Implementing and Sustaining Effective Debriefs: Support Call 2

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The speaker(s) and planning committee have no relevant financial relationships to disclose.

Welcome!

Slides and notes from this call will be posted in the Debrief Toolkit on the NCPS website.

https://www.nepatientsafety.org/resources-tools/patient-safety-improvement-tools/debrief-toolkit.html

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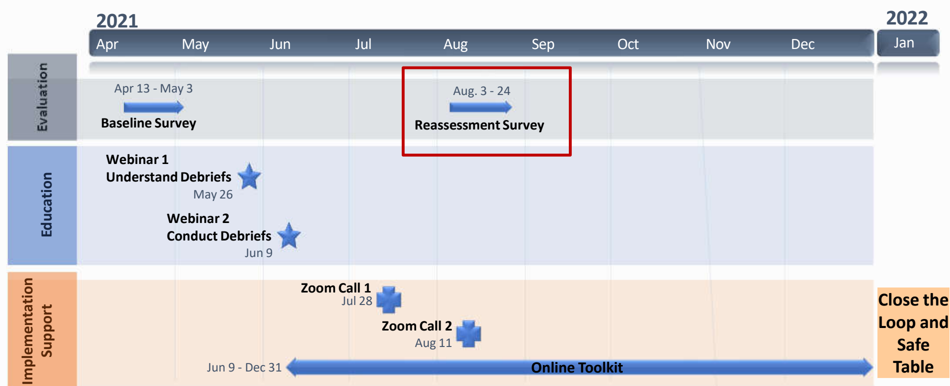
Debrief Collaborative Timeline



Debrief Toolkit Available at:
https://www.nepatientsafety.org/resources-tools/patient-safety-improvement-tools/debrief-toolkit.html

Call Agenda

1. Review strategy: implement debriefs for system improvement, which is facilitated by using categories of organizational errors to determine causes of preventable errors
2. Share barriers and successes to teaching leaders to use the concept of organizational errors when conducting debriefs
3. Review Next Steps including Safe Table in January to compare experiences teaching leaders to use the concept of organizational errors

Strategy: Debriefs to Improve System Outcomes

Debrief—

A specific type of team meeting in which members discuss, make sense of, and learn from a recent event in which they collaborated with the goal of improving system performance.

(Scott, Allen, Bonilla, et al., 2013; AHRQ, TeamSTEPPS)

Structure: Debrief Pocket Guide

Available at: https://www.nepatientsafety.org/resources-tools/patient-safety-improvement-tools/debrief-toolkit.html

By definition, if an error/event was preventable, there were one or more errors. The fix for an error depends upon its origin.

DEBRIEF POCKET GUIDE

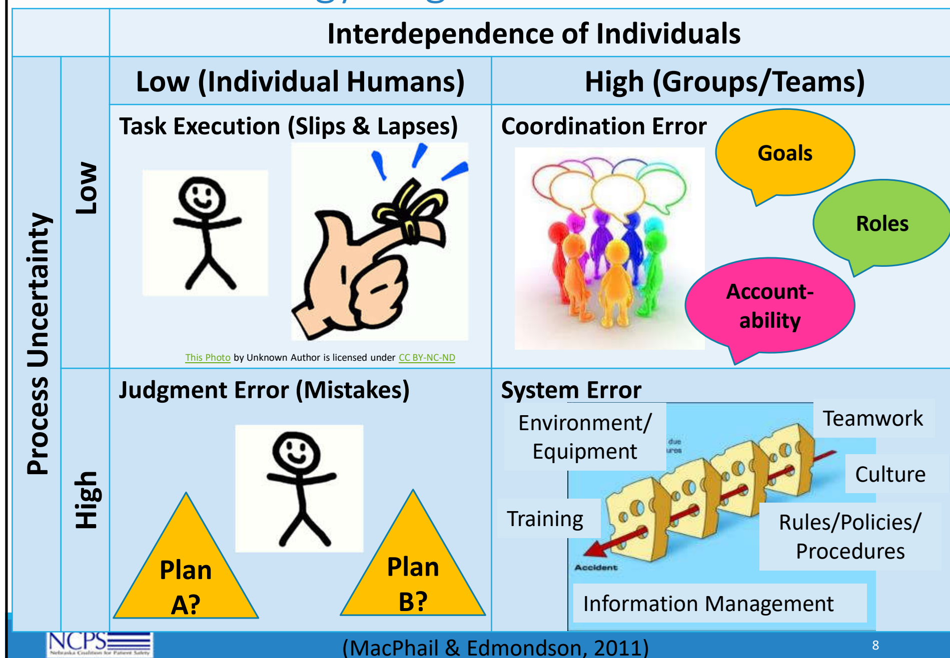
DEBRIEF STRUCTURE

1. Ask: What happened during the task/procedure/event?
   - ✓ What was different this time?
   - ✓ Ask why regarding unexpected outcomes of steps in task/procedure/event.
2. Ask: What happened related to teamwork and communication?
   - ✓ Goal(s) clear?
   - ✓ Roles clear?
   - ✓ Communication closed-loop?
   - ✓ Shared mental model of situation (e.g., urgency)?
   - ✓ Assistance sought & offered?
3. Ask: How could we have prevented negative outcomes? How do we duplicate positive outcomes?
4. Ask: What will we do differently going forward?
   - ✓ For this patient?
   - ✓ For the system as a whole?
5. Ask: What do we need to communicate to others?
6. Give constructive feedback.
7. Document outcomes in debrief log.

DEBRIEF FACILITATOR OBJECTIVES

1. Create a **psychologically safe** environment focused on learning and mutual support (*"We are here to better understand what happened, why it happened, and how we can improve our clinical skills and teamwork."*)
   - ✓ Call on team member with **least status to share first.**
   - ✓ **Listen** for what is/is **not said**.
   - ✓ Elicit facts, **do not judge**.
   - ✓ Ask additional team members to **share in turn**.
   - ✓ **Thank/praise** each team members' contribution ("Thank you," "good point").
2. Avoid immediately accepting the simplest explanation by asking **"why?"** multiple times to ensure a shared mental model of clinical and teamwork.
3. **Summarize errors** in terms of individual errors (task & judgement), coordination errors, and system errors.
4. **Summarize next steps.**
5. **Thank** all team members.

Strategy: Organizational Errors



Process Uncertainty	Interdependence of Individuals: Low (Individual Humans)	Interdependence of Individuals: High (Groups/Teams)
Low	Task Execution (Slips & Lapses)	Coordination Error (Goals; Roles; Account-ability)
High	Judgment Error (Mistakes) (Plan A?; Plan B?)	System Error (Environment/ Equipment; Teamwork; Culture; Training; Rules/Policies/ Procedures; Information Management)

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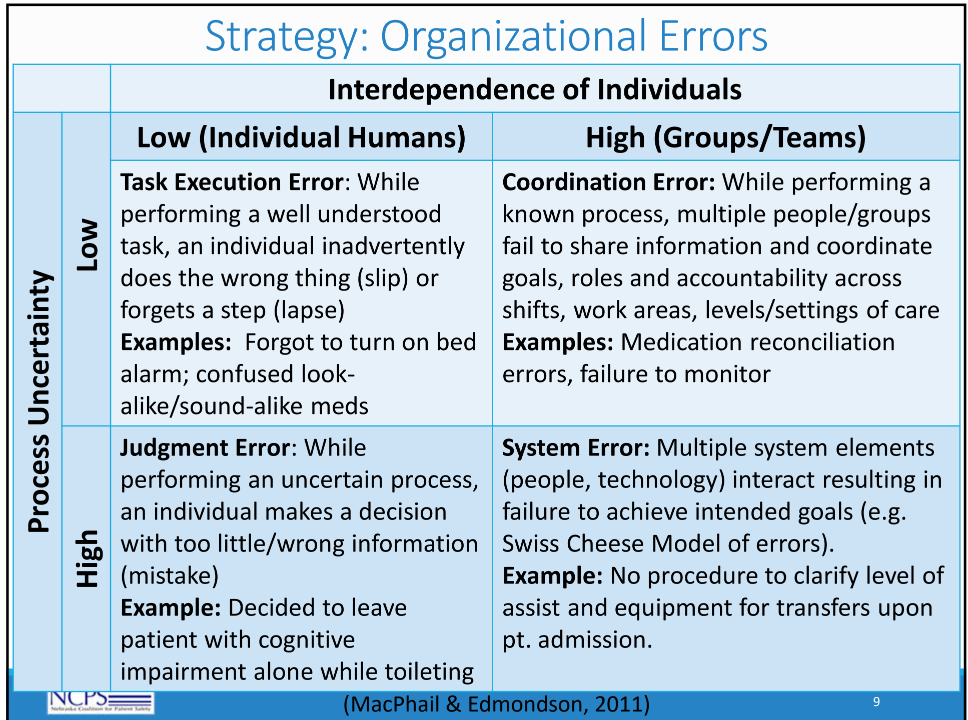
(MacPhail & Edmondson, 2011)


Strategy: Organizational Errors
Interdependence of Individuals
Low (Individual Humans)
High (Groups/Teams)
Process Uncertainty
Low
High
Task Execution Error: While performing a well understood task, an individual inadvertently does the wrong thing (slip) or forgets a step (lapse)
Examples: Forgot to turn on bed alarm; confused look-alike/sound-alike meds
Coordination Error: While performing a known process, multiple people/groups fail to share information and coordinate goals, roles and accountability across shifts, work areas, levels/settings of care
Examples: Medication reconciliation errors, failure to monitor
Judgment Error: While performing an uncertain process, an individual makes a decision with too little/wrong information (mistake)
Example: Decided to leave patient with cognitive impairment alone while toileting
System Error: Multiple system elements (people, technology) interact resulting in failure to achieve intended goals (e.g. Swiss Cheese Model of errors).
Example: No procedure to clarify level of assist and equipment for transfers upon pt. admission.
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(MacPhail & Edmondson, 2011)
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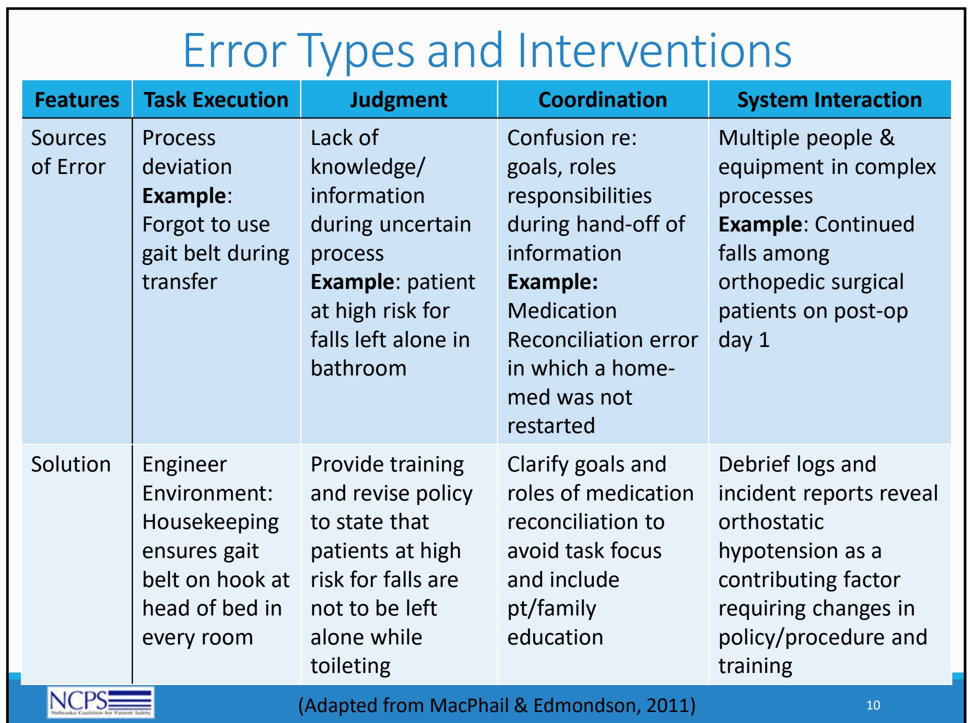
Error Types and Interventions
Features
Task Execution
Judgment
Coordination
System Interaction
Sources of Error
Process deviation Example: Forgot to use gait belt during transfer
Lack of knowledge/ information during uncertain process Example: patient at high risk for falls left alone in bathroom
Confusion re: goals, roles responsibilities during hand-off of information Example: Medication Reconciliation error in which a home-med was not restarted
Multiple people & equipment in complex processes Example: Continued falls among orthopedic surgical patients on post-op day 1
Solution
Engineer Environment: Housekeeping ensures gait belt on hook at head of bed in every room
Provide training and revise policy to state that patients at high risk for falls are not to be left alone while toileting
Clarify goals and roles of medication reconciliation to avoid task focus and include pt/family education
Debrief logs and incident reports reveal orthostatic hypotension as a contributing factor requiring changes in policy/procedure and training
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(Adapted from MacPhail & Edmondson, 2011)
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Share barriers to teaching leaders to use the concept of organizational errors when conducting debriefs

1. Lack of structure can be a barrier, thus the structured pocket guide is best for novices.
2. Considering organizational error types is an advanced skill that requires additional time and must be included in facilitator training. However, the categories facilitate objective labeling of errors in an organizational context. This language should simplify the performance improvement work needed to improve systems and reflects management's accountability for system design.
3. Timing of debriefs; it is best to conduct as soon as possible after patient needs are met but always within the same shift to avoid memory loss.
4. Staffing mix may be associated with error types; work arounds represent system errors associated with low staffing.

Share successes teaching leaders to use the concept of organizational errors when conducting debriefs

1. CHI uses debriefs in the context of their SAFETY FIRST program, which includes conducting debriefs. They perceive of the pocket guide and organizational error taxonomy and providing additional structure.
2. All levels of administration can reinforce importance of conducting debriefs and analyzing the data about error types to support organizational learning and system improvement.
3. Sharing learnings from the debriefs with all staff reinforce their value.

Putting it All Together

Implementation Strategy	Tools/Structures
Define the need for debriefs	Event reports, repeat events, Safety Culture Survey Results
Obtain support from Senior Leaders	Educate and persuade using Debrief Fact Sheet
Senior Leaders provide resources and support establishment of Debrief Coordinating Team	Debrief Coordinating Team Charter
Debrief Coordinating Team Standardizes and Plans Debrief Program	Debrief Policy/Procedure Debrief Training for Designated Leaders Debrief Fact Sheet Structured Debrief Guides Online Videos of Debriefs Work Area/Unit Debrief Log Debrief Database
Designated Leaders implement debriefs	Structured Debrief Guides Work Area/Unit Debrief Log

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Next Steps

- Review NCPS Debrief Toolkit for structures to support your strategy https://www.nepatientsafety.org/resources-tools/patient-safety-improvement-tools/debrief-toolkit.html
- Tell me about your barriers, successes, needs (kjjones57@gmail.com)
- Aug 3 – 24: Respond to Reassessment Survey
- Nov. 10: TeamSTEPPS Primer at NHA Rural QI Pre-Conference 1-5 pm, Kearney, NE
- January 2022 (date TBD) Safe Table to share your experience implementing debriefs and tracking organizational errors

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Homework: Track Debrief Outcomes

- Use/Adapt Debrief Log (for facilitators) and Database Templates (for Debrief Coordinating Team) in Toolkit
- Share results of lessons learned at Safe Table in January

Date	Facilitator Initials	Event	Error Type*	Actions Taken	Lessons Learned

*Task = While performing a well understood task, an individual inadvertently did the wrong thing (slip) or forgot a step (lapse)
Judgment = While performing an uncertain process, an individual made a decision with too little/wrong information (mistake)
Coordination = While performing a known process, multiple people failed to share information and coordinate goals, roles and accountability across shifts, work areas, levels/settings of care
System = Multiple system elements (people, technology) interact resulting in failure to achieve intended goals

Summary

(Iflaifel et al, 2020; Hollnagel et al., 2006; Jones, Crowe, Allen et al., 2019; Berenholtz et al., 2009)

Improved Perceptions of Safety Culture

- ✓ Teamwork
- ✓ Team Structure
- ✓ Team Leadership
- ✓ Leadership Support for Safety
- ✓ Organizational Learning
- ✓ Response to Error

Structured
Short
Trained Facilitator

Improved System Outcomes

(Tannenbaum & Cerasoli, 2013; Corbett et al., 2012; Jones, Crowe, Allen et al., 2019; Magill et al., 2017)

Opportunity for Patient/Staff Education

Improved Performance

Decreased Risk of

- ✓ Massive Transfusion for OB Hemorrhage
- ✓ Unplanned Hysterectomy
- ✓ Repeat Falls
- ✓ Surgical Adverse Events

TRUST

Organizational Resilience

Questions and Contact Information

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