Debriefs: An Evidence-based Team Leadership Tool to Improve Performance and Patient Safety

AUGUST 20, 2020

Katherine J. Jones, PT, PhD
President, NCPS Board of Directors

NCPS Nebraska Coalition for Patient Safety

1

1

Welcome!

This webinar will be recorded and available on the members-only page of the NCPS website (www.nepatientsafety.org).

Continuing Education Credit will only be available for participants who attend the live webinar. CE credit is not available for viewing the webinar recording. Participants are in listen-only mode.

- If you have questions, please type them in the question box.
- If we are unable to answer your question during the webinar, we will do our best to provide answers via email after the webinar.

If we experience technical difficulties, and our connection to attendees is lost, we will make one attempt to reconnect and will continue the program.

If we are unsuccessful with reconnecting, the date of the rescheduled program will be communicated to you via email as soon as it is made available.

NCPS

2

2

Continuing Medical Education Credit

This program has been approved to award 1.0 hour of continuing medical education.

The Nebraska Medical Education Trust designates this webinar for 1.0 AMA PRA Category 1 Credit(s).™ Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of Nebraska Medical Education Trust and the Nebraska Coalition for Patient Safety. The Nebraska Medical Education Trust is accredited by the Nebraska Medical Association to provide continuing medical education for physicians.

Participants must attend the entire event to get CE credit.

All attendees will be emailed a link to an attestation of attendance, and a link to an online program evaluation that we ask you to complete by Wednesday, June 2 in order to receive continuing education credit.

3

3

Nursing Continuing Education Credit

This program has been approved to award 1.0 hour of continuing education for nurses.

Continuing Education Contact Hours awarded by Iowa Western Community College, Iowa Board of Nursing Provider #6.

Participants must attend the entire event to get CE credit.

All attendees will be emailed a link to an online program evaluation that we ask you to complete by Wednesday, June 2 in order to receive continuing education credit.

Nurse attendees who desire continuing education credit are required to register and create a personal profile on Iowa Western Community College's web site.

- The email that is sent with a link to the program evaluation will contain a pdf attachment with instructions. Please read these!
- Completed profile and CE registration need to be submitted by Wednesday, June 2 in order to receive continuing education credit.

4

4

Funding Acknowledgement

Nebraska Department of Health and Human Services, Division of Public Health, Office of Rural Health

Planning Support

Bryan Health Rural Division – Jayne VanAsperen, RN

CHI Health Nebraska, CAH Network – Nikki Clement, MSN, RN

Nebraska Perinatal Quality Improvement Collaborative – Peggy Brown, DNP, RN, CPHQ

Nebraska Association for Healthcare Quality Risk and Safety – Darcy Ost, RN, BSN

Nebraska Coalition for Patient Safety – Gail Brondum, LPN, BS; Katherine Jones, PT, PhD

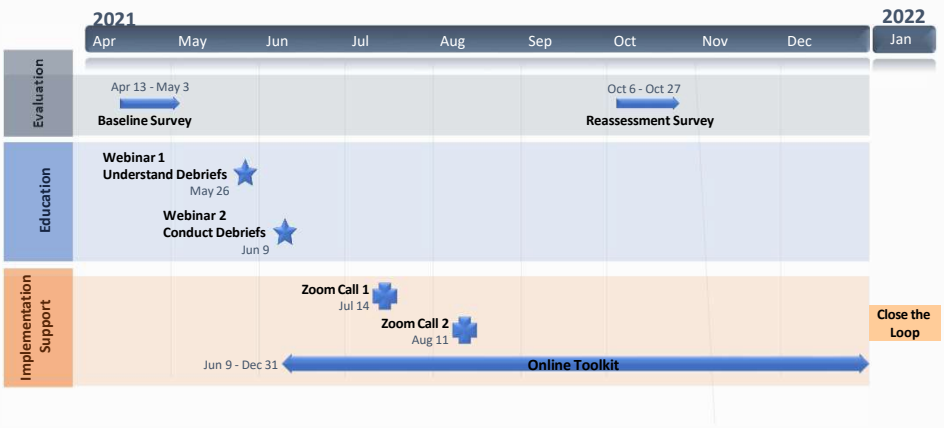
Nebraska Hospital Association – Margaret Woeppel, MSN, RN CPHQ

Disclosure

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

5

Debrief Collaborative Timeline



6

Objectives

1. Define debriefs as team meetings in which members discuss and make sense of a recent event in which they collaborated.
2. Recognize debriefs as a team leadership strategy that is integral to all other components of the teamwork system.
3. Explain the structure and organizational context of effective debriefs in which the goal is to improve system outcomes.
4. Summarize the evidence base regarding the impact of effective debriefs on organizational resilience, team performance, and patient outcomes.

NCPS

7

7

Objective 1

Define debriefs as team meetings in which members discuss and make sense of a recent event in which they collaborated.

8

8

Define Debriefs...what is a debrief?

A specific type of team meeting in which members discuss, make sense of, and learn from a recent event in which they collaborated. (Scott, Allen, Bonilla, et al., 2013)

- What is a team?
  - ✓ Two or more people
  - ✓ Interact dynamically, interdependently, and adaptively
  - ✓ Toward a common and valued goal (14% of team function)
  - ✓ Have complementary skills and specific roles (12% of team function)
  - ✓ Have a time-limited membership

(Salas, DiazGranados, Weaver, et al. , 2008)

NCPS

9

9

Make Sense of and Learn from an Event

Sensemaking is "the active process of assigning meaning to ambiguous data."

"The most fundamental level of data about patient safety is in the lived experience of staff, as they struggle to function within an imperfect system."

Sensemaking is a conversation among members of an organization about an unexpected, novel or ambiguous event that is conducted by a trained facilitator.

(Battles et al., 2006)

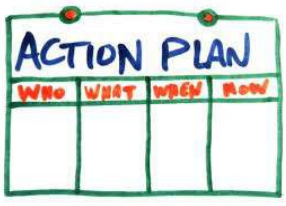
NCPS

10

10

Sensemaking is a Conversation

- Each team member brings their unique knowledge and experience of the event to the conversation
- A facilitator uses a structured process to help team members combine these unique perspectives into a new shared mental model of what happened
- Team members use this shared mental model to develop an action plan that decreases risks/hazards to individual patients and the system



(Battles et al., 2006)

11

Based on the Goal: 3 Types of Debriefs

Team Performance Debrief	Simulation Debrief	Critical Incident Stress Debrief
Goal: Systems Improvement	Goal: Formative feedback	Goal: Prevent and or decrease traumatic stress
Focus: What Happened/Why	Focus: Improvement in task/team skills	Focus: Individual resilience/recovery

(Twigg, 2020; Harrison and Wu, 2017)

12

Clarifying Debrief-Related Terms

(Allen, Reiter-Palmon, Crowe, 2018)

Military: After Action Review

First Responder: After Event Review

Aviation: Post-Flight Check

Healthcare: Briefs, Huddles, Debriefs

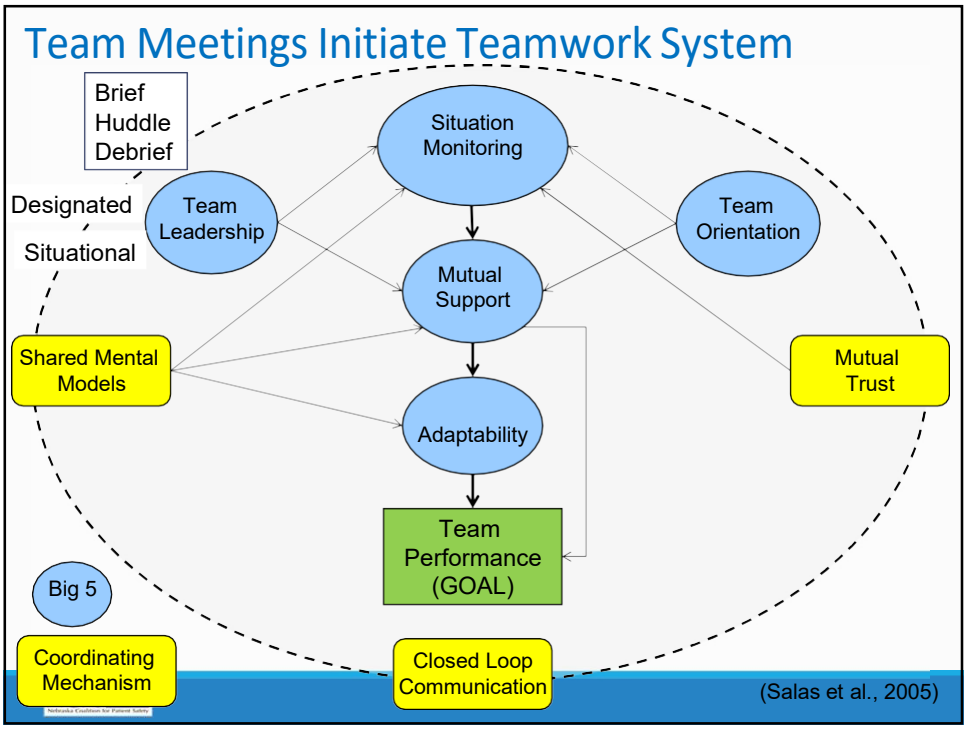
https://www.unmc.edu/patient-safety/capturefalls/learningmodules/huddles.html

13

Objective 2

Recognize debriefs as a team leadership strategy that is integral to all other components of the teamwork system.

14



15

Team Meetings Manage Performance

Effective team leaders use three types of meetings to manage team performance:

1. Brief: short, planned meeting to share the plan and organize the team
   - ✓Clarify goals, roles, and responsibilities (delegate)
   - ✓Anticipate needs, establish contingencies, manage resources
   - ✓Know the plan, share the plan, review the risks
2. Huddle: ad hoc meeting to monitor and adjust the plan
   - ✓Share information from individual situation monitoring
   - ✓Provide opportunities to seek and offer task assistance
3. Debrief: planned or ad hoc meeting to review the plan and team performance after event
   - ✓Review what happened and why it happened (regarding both task AND teamwork)
   - ✓Decide what will be done differently for a patient and what can be applied to the system
   - ✓Provide feedback and resolve conflict

(AHRQ, TeamSTEPPS)

NCPS

16

16

Briefs

Nursing Shift Change

Surgical Pre-procedure Check-In, Sign-In, Time-Out

Whole Hospital Morning Brief

Huddles

Called as needed by designated or situational leaders to manage changing circumstances

Debriefs

Falls

Medication Errors

Surgical Sign-Out

Codes

Rapid Response

Obstetric Incidents

System Failures

NCPS

(AHRQ, TeamSTEPPS)

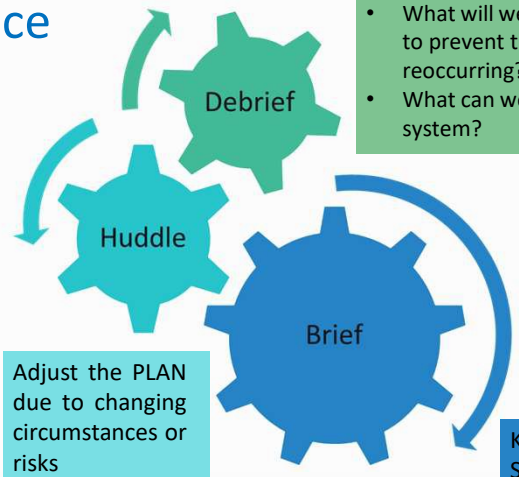
17

17

Leadership Tools to Manage Team Performance

"Briefs, huddles, and debriefs need to be routine... help establish a culture of safety and ensure successful implementation of safety bundles."

(Main et al., 2015. National Partnership for Maternal Safety: Consensus Bundle on Obstetric Hemorrhage)



Review the PLAN and team performance after event

- What happened?
- Why did it happen?
- What will we do differently to prevent this event from reoccurring?
- What can we apply to the system?

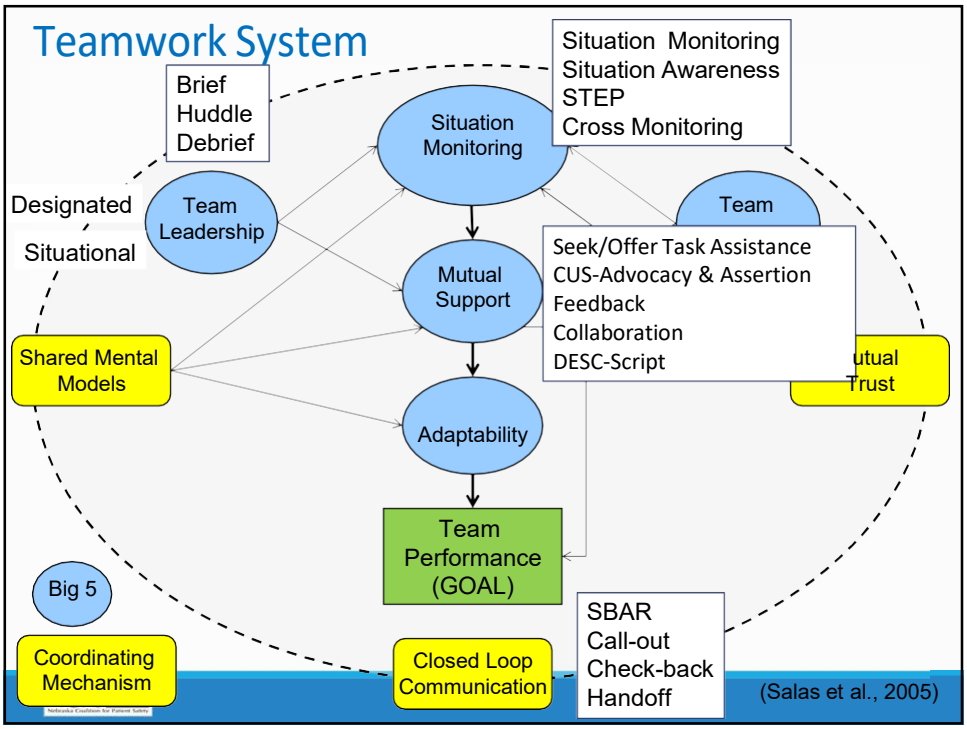
Adjust the PLAN due to changing circumstances or risks

Know the PLAN
Share the PLAN
Review the RISKS

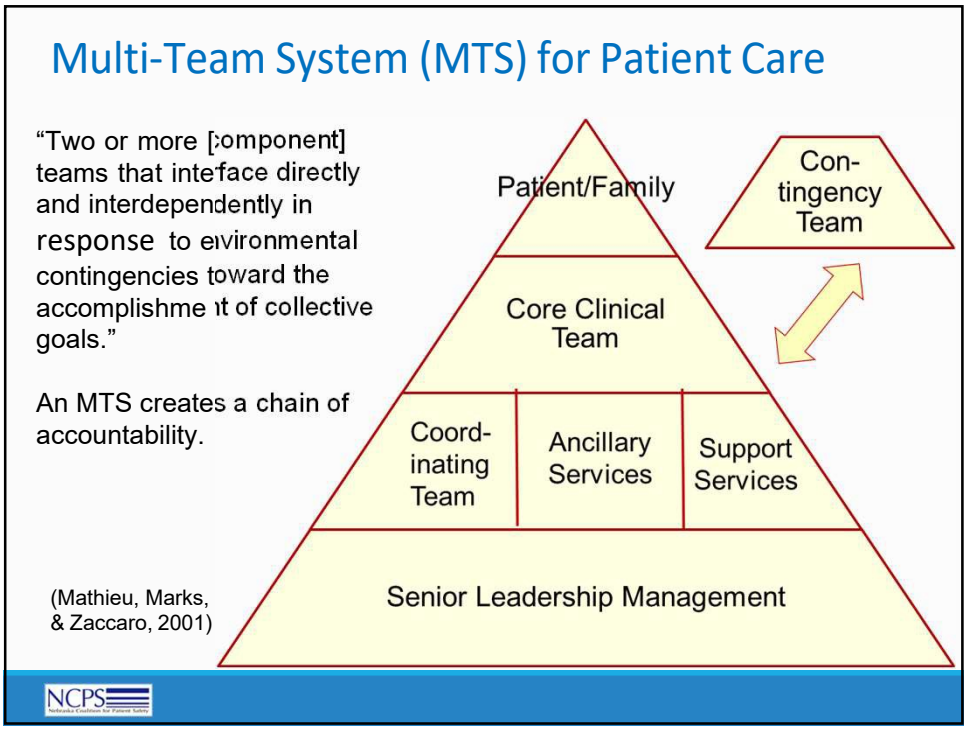
NCPS

18

18


Teamwork System
Situation Monitoring
Situation Awareness
STEP
Cross Monitoring
Brief
Huddle
Debrief
Situation Monitoring
Designated
Situational
Team Leadership
Team
Mutual Support
Seek/Offer Task Assistance
CUS-Advocacy & Assertion
Feedback
Collaboration
DESC-Script
Shared Mental Models
utual Trust
Adaptability
Team Performance (GOAL)
Big 5
Coordinating Mechanism
Closed Loop Communication
SBAR
Call-out
Check-back
Handoff
(Salas et al., 2005)

19


Multi-Team System (MTS) for Patient Care
"Two or more [component] teams that interface directly and interdependently in response to environmental contingencies toward the accomplishment of collective goals."
An MTS creates a chain of accountability.
(Mathieu, Marks, & Zaccaro, 2001)
Patient/Family
Con-tingency Team
Core Clinical Team
Coord-inating Team
Ancillary Services
Support Services
Senior Leadership Management
NCPS

20

Debriefs: First step to implementing a teamwork system

Train all staff in closed-loop communication, situation monitoring, and mutual support

Coordinating Team trains leaders to conduct briefs and huddles

Facilitators elicit team members' situational awareness and provide opportunity to seek/offer task assistance

Trained facilitators conduct debriefs

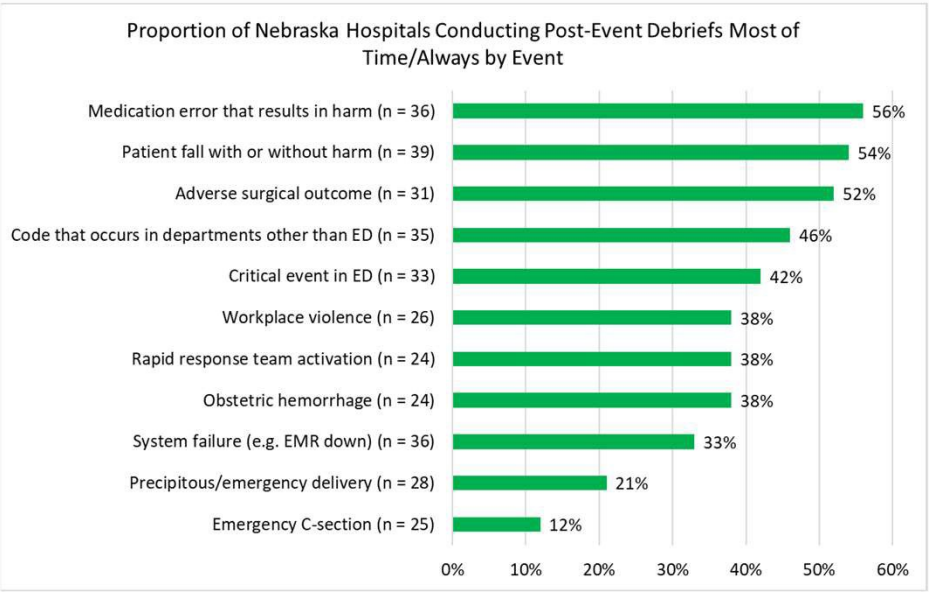
Coordinating Team standardizes/plans debrief program including leadership training

NCPS

21

21

When are we conducting debriefs?



NCPS

22

22

Objective 3

Explain the structure and organizational context of effective debriefs in which the goal is to improve system outcomes.

23

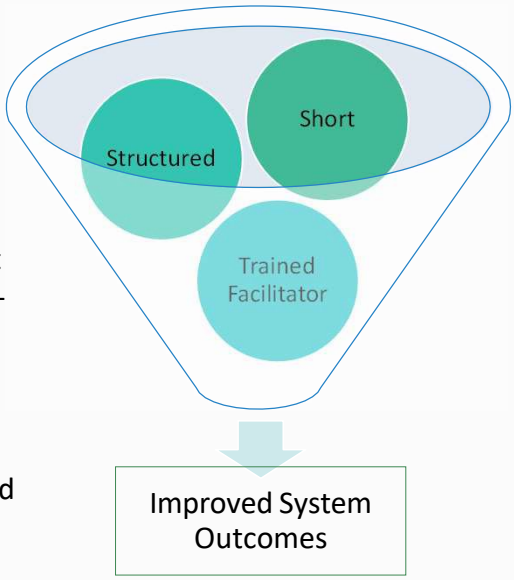
23

Characteristics of Effective Debriefs

(Allen et al., 2019; Tannenbaum & Cerasoli, 2013; Smith-Jentsch et al., 2008; Smith-Jentsch et al., 1998)

Structure is Needed to...

- ✓ Ensure focus on specific situation AND on how decisions were made (right decision and right decision-making process)
- ✓ Avoid conflict
- ✓ Summarize both positive (what went well) and negative feedback (what did not go well)



NCPS

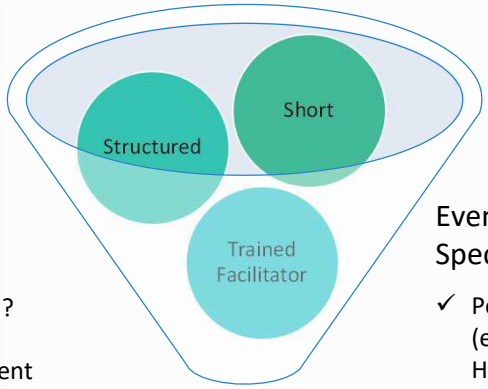
24

24

Characteristics of Effective Debriefs

(Allen et al., 2019; Tannenbaum & Cerasoli, 2013; Smith-Jentsch et al., 2008)

Examples available at: https://www.nepatientsafety.org/members/patient-safety-toolkits/



Generic Structure

- ✓ Create a safe environment
- ✓ Begin with those with least status
- ✓ What happened?
- ✓ Why did it happen?
- ✓ What will we do differently to prevent recurrence of this event? (consider task and teamwork)
- ✓ What can we apply to the system?

Event/Context Specific Structure

- ✓ Peri-natal Events (e.g. OB Hemorrhage)
- ✓ Post-fall Huddle
- ✓ Surgery – (Integral to Comprehensive Surgical Checklist)

Improved System Outcomes

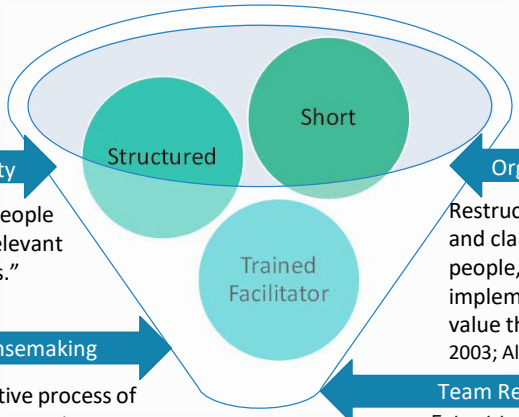
NCPS

25

25

Context of Effective Debriefs

(Allen et al., 2019)



Psychological Safety

"A climate in which people feel free to express relevant thoughts and feelings." (Edmondson, 2012)

Organizational Support

Restructure the organization and clarify roles to provide people, training, time to implement changes; overtly value the change (Rogers, 2003; Allen et al., 2012)

Sensemaking

"...the active process of assigning meaning to ambiguous data." (Edmondson, 2012)

Team Reflexivity

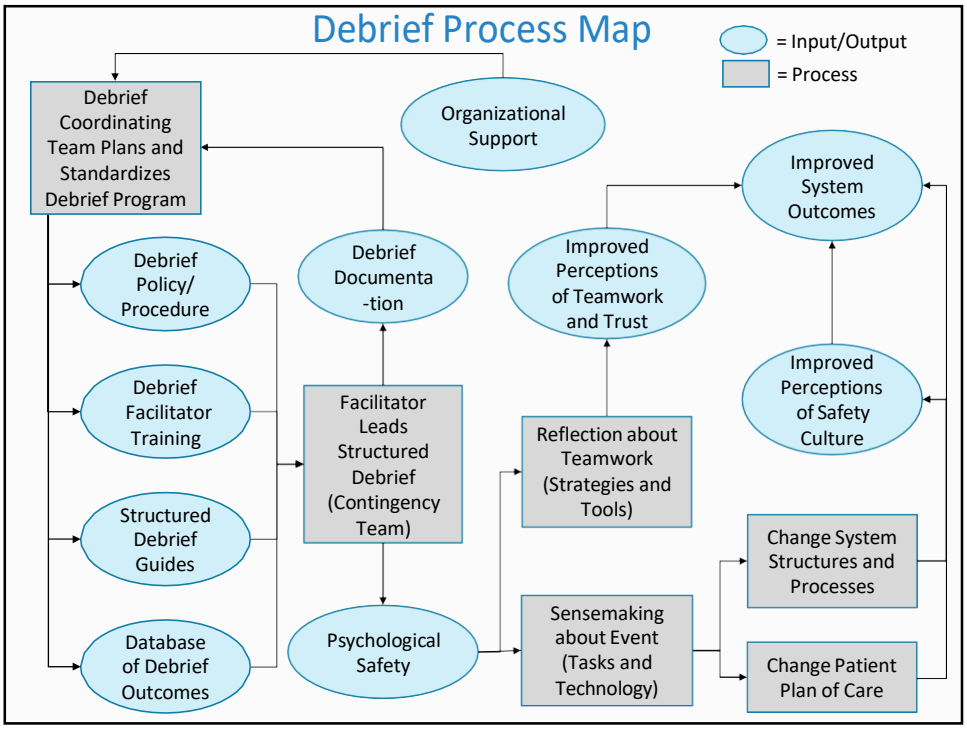
Extent to which team members reflect upon the team's goals, decision-making strategies, and processes (West, 2000)

Improved System Outcomes

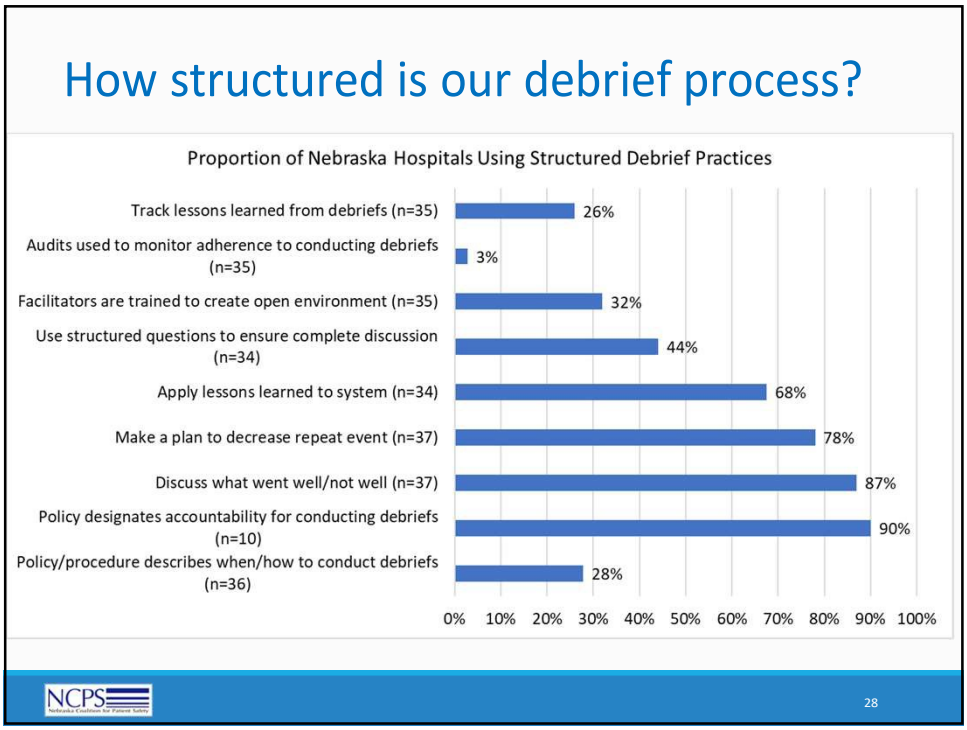
NCPS

26

26


Debrief Process Map
= Input/Output
= Process
Debrief Coordinating Team Plans and Standardizes Debrief Program
Organizational Support
Improved System Outcomes
Debrief Policy/ Procedure
Debrief Documenta -tion
Improved Perceptions of Teamwork and Trust
Improved Perceptions of Safety Culture
Debrief Facilitator Training
Facilitator Leads Structured Debrief (Contingency Team)
Reflection about Teamwork (Strategies and Tools)
Change System Structures and Processes
Structured Debrief Guides
Sensemaking about Event (Tasks and Technology)
Database of Debrief Outcomes
Psychological Safety
Change Patient Plan of Care

27


How structured is our debrief process?
Proportion of Nebraska Hospitals Using Structured Debrief Practices
Track lessons learned from debriefs (n=35)
26%
Audits used to monitor adherence to conducting debriefs (n=35)
3%
Facilitators are trained to create open environment (n=35)
32%
Use structured questions to ensure complete discussion (n=34)
44%
Apply lessons learned to system (n=34)
68%
Make a plan to decrease repeat event (n=37)
78%
Discuss what went well/not well (n=37)
87%
Policy designates accountability for conducting debriefs (n=10)
90%
Policy/procedure describes when/how to conduct debriefs (n=36)
28%
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
NCPS
28

28

Objective 4

Summarize the evidence base regarding the impact of effective debriefs on organizational resilience, team performance, and patient outcomes.

29

29

Debriefs Improve Organizational Resilience

Systematic review of 36 studies sought to understand factors associated with resilient health care. Resilience refers to a system's ability to manage complexity and changing conditions; especially in complex sociotechnical systems. Resilience requires the ability to anticipate (e.g. a brief), monitor and respond (e.g. a huddle), and learn (e.g. a debrief). The following factors contributed to resilience:

- Implementing effective teamwork (i.e. team meetings, closed-loop communication, and leadership).
- Frequent exchange of information between experts and novices.
- Integrating diverse perspectives during team meetings.
- Using protocols and checklists.
- Creating a shared mental model of work as imagined and work as done.

Conclusion: The ability to adjust and adapt is integral to resilience. Implementing briefs, huddles, and debriefs are key strategies to improve organizational resilience in response to internal and external challenges. (Iflaifel et al, 2020; Hollnagel et al., 2006).

NCPS

30

30

Debriefs Improve Team Performance

Meta-analysis of 46 studies across diverse disciplines (e.g. psychology, medicine, military, government) in which debriefs about specific events included active learning for improvement purposes using multiple sources of information (e.g. a team). Performance was measured before and after debriefing.

- Conducting debriefs improved performance by 25%
- Conducting facilitated debriefs were three times more effective than unfacilitated debriefs
- Highly structured debriefs were more effective than less structured debriefs

Conclusion: Organizations can improve team performance by implementing structured debriefs conducted by trained facilitators. (Tannenbaum & Cerasoli, 2013)

NCPS 31

31

Debriefs Improve Management of OB Hemorrhage

Case study of tertiary hospital with 4,500 births/year that established a policy to debrief after all critical perinatal events. Certified nurse midwives were designated and trained to facilitate debriefs using a structured debriefing form. Conducting debriefs was associated with:

- 33% decrease in incidence of massive transfusion with 5+ units of blood
- 78% decrease in incidence of unplanned hysterectomies not related to placenta accreta or percreta
- No readmissions for postpartum hemorrhage
- Improved adherence to new clinical practices and ability to identify system weaknesses

Conclusion: Improving patient safety using debriefs requires trained facilitators and a "safety action team" (i.e. coordinating team) to coordinate the debriefing program and ensure implementation of recommended system improvements. (Corbett et al., 2012)

NCPS 32

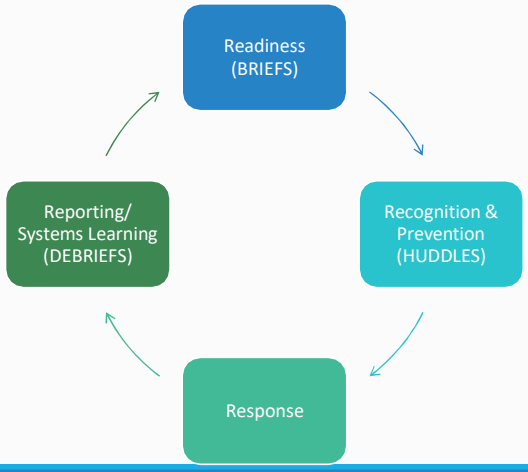
32

Alliance for Innovation on Maternal Health (AIM)

National maternal safety/quality improvement initiative based on interdisciplinary consensus-based practices to promote adoption of evidence-based safety bundles that integrate briefs, huddles, and debriefs (ACOG)

- Obstetric Care for Women with Opioid Use Disorder
- Obstetric Hemorrhage
- Safe Reduction of Primary Cesarean Birth
- Severe Hypertension in Pregnancy

(Council on Patient Safety in Women's Health Care)



NCPS

33

33

Critical Perinatal Events to Debrief

- Term infant with Apgar ≤ 6 at 5 minutes post delivery
- Intrapartum fetal demise
- Emergency C-section
- Postpartum hemorrhage
- Seizure
- Preterm delivery on antenatal unit
- Shoulder dystocia requiring more than suprapubic and McRoberts maneuver
- Unexpected maternal transfer to ICU
- Unexpected admission of term infant to neonatal ICU

(Corbett et al., 2012)

NCPS

34

34

Debriefs Improve OR Safety, Efficiency and Culture

Implementing debriefs associated with:

- Improved perceptions of safety climate/culture among neurosurgical (Magill et al., 2017) and general OR staff (Leong et al., 2017)
- Improved perceptions of teamwork and communication among OR staff (Berenholtz et al., 2009)
- Improved identification and mitigation of OR inefficiencies (Wolf et al., 2010; Magill et al., 2017) and defects in instrumentation and communication (Bandari et al., 2012)
- Prevention of potential adverse events (Magill et al., 2017)
- Surgical teams with frequent changes in team members may benefit the most from briefs and debriefs (Leong et al., 2017)

Conclusion: Briefings and debriefings in the OR can each be done in less than 3 minutes (Berenholtz et al., 2009). They are practical/feasible strategies to prospectively identify and mitigate clinical and operational defects in surgical care and improve perceptions of safety culture and teamwork (Bandari et al., 2012).

NCPS

35

35

Joint Commission: 7 Reasons to Debrief Every Time

Debriefing process during surgical sign-out ...

1. Ensures a shared mental model of confirmed count, blood loss, pain management, and VTE prophylaxis.
2. Provides team members opportunity to identify improvements in efficiency and patient safety, as well as any defects in care.
3. Provides opportunity for all team members to confirm and discuss the plan for patient care transition from the OR to another team.
4. Identifies care relevant to specific patient populations.
5. Using focused questions tailored to the procedure increases sustainability.
6. Stopping unnecessary activities and conversations improves debrief effectiveness.
7. Using checklists/guides ensures standardization and consistency.

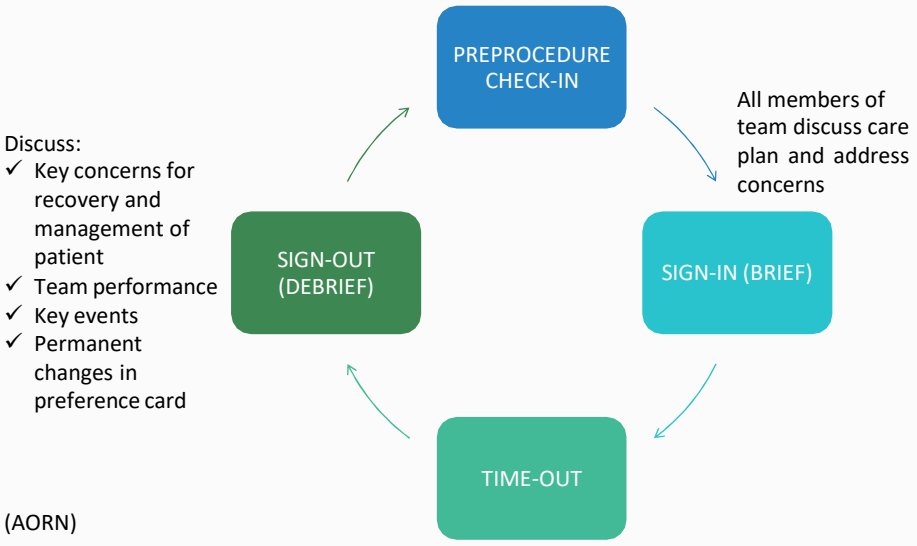
(Spruce, 2018)

NCPS

36

36

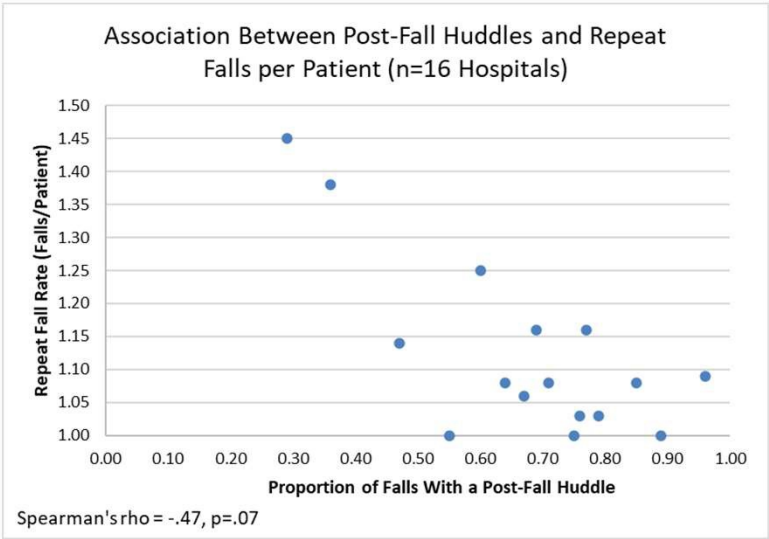
Association of periOperative Registered Nurses Comprehensive Surgical Checklist



(AORN)

37

Debriefs (Post-Fall Huddles) Decrease Risk of Repeat Falls (Jones et al., 2019)



38

Debriefs (Post-Fall Huddles) Improve Perceptions of Teamwork and Safety Culture (Jones et al., 2019)

As compared to ~ 450 respondents who did not participate in post-fall huddles, those ~ 260 who participated in at least one post-fall huddle had more positive perceptions of

- Team structure to support fall-risk reduction (e.g. My unit/department has clearly articulated goals for fall-risk reduction; 86% vs. 93%)
- Leadership support for fall-risk reduction (e.g. My supervisor/manager provides opportunities to discuss the unit/department's performance after a patient fall; 78% vs. 91%)
- Organizational Learning (e.g. We are actively doing things to improve patient safety; 91% vs. 96%)
- Nonpunitive Response to Error (e.g. When an event is reported, it feels like the person is being written up, not the problem; 56% vs 69%)
- Teamwork across Hospital Depts (e.g. Hospital departments work well together to provide the best care for patients; 76% vs. 86%)
- Hospital Handoffs and Transitions (e.g. Important patient care information is often lost during shift changes; 50% vs. 63%)

39

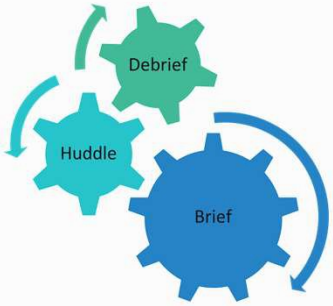
Summary

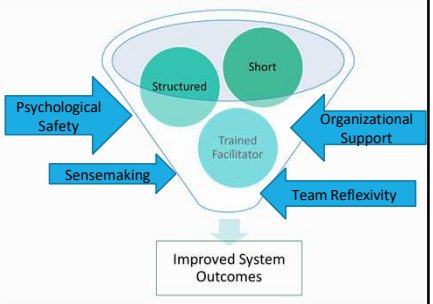
Debriefs are team meeting in which members discuss, make sense of, and learn from a recent event in which they collaborated.

Briefs, huddles, and debriefs initiate the teamwork system.

Effective debriefs are conducted by a trained facilitator who uses a structured guide to ensure psychological safety and team reflection.

Structured debriefs may be generic or event specific and used by clinical and non-clinical teams to improve system outcomes.





40

Before June 9 Webinar: Review Examples

Checklist for Video Examples of Debriefs

- ✓ Did the facilitator create a safe, psychologically safe environment?
- ✓ Did the facilitator use a structured approach to conduct the debrief?
- ✓ Was the team member with the least status/power invited to share their perspective (preferably early in the debrief)?
- ✓ Did multiple team members share their perception of what happened regarding technical care/tasks?
- ✓ Did multiple team members share their perception of what happened regarding teamwork and communication?
- ✓ Did the team develop a clear plan to prevent a recurrence of the event?
- ✓ Did the team discuss how to apply lessons learned to the system as a whole?

NCPS 41

41

Before June 9 Webinar: Review Examples

1. Effective Huddle and Debrief in a Medical Office. In this example, a situational leader and a designated leader ensure an effective response to a changing workload and system improvement.

Agency for Health Care Leadership and Quality. TeamSTEPPS Office Based Care.
https://www.ahrq.gov/teamstepps/officebasedcare/2_leadership_good/index.html

2. Post-Fall Huddle Good Example. In this example, an effective facilitator leads to an effective debrief and system improvement.

   University of Nebraska Medical Center. CAPTURE Falls. Post-Fall Huddle Tools. https://www.unmc.edu/patient-safety/capturefalls/tool-inventory.html

   Available at: https://www.youtube.com/watch?v=ZIqAmNEL6Q4

NCPS

42

Before June 9 Webinar: Review Examples

3. **Post-Fall Huddle Bad Example.** In this example an ineffective facilitator results in an ineffective debrief.

   University of Nebraska Medical Center. CAPTURE Falls. Post-Fall Huddle Tools. https://www.unmc.edu/patient-safety/capturefalls/tool-inventory.html

   Available at: https://www.youtube.com/watch?v=tCy0vk5MWW4

4. **Successful Team Formation in Subacute Care.** In this example effective teamwork including situation monitoring, advocacy and assertion (CUS), closed-loop communication, SBAR and a debrief results in timely attention to a safety issue and acknowledgment of effective team performance. Note how the person with least status feels free to speak up and suggest system improvements during the debrief.

   Agency for Healthcare Leadership and Quality. TeamSTEPPS 2.0 for Long Term Care. Teamwork Success (Subacute). Available at: https://www.youtube.com/watch?v=5FsA3k7pDEU

43

NCPS Debrief Toolkit

Generic Debrief Pocket Guide

OB Hemorrhage

Council On Patient Safety In Women's Health Care Patient Safety Bundles

Post-Fall Huddle

AORN Comprehensive Surgical Checklist

Template for Debrief Log

Template for Debrief Policy/Procedure

Available at:
https://www.nepatientsafety.org/members/patient-safety-toolkits/

44

QUESTIONS

45

45

REFERENCES

AORN. AORN Comprehensive Surgical Checklist. Available at: https://www.aorn.org/guidelines/clinical-resources/tool-kits/correct-site-surgery-tool-kit/aorn-comprehensive-surgical-checklist

ACOG. Alliance for Innovation on Maternal Health (AIM). Available at: https://www.acog.org/en/Practice%20Management/Patient%20Safety%20and%20Quality/Partnerships/Alliance%20for%20Innovation%20on%20Maternal%20Health%20AIM

Agency for Healthcare Research and Quality (AHRQ). TeamSTEPPS. Available at: https://www.ahrq.gov/teamstepps/index.html

Allen J, Reiter-Palmon R, Crowe J. Debriefs: Teams learning from doing in context. American Psychologist. 2018;73:504-516.

Battles JB, Dixson NM, Borotkanics RJ et al. Sensemaking of Patient Safety Risks and Hazards. HSR. 2006; 41 (Part II):1555-1575.

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.

Corbett N, Hurko P, Vallee JT. Debriefing as a strategic tool for performance improvement. JOGNN. 2012;41:572-579.

Council on Patient Safety in Women's Health Care. Patient Safety Bundles. Available at: https://safehealthcareforeverywoman.org/council/patient-safety-bundles/maternal-safety-bundles/

Edmondson AC. Teaming: How Organizations Learn, Innovate, and Compete in the Knowledge Economy. San Francisco: John Wiley & Sons; 2012.

Harrison R, Wu A. Critical incident stress debriefing after adverse patient safety events. The American Journal of Managed Care. 2017;23:310-312.

Hollnagel E, Woods DD, Leveson NC. Resilience engineering: concepts and precepts. Aldershot: Ashgate; 2006.

46

REFERENCES

Iflaifel M, Lim RH, Ryan K, Crowley C. Resilient Health Care: a systematic review of conceptualisations, study methods and factors that develop resilience. BMC Health Services Research. 2020;20:324. https://doi.org/10.1186/s12913-020-05208-3

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

Leong KBMSL, Hanskamp-Sebregts M, van der Wal RA, et al. Effects of perioperative briefing and debriefing on patient safety: a prospective intervention study. BMJ Open. 2017;7:e018367. doi:10.1136/ bmjopen-2017-018367.

Main EK, Goffman D, Scavone BM, et al. National Partnership for Maternal Safety: Consensus bundle on obstetric hemorrhage. Anesth Analg. 2015;121:142–148.

Salas E, Sims DE, Burke CS. Is there a “Big Five” in teamwork? Small Group Research. 2005; 36:555-599.

Salas E, DiazGranados D, Weaver SJ, et al. Does team training work? Principles for health care. Acad Emerg Med. 2008;15:1-8.

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

Smith-Jentsch KA, Cannon-Bowers JA, Tannenbaum SI, Salas E. Guided team self-correction: Impacts on team mental models, processes, and effectiveness. Small Group Research. 2008;39:303-327.

Smith-Jentsch KA, Zeisig RL, McPherson J, & Acton B. Team dimensional training: A strategy for guided team self-correction. In J. A. Cannon-Bowers & E. Salas (Eds.), Decision making under stress: Implications for individual and team training (pp. 271-297). Washington, DC: American Psychological Association; 1998.

47

REFERENCES

Spruce L. 7 Reasons Your Surgical Team Should Debrief for Every Patient, Every Time. Available at: https://www.jointcommission.org/resources/news-and-multimedia/blogs/leading-hospital-improvement/2018/06/7-reasons-your-surgical-team-should-debrief-for-every-patient-every-time/

Tannenbaum SI, Cerasoli CP. Do team and individual debriefs enhance performance? A meta-analysis. Human Factors. 2013;55:231-245.

Twigg S. Clinical event debriefing: A review of approaches and objectives. Curr Opin Pediatr. 2020;32(3):337-342. doi: 10.1097/MOP.0000000000000890.

West MA. Reflexivity, revolution and innovation in work teams. In MM Beyerlein, DA Johnson, & ST Beyerlein (Eds.), Product development teams (Vol. 5, pp. 1–29). Stamford CT: JAI Press; 2000.

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.

48

NCPS Contact Information

Gail Brondum, BS, LPN
NCPS Executive Director
Gail.brondum@unmc.edu
Regina Nailon, PhD, RN
NCPS Patient Safety Program Director
Regina.nailon@unmc.edu
Ashley Dawson, MS
Health Data Analyst
Ashley.dawson@unmc.edu
Katherine Jones, PT, PhD
President, Board of Directors
kjjones57@gmail.com