be mindful of sterile technique, and be exposed to areas with more procedures to be done. In terms of increasing the grasp of a patient's case, thus preventing reporting & referral errors, a case study is recommended.

Lastly, for improving documentation skills, they should do the proper way of charting, write understandable information in the nurses' notes, review their charting and attend seminars on documentation.

Table 7. *Frequency of Learning/Training Needs of the Participants to Prevent the Commission of a Clinical Error*

Learning/Trainings Needs	Frequency
A. Medication Errors	
Intravenous Therapy	2
Review of the administration of Intravenous drugs	1
Updates about new drugs	1
Basic Life Support	1
Advanced Cardiac Life Support	1
Do not disturb the medicating nurse	1
B. Procedural Errors	
Basic hospital procedures	1
Sterile technique	1
Updates on new procedures	2
Basic Life Support	1
Advanced Cardiac Life Support	1
Exposure to areas	1
C. Reporting and Referral Errors	
Patient Case Study	1
D. Charting and Recording Errors	
Seminars on documentation	1
Proper way of charting & often-missed info in the nurses' notes	2

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 6 (June 2026)

DISCUSSION

Being a beginner has a great impact on working performance. The years of experience in a hospital can be translated to good critical thinking and sound clinical decision-making, thus preventing occurrences of clinical errors; this is consistent with the conclusion of Thompson (2009) and Westbrook, Rob, Woods, and Parry (2011). It also appears that the nursing industry is still female-dominated, but does not indicate an increasing incidence of clinical errors, in contrast to the study of Fry and Dacey, as mentioned by Price-Miller (2009), that women are predisposed to errors as compared to men. They may be novices, but they perform roles that of the regular employees, which has a heavier load and expectations. The number of patients is also equated to an increasing nursing workload, which increases the incidence of clinical errors. On the note that 75 out of 144 have attended the intravenous therapy training may be influenced by the trend that hospitals require nurses to be an IV therapist before they can be hired.

While health care institutions continue to tap into intravenous therapy trainings and updates as a priority, Intravenous medications and fluids administration tops the most common clinical errors. Communication through endorsement is likewise unspared from the inseparability of interruption, which is blamed to result in error; the gap must be bridged with a clear, complete and understandable recording. However, the challenge for all of these clinical errors is to balance nursing workload, increase individual knowledge and improve clarity of endorsement.

The order of clinical errors shows medication and charting lead, followed by reporting/referral, then the charting/ recording. Several studies are also in support of the findings (Cheragi et al., 2013, Berkow and Virktis, 2009, Mrayyon as cited by Eshani, 2013). This has been committed rarely, which is good enough, and this can be attributed to the type of nursing curriculum they were prepared with before becoming a nurse, a similar conclusion to Morrow (2009) and Kenward and Zhong, as cited by Knowles (2013).

On personal efforts, the execution of the 10Rs in medication was challenging because of confusion brought about by the same-sounding names, available medication ticket, and incomplete information about the medicine. Likewise, the issues with confidence in the performance of the procedure is tougher for nurses who are new graduates or those nurses who return to the workplace after a long absence. Apparently, the documentation skill and in making an effective nursing endorsement or relaying patient condition, participants have difficulty managing time and activities, and tends to rush through these activities, which is consistent with the findings of Ward (2013).

Institutional corrective measures were usually guided by the DOH manual and institutional guidelines. They have dialogue with department heads, meetings conducted within each unit/ service for discussion of solutions. However, this lies in reporting the clinical errors. Unfortunately, while participants say to report errors to their heads, some informants deny voluntary reporting, which is supported by Hashemi, Nasrabadi, and Asghari (2012) and Jolaee, Hajibabaiee, Payravi and Haghani (2012). Negative notions are attached to clinical errors affecting the participants' reporting behaviour; this is similar to the report of de Guzman (2012).

Current results on heavy nursing workloads brought about by the number of patients attended greatly influence the commission of clinical errors and therefore affect the quality of care being rendered; this is consistent with the findings of Carayon and Gurses (2008), Stratton, as cited by Gorgich (2015). Health care leaders, likewise, associated workload with nurse-patient ratios, which is in line with the findings of Spetz, Donaldson, Aydin and Brown (2008). Conversely, age, gender, area, and amount of continuing education have comparable risks of experiencing clinical errors.

These results are meaningful for the academe to intensify the preparation of future nurses. Equally, hospitals today assume roles to continue and sustain continuing education programs with the nurses who

have the duty to operate with a genuine understanding of the total situation. As always, continuing education of nursing staff can help, if not eliminate or reduce errors, special emphasis on medication error as advocated by Anderson and Townsend (2013) in their article on "Medication Errors: Don't Let It Happen to You".

CONCLUSION

Clinical errors must be positively perceived as an opportunity to make caring acts more precise and to prevent errors the next time. Medication administration and documentation skills are crucial tasks for every beginning nurse; however, making them competent is a mutual role of individual selves and partners-the hospitals. It is believed that when personal and institutional efforts are collaborated, this will make a tremendous change in their performance, and exquisite nursing care can be expected. Committing errors is never intentional and is understood to compromise both patients' safety and nurses' security; hence, redesigning the structure to improve the system, nursing workload and personal factors may be given special attention.

Recommendation

Practical and theoretical implications based on the conclusion of the study, the researcher makes the following suggestions:

1. Health care professionals should pursue personal and professional education that enhances pharmacological information adeptness and improves their grasp of patient cases to correlate with patient management.
2. Nurse educators to strengthen basic nursing curricula in pharmacology, skills laboratory, mathematics, and chemistry subjects.
3. Health care institutions to introduce or reinforce safe practices that are proven to eliminate or minimise harm to patients through a reporting system, root cause analysis and use of technology.
4. Replication of the study can be done in other areas of the country.
5. Further research can be undertaken with regard to the magnitude of clinical errors in government hospitals compared to that of private hospitals, government hospitals catering to both pay and service patients or to all nurses (new and old) with direct bedside care.

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