PROBLEM
Changes in health care related to quality and safety have not been translated well into our undergraduate nursing curriculum. The traditional dominant approach to student errors made in clinical has been a “culture of blame”, in which a student is held accountable for clinical errors, regardless of the course of mistake. This approach has led to student nurses’ fearing to report errors made in practice.

BACKGROUND
- In any given semester, 90–130 clinical errors/near misses are reported by students. There was no formal process for analysis of trends and implementing improvements within curriculum.
- A 2016 survey of 300 BSN students in levels 1–6 confirmed our students fear report errors made in practice.
- The previous BCIT BSN “Incident Report Form” was seen as punitive and based on individual mistakes, rather than from a systems and human factors perspective.
- The “incident report form” was 20 years old and did not reflect the current language used to describe safety events/near misses in the health care setting.

AIM
Create a new safety reporting system that will:
- Emphasize the complexities of safety events/near misses in the health care system
- Promote a blame free, positive learning process
- Collect statistics to identify gaps in practice + impact of teaching strategies
- Prevent or minimize risk of harm to patients
- Develop safety behaviors in nursing students
- Increase feeling of safety for students.

APPLICATION OF THE SAFETY EVENT REPORTING AND LEARNING TOOL TO DATE:
- Developed a Safety Event Reporting and Learning Tool for faculty and students
- Implemented in September 2016 semester and January 2017 semester with 1100 students
- Received 150 safety event/near misses (med errors, blood exposure, policy breaches, needle stick injuries, etc.)
- Delivered 2 professional development seminars to colleagues on how to use the tool
- Created a new safety reporting system that will:
- Facilitate a just culture
- Encourage reporting to prevent or minimize risk of harm to patients
- Improve teaching strategies in the classroom and clinical setting

ACKNOWLEDGEMENTS
To Dr. Lenora Marcellus, Faculty, University of Victoria who contributed greatly to our understanding of best practices to improve safety behaviors in health care.

REFERENCES