<table>
<thead>
<tr>
<th>Step</th>
<th>Actions to Address Individual Accountability</th>
<th>Rationale</th>
<th>Alignment with QSEN Competencies</th>
</tr>
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<tbody>
<tr>
<td>1.</td>
<td>Gather information about error from involved instructor</td>
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</table>
| 2.   | Meet with student outside of clinical site | Provide privacy away from environment where error occurred | 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. |
| 3.   | Question: Tell me about what happened | Allow student to share perceptions of event and impact on patient care |                                  |
| 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/](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 |
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| 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 |