Reflection and Quality and Safety Competencies.				
Step	Actions to Address Individual	Rationale	Alignment with QSEN	
	Accountability		Competencies	
1.	Gather information about error			
	from involved instructor			
2.	Meet with student outside of	Provide privacy away		
	clinical site	from environment where		
		error occurred		
3.	Question: Tell me about what	Allow student to share	Quality Improvement	
	happened	perceptions of event and	Recognize that nursing	
		impact on patient care	and other health	
			professions students are	
			parts of systems of care	
			and care processes that	
			affect outcomes for	
			patient and families.	
		Allows student to consider	Patient Centered Care	
		the perspective of the	V	
	happened, would you feel you	the perspective of the patient		
	happened, would you feel you were receiving safe care?			
	were receiving safe care?	patient	V	
6.	were receiving safe care? Question: What strategies can	patient Identify standardized	V Safety	
6.	were receiving safe care? Question: What strategies can you use in your own practice to	patient Identify standardized practices and strategies	V Safe ty Value the contributions	
6.	Were receiving safe care? Question: What strategies can you use in your own practice to minimize the risk for this type	patient Identify standardized	V Safe ty Value the contributions of standardization-	
	Question: What strategies can you use in your own practice to minimize the risk for this type of error in the future?	Identify standardized practices and strategies that support safe practice	V Safe ty Value the contributions of standardization- reliability to safety.	
6.	Were receiving safe care? Question: What strategies can you use in your own practice to minimize the risk for this type of error in the future? Question: Would you be willing	Identify standardized practices and strategies that support safe practice Understand there is	V Safety Value the contributions of standardization- reliability to safety. Quality Improvement	
	Were receiving safe care?Question: What strategies can you use in your own practice to minimize the risk for this type of error in the future?Question: Would you be willing to share your experience with	Identify standardized practices and strategies that support safe practice Understand there is opportunity to improve	V Safe ty Value the contributions of standardization- reliability to safety. Quality Improvement Appreciate the value of	
	Were receiving safe care?Question: What strategies can you use in your own practice to minimize the risk for this type of error in the future?Question: Would you be willing to share your experience with your colleagues in your clinical	Identify standardized practices and strategies that support safe practice Understand there is opportunity to improve safety by	V Safe ty Value the contributions of standardization- reliability to safety. Quality Improvement Appreciate the value of what individuals and	
	Were receiving safe care?Question: What strategies can you use in your own practice to minimize the risk for this type of error in the future?Question: Would you be willing to share your experience with	Identify standardized practices and strategies that support safe practice Understand there is opportunity to improve	V Safe ty Value the contributions of standardization- reliability to safety. Quality Improvement Appreciate the value of	

## Template for Debriefing Following a Student Error Using Reflection and Quality and Safety Competencies.

Anonymous Reporting System	improvement	near-miss and error
		reporting

student submit description of

error to ISMP Medication Error

Emphasizes the impact

event reporting can have

on patient safety and

**Safe ty** 

Use organizational error

reporting systems for

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