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

	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	patient					
	happened, would you feel you were receiving safe care?	patient					
	• • • • • • • • • • • • • • • • • • • •	patient					
	• • • • • • • • • • • • • • • • • • • •	patient					
	• • • • • • • • • • • • • • • • • • • •	patient					
	were receiving safe care?						
6.	were receiving safe care? Question: What strategies can	Identify standardized	Safety				
6.	Were receiving safe care? Question: What strategies can you use in your own practice to	Identify standardized practices and strategies	Value the contributions				
6.	Question: What strategies can you use in your own practice to minimize the risk for this type	Identify standardized	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	Value the contributions of standardization-reliability to safety.				
6.	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	Value the contributions of standardization-reliability to safety. Quality Improvement				
	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	Value the contributions of standardization-reliability to safety. Quality Improvement Appreciate the value of				
	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	Value the contributions of standardization-reliability to safety. Quality Improvement Appreciate the value of what individuals and				
	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	Value the contributions of standardization-reliability to safety. Quality Improvement Appreciate the value of				

	Emphasizes the impact	Safe ty
student submit description of	event reporting can have	Use organizational error
error to ISMP Medication Error	on patient safety and	reporting systems for
Anonymous Reporting System	improvement	near-miss and error
		reporting