QSEN INSTITUTE REGIONAL CENTER AT THE COLLEGE OF NEW JERSEY

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

Step	Actions to Address Individual Accountability	Rationale	Alignment with QSEN Competencies
1.	Gather information about error from involved instructor		
2.	Meet with student outside of clinical site	Provide privacy away from environment where error occurred	
3.	Question: Tell me about what happened	Allow student to share perceptions of event and impact on patient care	**Quality Improvement** Recognize that nursing and other health professions students are parts of systems of care and care processes that affect outcomes for patient and families.
4.	Question: If you were the patient and you knew this happened, would you feel you were receiving safe care?	Allows student to consider the perspective of the patient	**Patient Centered Care** Value seeing health care situations "through patients' eyes".
5.	Question: How did your actions/inactions contribute to what happened?	Opportunity for reflection on individual practice	**Safety** Appreciate the cognitive and physical limits of human performance.
6.	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	**Safety** Value the contributions of standardization-reliability to safety.
7.	Question: Would you be willing to share your experience with your colleagues in your clinical group so that they can learn from this mistake?	Understand there is opportunity to improve safety by reporting/sharing information about errors	**Quality Improvement** Appreciate the value of what individuals and teams can do to improve care.
8.	Question: What outcome do you want to see after this?	Allows for identification of personal and professional goals	**Safety** Value own role in preventing errors.
9.	Question: Do you have any questions?	Opportunity for clarifications	
10.	If medication error, with student submit description of error to ISMP Medication Error Anonymous Reporting System https://www.ismp.org/	Emphasizes the impact event reporting can have on patient safety and improvement	**Safety** Use organizational error reporting systems for near-miss and error reporting

Step	Actions to Address System Accountability	Rationale	Alignment with QSEN Competencies
1.	Share information with involved instructor regarding meeting and student reflection	Partnership between clinical instructor and theory instructor/course leader supports student learning	**Teamwork and Collaboration** Appreciate importance of intra-and interprofessional collaboration
2.	Contact Simulation Coordinator to discuss implementation activities to address knowledge and skill deficits associated with the error	Address gaps between local and best practices	**Teamwork and Collaboration** Value the influence of system solutions in achieving effective team functioning
3.	Contact Fundamentals of Nursing course coordinator to discuss integrating activity to address knowledge deficits associated with the error	Address gaps between local and best practices	**Quality Improvement** Appreciate the value of what individuals and teams can do to improve care
4.	Identify area within student's current course where activity can be included to address knowledge deficits associated with the error	Address gaps between local and best practices	**Quality Improvement** Appreciate that continuous quality improvement is an essential part of the daily work of all health professionals