NCPS
Nebraska Coalition for Patient Safety

DEBRIEF FACT SHEET

What is a debrief?

A debrief that is intended to improve system performance is a short, structured team meeting[1] conducted after an event by a designated leader within a work area or department.[2]

When can debriefs be conducted?

Debriefs can be conducted after unexpected negative (or positive) outcomes in clinical and non-clinical areas.

Who should conduct debriefs?

Designated leaders (i.e. manager/supervisor) of departments/work areas or shifts conduct debriefs as a leadership strategy.[2]

What training do designated leaders need to facilitate effective debriefs?

Leaders should be trained to use structured guides to ensure members attending debriefs:[3]

1. feel psychologically safe to speak up about what they observed and did during the event
2. make sense of what happened and why
3. reflect on the effectiveness of their teamwork and communication
   - ✓ Did team members have a shared mental model of the goal and their role in achieving the goal?
   - ✓ Did team members use closed-loop communication?
   - ✓ Did team members have a shared mental model of the urgency?
   - ✓ Did team members seek and offer task assistance?

What are the outcomes of effective debriefs?

Effective debriefs are short (3 – 10 minutes), structured, and facilitated by a trained designated leader; their outcomes include:

1. Improved team performance[4] such as...
   - ✓ Improved management of OB hemorrhage and decreased risk of unplanned hysterectomies[5]
   - ✓ Improved adherence to new clinical practices[5]
   - ✓ Decreased risk of adverse events in surgery[6,7]
   - ✓ Improved efficiency in the OR[7]
   - ✓ Decreased risk of repeat events such as falls[8]
2. Improved perceptions of safety culture[8,9]
3. Improved trust and teamwork among team members[8]

What resources are needed to conduct effective debriefs?

1. Support from senior leaders, department managers, and providers[3]
2. A coordinating team to plan and standardize the debrief program[8] across the organization including
   - o Structured guides to conduct generic and event-specific debriefs (i.e. OB events, surgical events, and post-fall huddles)
   - o Training program for designated leaders
   - o Log or database to track lessons learned during debriefs to improve systems

[1] Scott C, Allen JA, Bonilla D, et al. Ambiguity and freedom of dissent in post incident discussion. Journal of Business Communication. 2013;50: 383– 402. http://dx.doi.org/10.1177/0021943613497054
[2] Agency for Healthcare Research and Quality (AHRQ). TeamSTEPPS. Available at: https://www.ahrq.gov/teamstepps/index.html
[3] Allen J, Reiter-Palmon R, Crowe J. Debriefs: Teams learning from doing in context. American Psychologist. 2018;73:504-516.
[4] Tannenbaum SI, Cerasoli CP. Do team and individual debriefs enhance performance? A meta-analysis. Human Factors. 2013;55:231-245.
[5] Corbett N, Hurko P, Vallee JT. Debriefing as a strategic tool for performance improvement. JOGNN. 2012;41:572-579.
[6] Magill ST, Wang DD, Rutledge WC, et al. Changing operating room culture: Implementation of a postoperative debrief and improved safety culture. World Neurosurgery. 2017;107:597-603.
[7] Wolf FA, Way LW, Stewart L. The efficacy of medical team training: improved team performance and decreased operating room delays: a detailed analysis of 4863 cases. Ann Surg. 2010;252:477–485.
[8] Jones KJ, Crowe J, Allen J, et al. The impact of post-fall huddles on repeat fall rates and perceptions of safety culture: a quasi-experimental evaluation of a patient safety demonstration project. BMC Health Services Research.2019;19(650):1-14. https://doi.org/10.1186/s12913-019-4453-y
[9] Berenholtz SM, Schumacher K, Hayanga AJ, et al. Implementing Standardized operating room briefings and debriefings at a large regional medical center. The Joint Commission Journal on Quality and Patient Safety. 2009;35:391-397.