Strategies to Conduct Effective Debriefs

AUGUST 20, 2020

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President, NCPS Board of Directors

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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.

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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 medical provider attendees will be emailed a link to an attestation form and an online program evaluation that we ask you to complete by Wednesday, June 16 in order to receive continuing education credit.

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 16 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 16 in order to receive continuing education credit.

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

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Disclosure

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

Debrief Collaborative Timeline

2021 / 2022

Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan

Evaluation
- Apr 13 - May 3: Baseline Survey
- Oct 6 - Oct 27: Reassessment Survey

Education
- Webinar 1 Understand Debriefs – May 26
- Webinar 2 Conduct Debriefs – Jun 9

Implementation Support
- Zoom Call 1 – Jul 14
- Zoom Call 2 – Aug 11
- Jun 9 - Dec 31: Online Toolkit
- Jan 2022: Close the Loop and Safe Table

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

Course Objectives

1. Review best practices in conducting debriefs as a leadership strategy to identify root causes of events, apply lessons learned to improve the system and improve trust among team members.
2. Identify barriers to implementing debriefs in Nebraska hospitals.
3. Use change management strategies to overcome barriers to conducting and sustaining debriefs across your organization.
4. Increase the likelihood of system improvements from debriefs by recognizing and tracking individual and organizational errors using a debrief log.

Objective 1

Review best practices in conducting debriefs as a leadership strategy to identify root causes of events, apply lessons learned to improve the system and improve trust among team members.

Using Debriefs to Improve System Performance

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)

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Briefs, Huddles, Debriefs Initiate Teamwork

Debrief

Huddle

Brief

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

(AHRQ TeamSTEPPS, Main et al., 2015)

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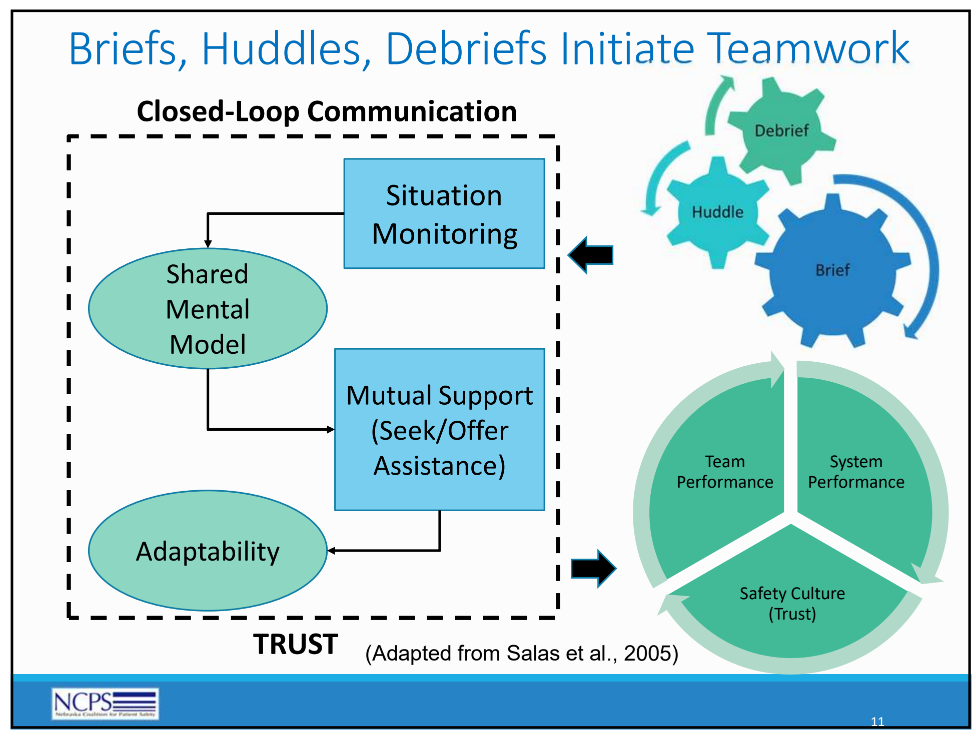
Briefs, Huddles, Debriefs Initiate Teamwork
Closed-Loop Communication
Situation Monitoring
Shared Mental Model
Mutual Support (Seek/Offer Assistance)
Adaptability
TRUST
(Adapted from Salas et al., 2005)
Debrief
Huddle
Brief
Team Performance
System Performance
Safety Culture (Trust)
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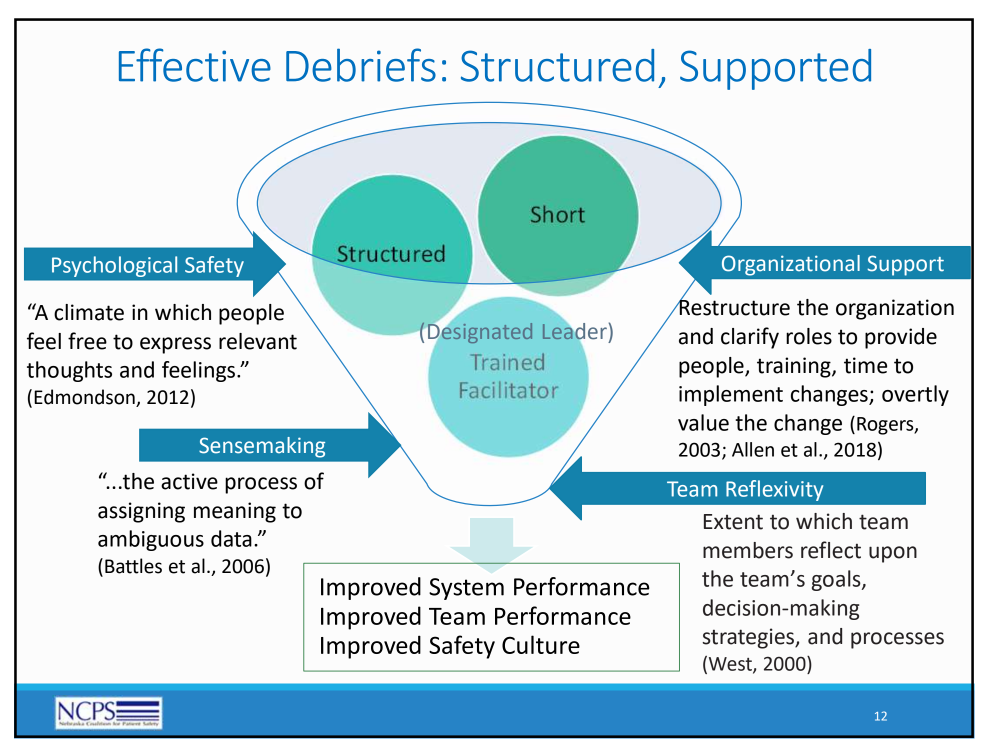
Effective Debriefs: Structured, Supported
Short
Structured
(Designated Leader) Trained Facilitator
Psychological Safety
"A climate in which people feel free to express relevant thoughts and feelings." (Edmondson, 2012)
Sensemaking
"...the active process of assigning meaning to ambiguous data." (Battles et al., 2006)
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., 2018)
Team Reflexivity
Extent to which team members reflect upon the team's goals, decision-making strategies, and processes (West, 2000)
Improved System Performance
Improved Team Performance
Improved Safety Culture
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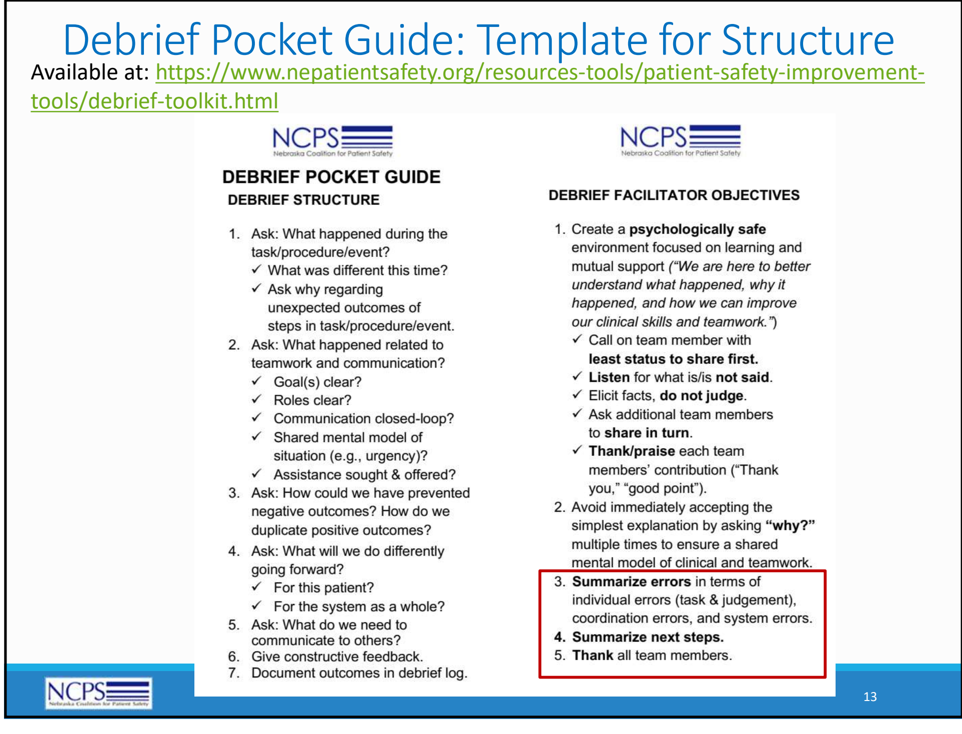

Video Examples of Debrief Best Practices

Checklist for Video Examples of Debriefs

- ✓ Who was the facilitator? (A designated leader in the work area)
- ✓ Did the facilitator create a 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 perceptions of what happened regarding technical care/tasks?
- ✓ Did multiple team members share their perceptions of what happened regarding teamwork and communication?
- ✓ Did the team develop a plan to prevent a recurrence of the event?
- ✓ Did the team discuss how to apply lessons learned to the system?

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Video Examples of Debrief Best Practices

Setting	Clinic Triage Nurse Calls in Sick	Source
Medical Office	✓ Provider (designated leader) facilitated ✓ Short, structured huddle to adapt staffing plan followed by end-of-day debrief ✓ Staff demonstrated psychological safety ✓ Multiple team members shared their perspectives about the plan ✓ Designated leader ➢ Started debrief with open-ended question: "What do we think about how we handled our workflow today? ➢ Thanked members ➢ Gave feedback ("Good question, Good point") ✓ Conclusion: Conducting the huddle and debrief enable the clinic to adapt to triage nurse absence and develop plans to address similar future events despite initial resistance ("we don't have time to stand around")	Agency for Health Care Leadership and Quality. TeamSTEPPS Office Based Care. https://www.ahrq.gov/teamstepps/officebasedcare/2_leadership_good/index.html Available at: https://www.youtube.com/watch?v=kefIIW7_DVo&t=35s

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Video Examples of Debrief Best Practices

Setting	Post-Fall Huddle Reveals Lack of Information Sharing	Source
Acute Care	✓ Charge nurse (designated leader) facilitated ✓ Structured debrief included patient (longer, 8 min) ✓ Staff demonstrated psychological safety ✓ Multiple team members shared their perspectives, which revealed: ➢ Lack of communication with patient: "I wasn't aware my medication had changed" (coordination error) ➢ lack of shared mental model among nursing and PT regarding monitoring orthostatic BP, when and how to conduct orthostatic BP (system error) ➢ Lack of hand-off from PT to nursing (coordination error) ✓ Designated leader ➢ Started with focus on patient: "We are sorry you fell, we want to figure out why you fell and what we can do to prevent it from happening again." ➢ Asked all to summarize lessons learned ➢ Thanked members for attending ✓ Conclusion: Structured debrief decreased risk of repeat fall for patient and developed plan to address coordination and system errors	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

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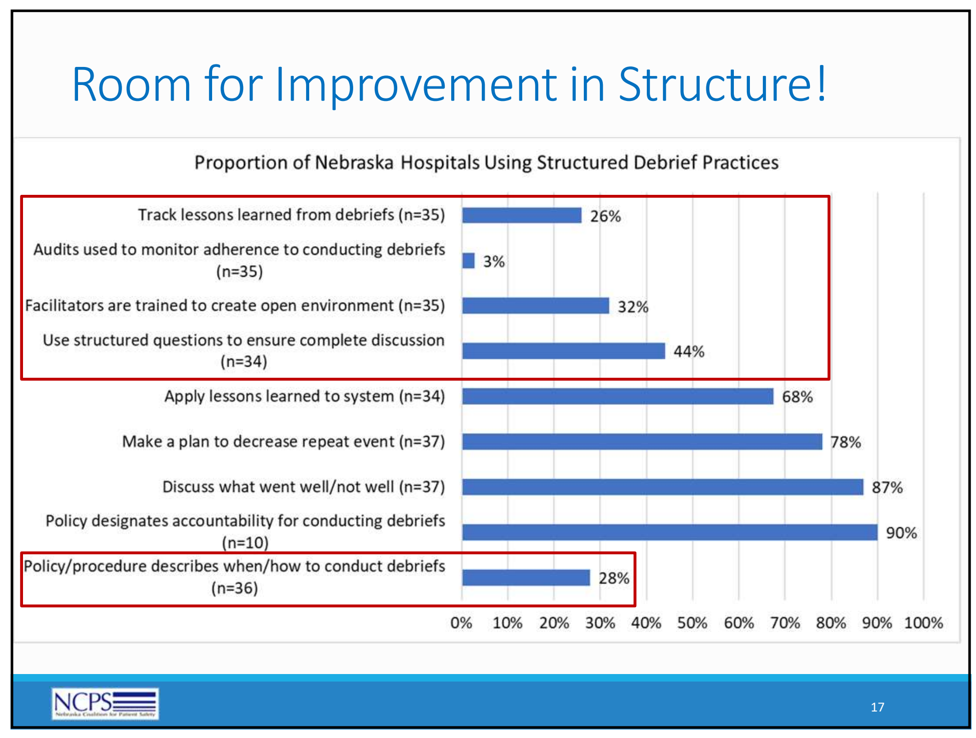

Objective 2

Identify barriers to implementing debriefs in Nebraska hospitals.

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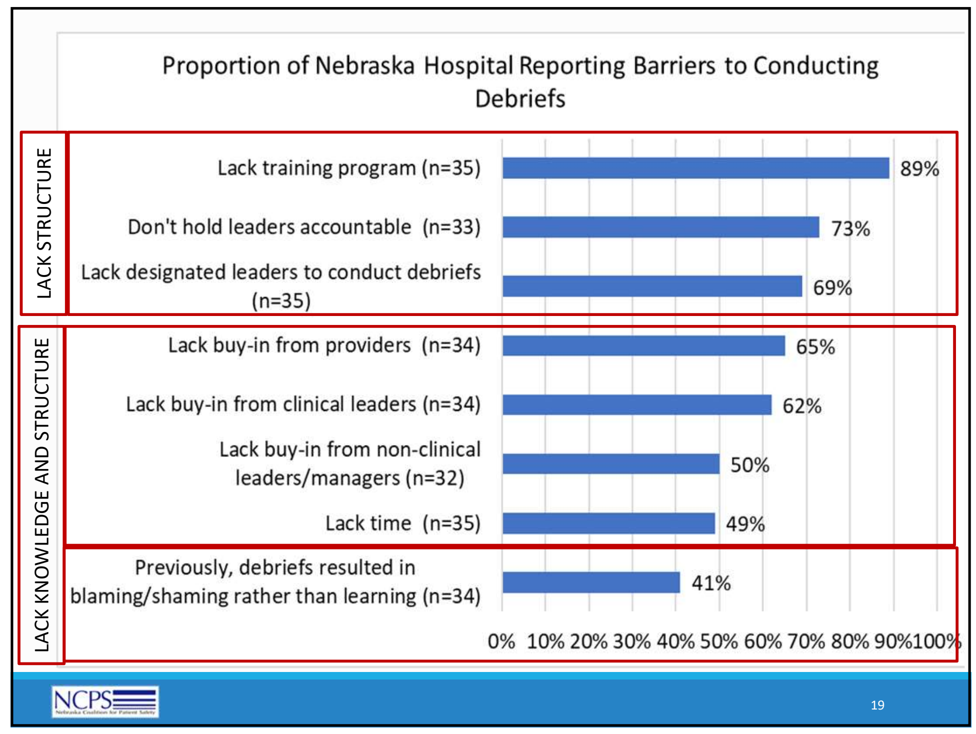

Objective 3

Use change management strategies to overcome barriers to conducting and sustaining debriefs across your organization.

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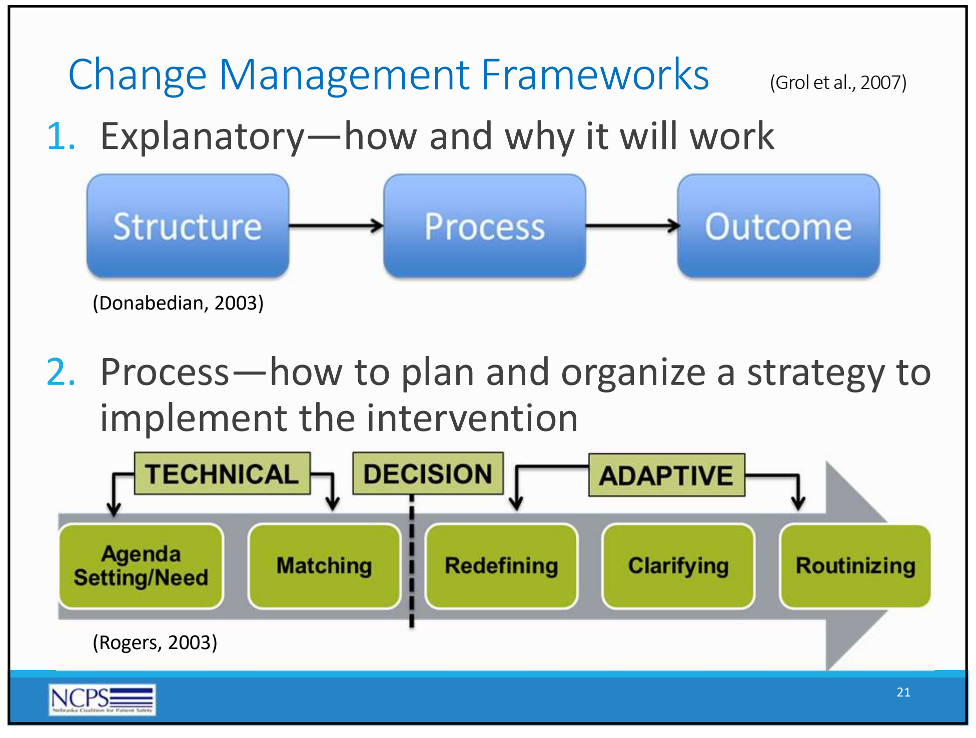
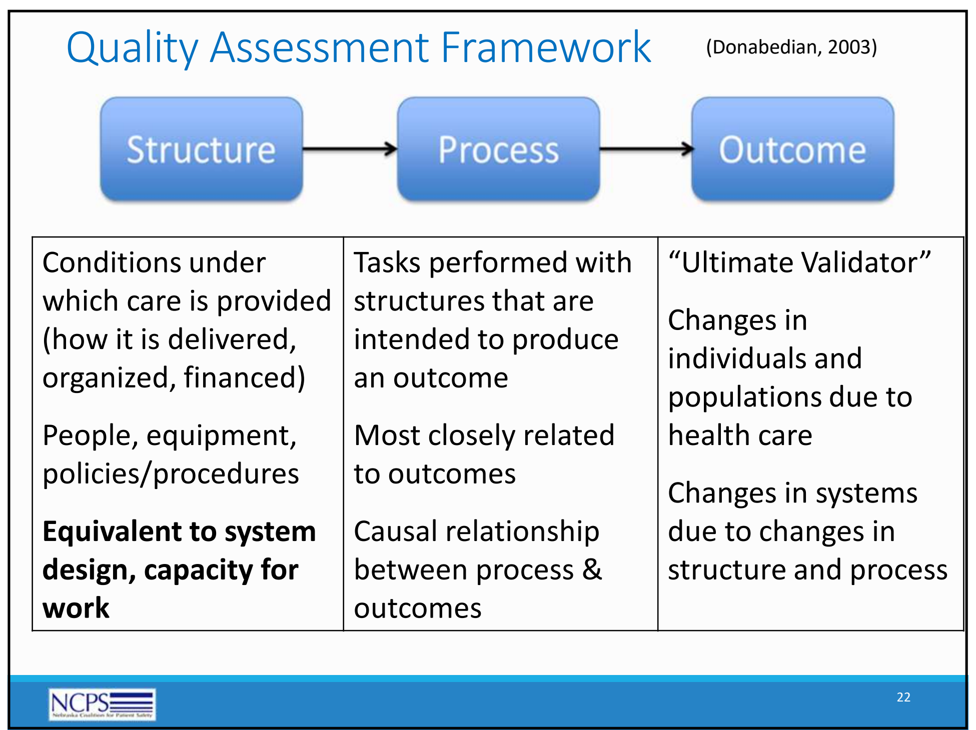
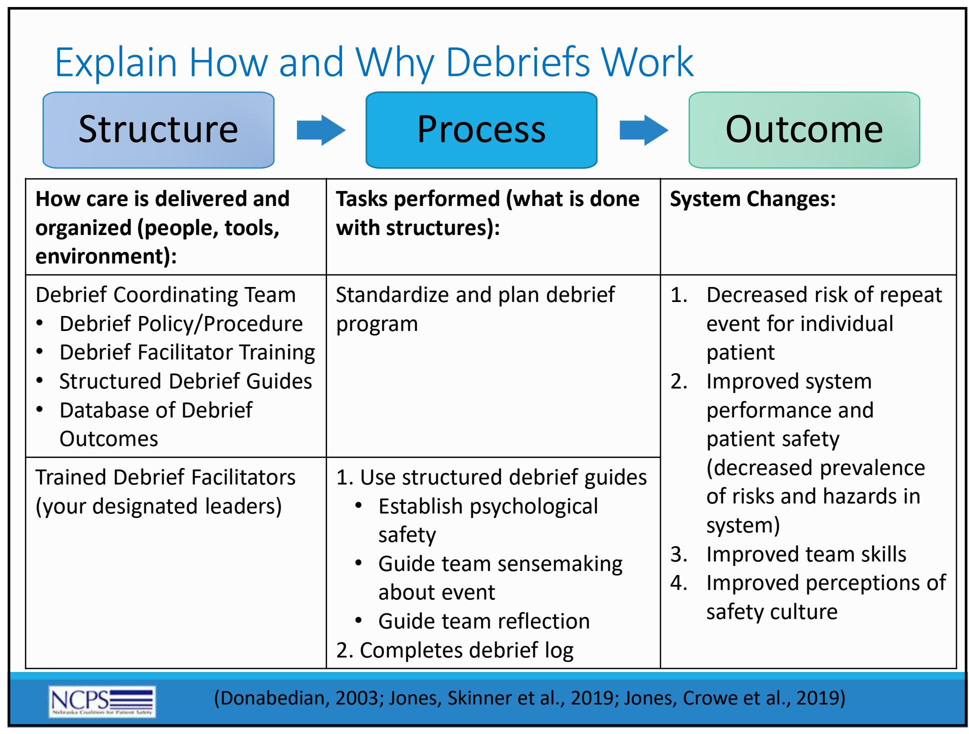




Structure	Process	Outcome
Conditions under which care is provided (how it is delivered, organized, financed) People, equipment, policies/procedures **Equivalent to system design, capacity for work**	Tasks performed with structures that are intended to produce an outcome Most closely related to outcomes Causal relationship between process & outcomes	“Ultimate Validator” Changes in individuals and populations due to health care Changes in systems due to changes in structure and process



Explain How and Why Debriefs Work
Structure
Process
Outcome
How care is delivered and organized (people, tools, environment):
Tasks performed (what is done with structures):
System Changes:
Debrief Coordinating Team
• Debrief Policy/Procedure
• Debrief Facilitator Training
• Structured Debrief Guides
• Database of Debrief Outcomes
Standardize and plan debrief program
1. Decreased risk of repeat event for individual patient
2. Improved system performance and patient safety (decreased prevalence of risks and hazards in system)
3. Improved team skills
4. Improved perceptions of safety culture
Trained Debrief Facilitators (your designated leaders)
1. Use structured debrief guides
• Establish psychological safety
• Guide team sensemaking about event
• Guide team reflection
2. Completes debrief log
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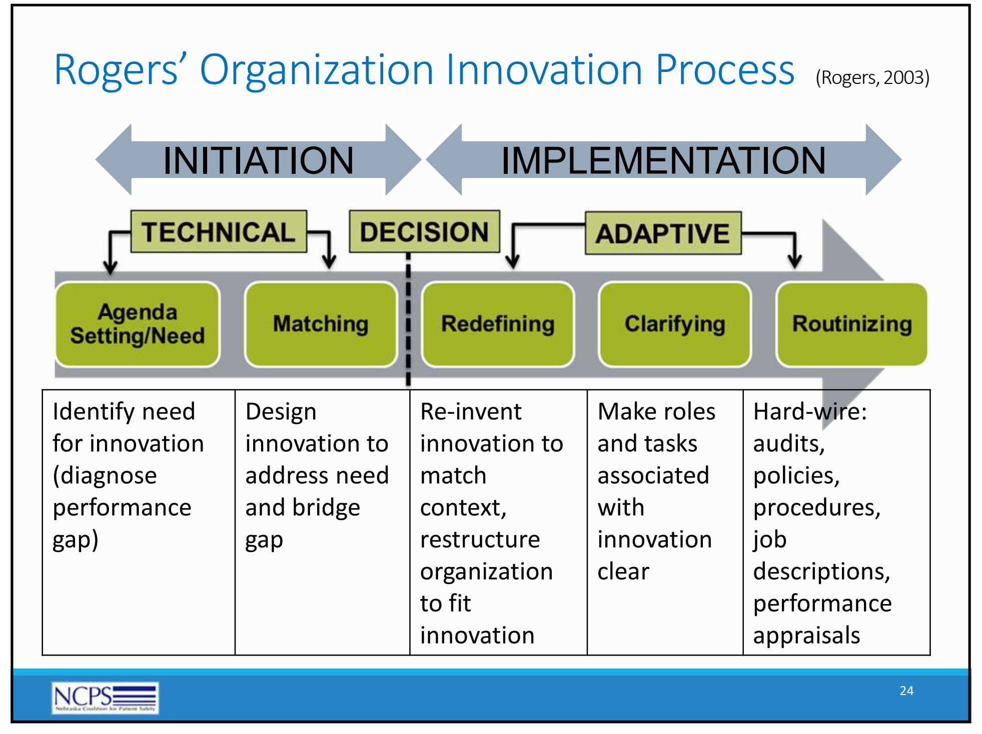
(Donabedian, 2003; Jones, Skinner et al., 2019; Jones, Crowe et al., 2019)



Rogers' Organization Innovation Process (Rogers, 2003)
INITIATION
IMPLEMENTATION
TECHNICAL
DECISION
ADAPTIVE
Agenda Setting/Need
Matching
Redefining
Clarifying
Routinizing
Identify need for innovation (diagnose performance gap)
Design innovation to address need and bridge gap
Re-invent innovation to match context, restructure organization to fit innovation
Make roles and tasks associated with innovation clear
Hard-wire: audits, policies, procedures, job descriptions, performance appraisals
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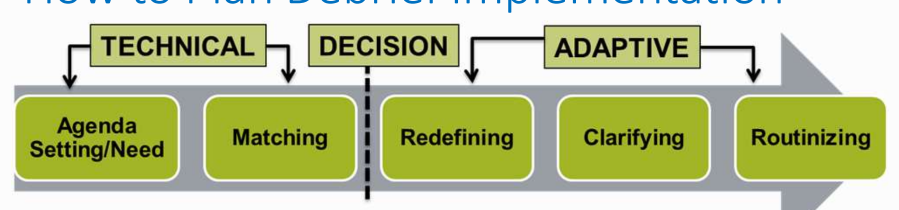
How to Plan Debrief Implementation



1. Set agenda by establishing need based on performance gaps revealed in event reports, by benchmarking event rates, by conducting a safety culture survey
2. Match intervention to need ... implementing effective debriefs can decrease performance gaps and improve perceptions of safety culture
3. Redefine intervention to meet your needs ... what type of debrief will you start with? Generic or event specific? Let end users suggest changes/adaptations.
4. Clarify roles and responsibilities: establish a debrief coordinating team; educate providers and managers so they are persuaded that implementing debriefs should be an organizational priority
5. Routinize conducting debriefs by establishing policies/procedures, conducting audits, and changing job descriptions and performance appraisals

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Set Agenda: Identify Performance Gaps

- Event reports: medication errors, patient falls; events in surgery, OB, ED; repeated events
- Benchmark Event Rates (e.g. NDNQI)
- System failures: Are lessons learned recalled and disseminated?
- Safety culture survey results < 75% positive within Work Area
  - ✓ Manager: *My supervisor, manager, or clinical leader seriously considers staff suggestions for improving patient safety.*
  - ✓ Communication Openness: *When staff in this unit speak up, those with more authority are open to their patient safety concerns.*
  - ✓ Organizational Learning: *This unit lets the same patient safety problems keep happening (reverse-worded).*
  - ✓ Communication about Error: *When errors happen in this unit, we discuss ways to prevent them from happening again.*
  - ✓ Response to Error: *When staff make errors, this unit focuses on learning rather than blaming individuals.*
  - ✓ Hospital Management: *Hospital management seems interested in patient safety only after an adverse event happens (reverse-worded).*

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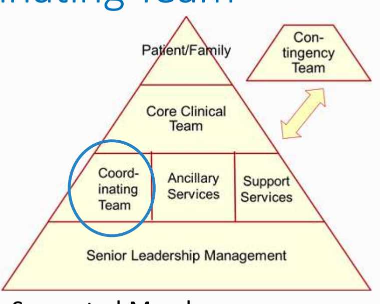
Clarify Role of Debrief Coordinating Team

- ✓Lead debrief multi-team system
- ✓Accountable to senior leaders for planning and standardizing how to use debriefs to improve system performance (e.g. debrief log and database)
- ✓Holds core teams accountable for reliably implementing debriefs
- ✓Effective coordinating teams
  - ✓ Interprofessional (have diverse skills needed to achieve a goal)
  - ✓ Mixture of members from other teams
  - ✓ Actively engaged and reflect on their own performance

(Jones, Skinner, Venema et al., 2019)



Suggested Members:

- ✓ Quality improvement skills
- ✓ TeamSTEPPS skills
- ✓ Representatives from existing safety coordinating teams (e.g. fall-risk reduction, medication safety, surgical safety, ED, OB, infection prevention)
- ✓ Senior Leader Sponsor
- ✓ Provider (Opinion-leader)

Debrief Coordinating Team Charter

Posted in Word for ease of editing; adapt and make it your own!

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

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DEBRIEF COORDINATING TEAM CHARTER

Team Purpose

The purpose of the debrief coordinating team is to standardize and plan the debrief program by providing tools and strategies to designated leaders to conduct effective debriefs.

These designated leaders include senior leaders, department managers, shift leaders, and service-line leaders in clinical and non-clinical areas.

The tools and strategies include:

- ✓ Policy and Procedure for Conducting Effective Debriefs
- ✓ Structured generic and event specific guides for conducting effective debriefs
- ✓ Debrief training for designated leaders using the debrief fact sheet, online videos, and structured guides
- ✓ Maintaining a database of lessons learned from conducting debriefs

Team Objective

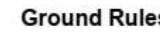
To hold clinical and non-clinical leaders in this organization accountable for conducting effective debriefs that improve system performance and safety culture.

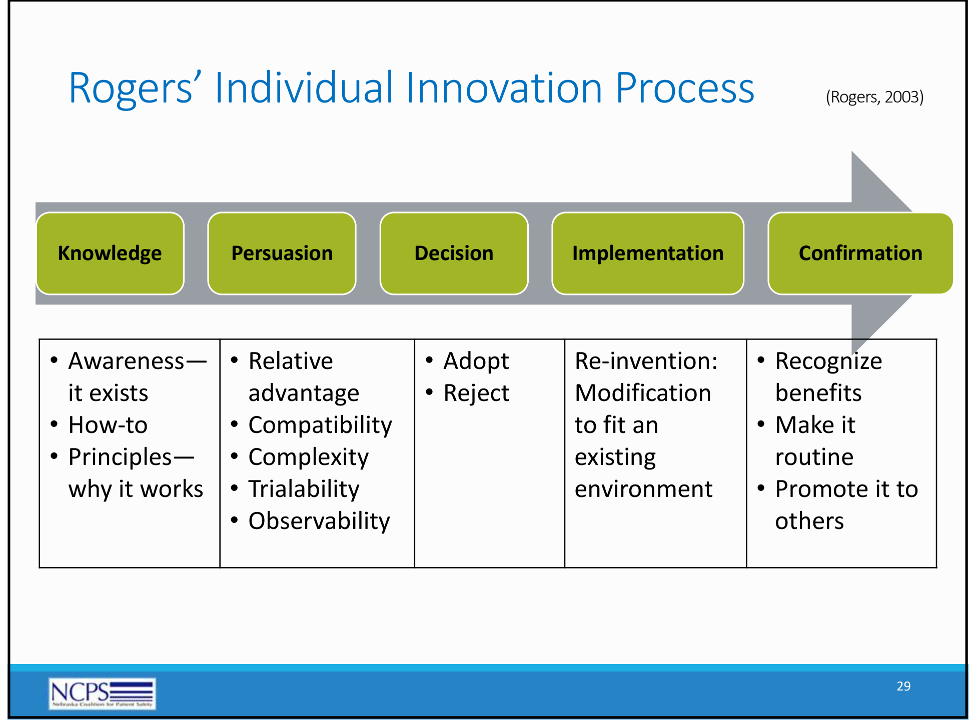
Team Member Roles and Responsibilities

Team Member	Roles/Responsibilities
Senior leader/sponsor	Ensure access to resources and overcome barriers such as ensuring other team members can attend meetings
Staff education content expert	Ensure debrief training program integrates adult learning principles
Quality improvement/patient safety content expert	• Develop, manage, and analyze database for tracking outcomes of debriefs • Train leaders to identify four types of organizational errors: task, judgment, coordination, and system
Team training content expert (i.e. TeamSTEPPS master trainer)	• Ensure debrief processes integrate evidence-based team training strategies and tools • Guide advancement from debriefs to full implementation of team strategies and tools including situation monitoring, closed-loop communication, and mutual support
OB safety content expert	Ensure debrief processes integrate evidence-based safe OB practices
Surgical safety content expert	Ensure debrief processes integrate evidence-based safe surgical practices
Medication safety content expert	Ensure debrief processes integrate evidence-based safe medication practices
Surgical safety content expert	Ensure debrief processes integrate evidence-based safe surgical practices

Ground Rules

Team meets monthly and is chaired by the quality improvement/patient safety content expert.




Rogers' Individual Innovation Process
(Rogers, 2003)
Knowledge
Persuasion
Decision
Implementation
Confirmation
• Awareness—it exists
• How-to
• Principles—why it works
• Relative advantage
• Compatibility
• Complexity
• Trialability
• Observability
• Adopt
• Reject
Re-invention: Modification to fit an existing environment
• Recognize benefits
• Make it routine
• Promote it to others
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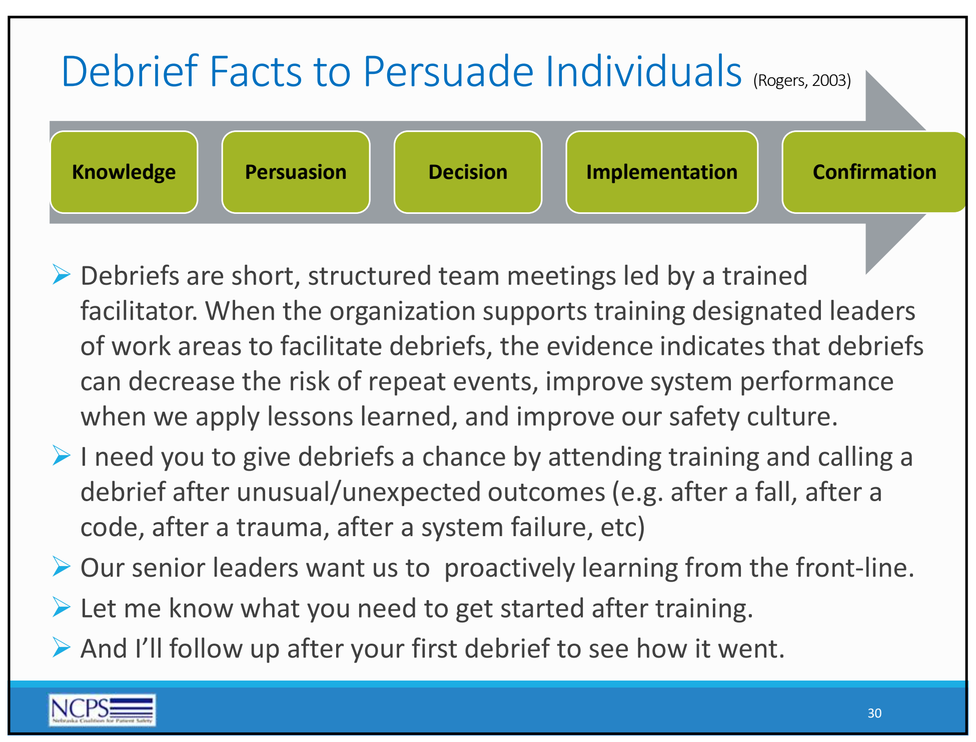
Debrief Facts to Persuade Individuals (Rogers, 2003)
Knowledge
Persuasion
Decision
Implementation
Confirmation
Debriefs are short, structured team meetings led by a trained facilitator. When the organization supports training designated leaders of work areas to facilitate debriefs, the evidence indicates that debriefs can decrease the risk of repeat events, improve system performance when we apply lessons learned, and improve our safety culture.
I need you to give debriefs a chance by attending training and calling a debrief after unusual/unexpected outcomes (e.g. after a fall, after a code, after a trauma, after a system failure, etc)
Our senior leaders want us to proactively learning from the front-line.
Let me know what you need to get started after training.
And I'll follow up after your first debrief to see how it went.
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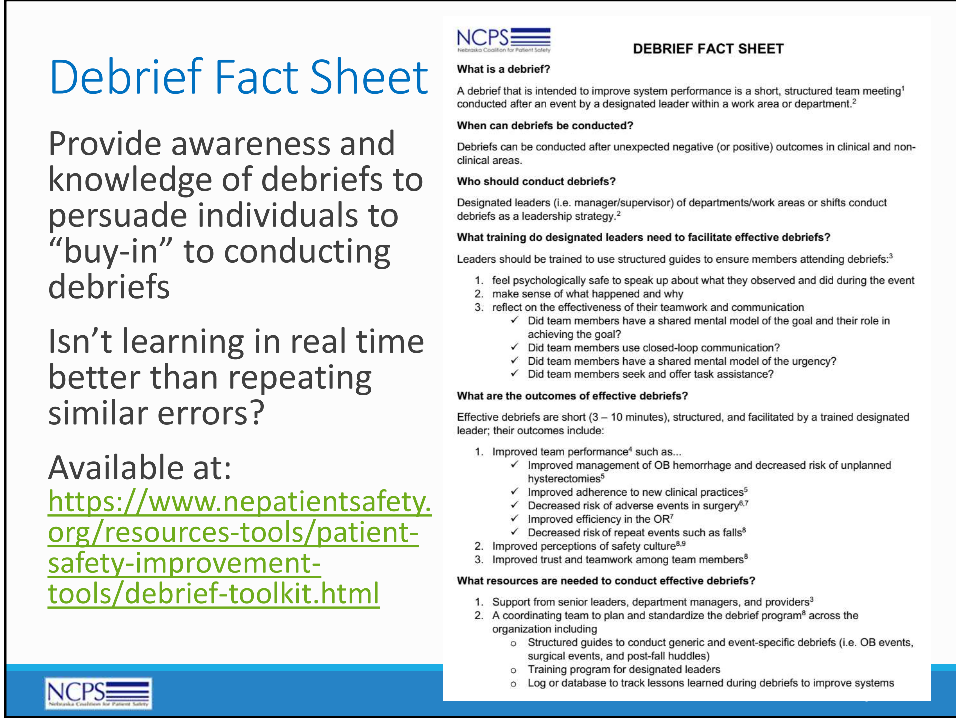
Debrief Fact Sheet
Provide awareness and knowledge of debriefs to persuade individuals to "buy-in" to conducting debriefs
Isn't learning in real time better than repeating similar errors?
Available at:
https://www.nepatientsafety.org/resources-tools/patient-safety-improvement-tools/debrief-toolkit.html
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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
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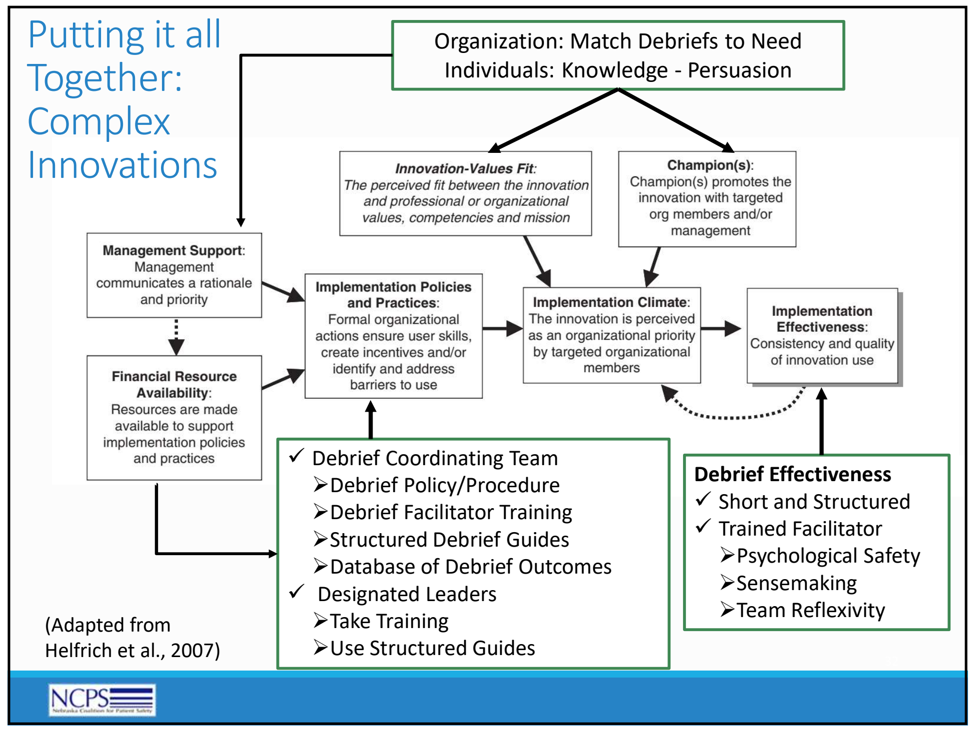
Putting it all Together: Complex Innovations
Organization: Match Debriefs to Need
Individuals: Knowledge - Persuasion
Innovation-Values Fit: The perceived fit between the innovation and professional or organizational values, competencies and mission
Champion(s): Champion(s) promotes the innovation with targeted org members and/or management
Management Support: Management communicates a rationale and priority
Financial Resource Availability: Resources are made available to support implementation policies and practices
Implementation Policies and Practices: Formal organizational actions ensure user skills, create incentives and/or identify and address barriers to use
Implementation Climate: The innovation is perceived as an organizational priority by targeted organizational members
Implementation Effectiveness: Consistency and quality of innovation use
✓ Debrief Coordinating Team
➢Debrief Policy/Procedure
➢Debrief Facilitator Training
➢Structured Debrief Guides
➢Database of Debrief Outcomes
✓ Designated Leaders
➢Take Training
➢Use Structured Guides
Debrief Effectiveness
✓ Short and Structured
✓ Trained Facilitator
➢Psychological Safety
➢Sensemaking
➢Team Reflexivity
(Adapted from Helfrich et al., 2007)
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Objective 4

Increase the likelihood of system improvements from debriefs by recognizing and tracking individual and organizational errors using a debrief log.

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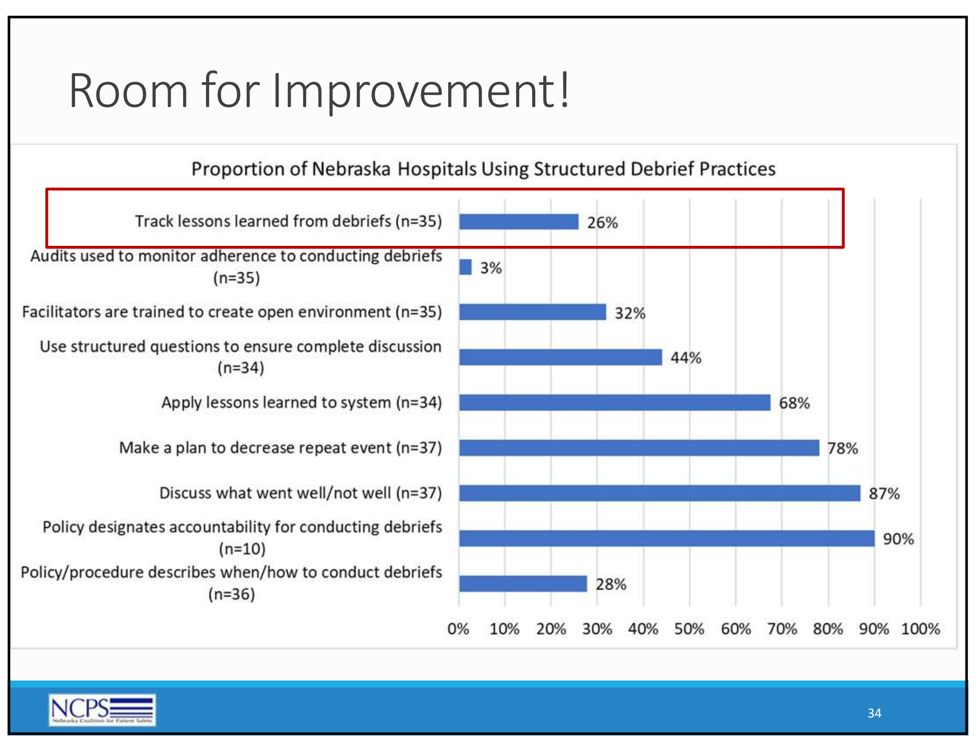
Room for Improvement!



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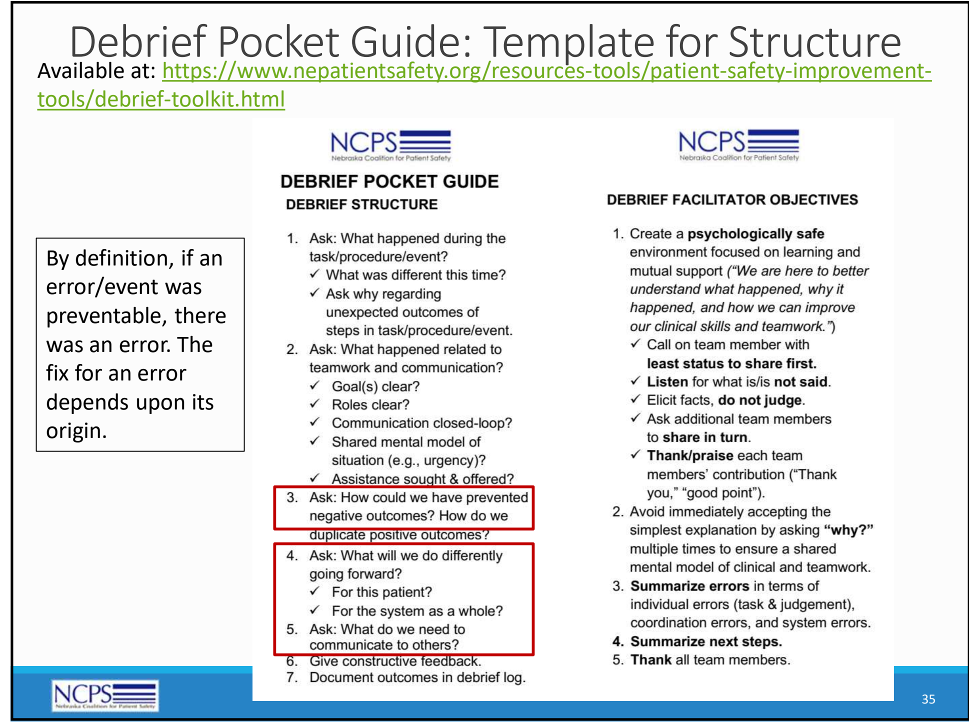

Debrief Pocket Guide: Template for Structure
Available at: https://www.nepatientsafety.org/resources-tools/patient-safety-improvement-tools/debrief-toolkit.html
By definition, if an error/event was preventable, there was an error. The fix for an error depends upon its origin.
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DEBRIEF 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.
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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.
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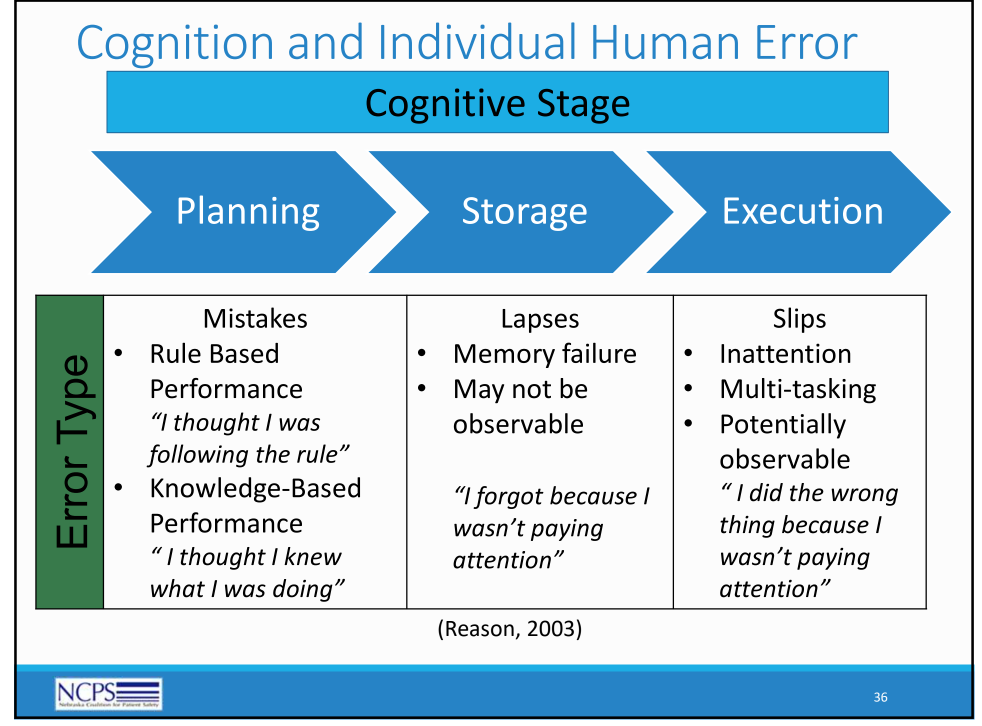

Cognition and Individual Human Error
Cognitive Stage
Planning
Storage
Execution
Error Type
Mistakes
• Rule Based Performance
"I thought I was following the rule"
• Knowledge-Based Performance
" I thought I knew what I was doing"
Lapses
• Memory failure
• May not be observable
"I forgot because I wasn't paying attention"
Slips
• Inattention
• Multi-tasking
• Potentially observable
" I did the wrong thing because I wasn't paying attention"
(Reason, 2003)
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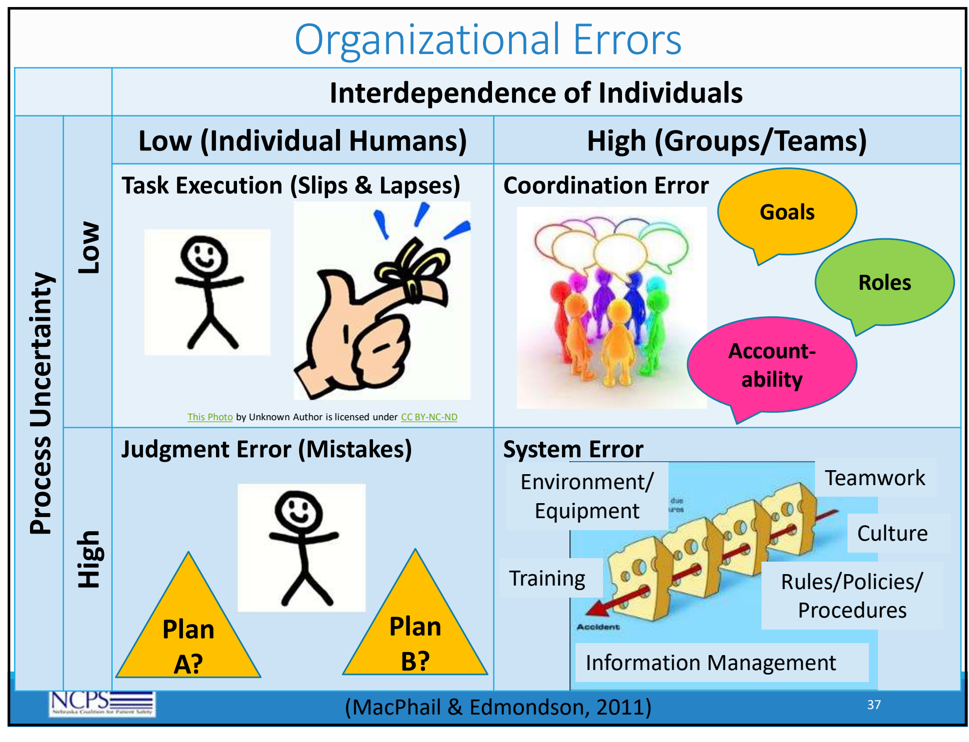

Organizational Errors

Process Uncertainty		Interdependence of Individuals: Low (Individual Humans)	Interdependence of Individuals: High (Groups/Teams)
	Low	**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
	High	**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	Lack of knowledge in uncertain processes	Confusion re: goals, roles, and accountability	Multiple system factors interact
How to learn from error	Process mapping, direct observation, and **DEBRIEF**	Collective sense-making of those knowledgeable of process **(DEBRIEF)**	Collective sense-making of those knowledgeable of system **(DEBRIEF)**	Organizational tracking and analysis of system vulnerabilities **(including DEBRIEF Log)**
Solution	Standardize process/environment, error proof, practice and competency assessment	Training in decision-making, remove uncertainty by developing rules/ policies/ procedures	Increase standardization of communication tools and strategies	Continuous quality improvement

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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	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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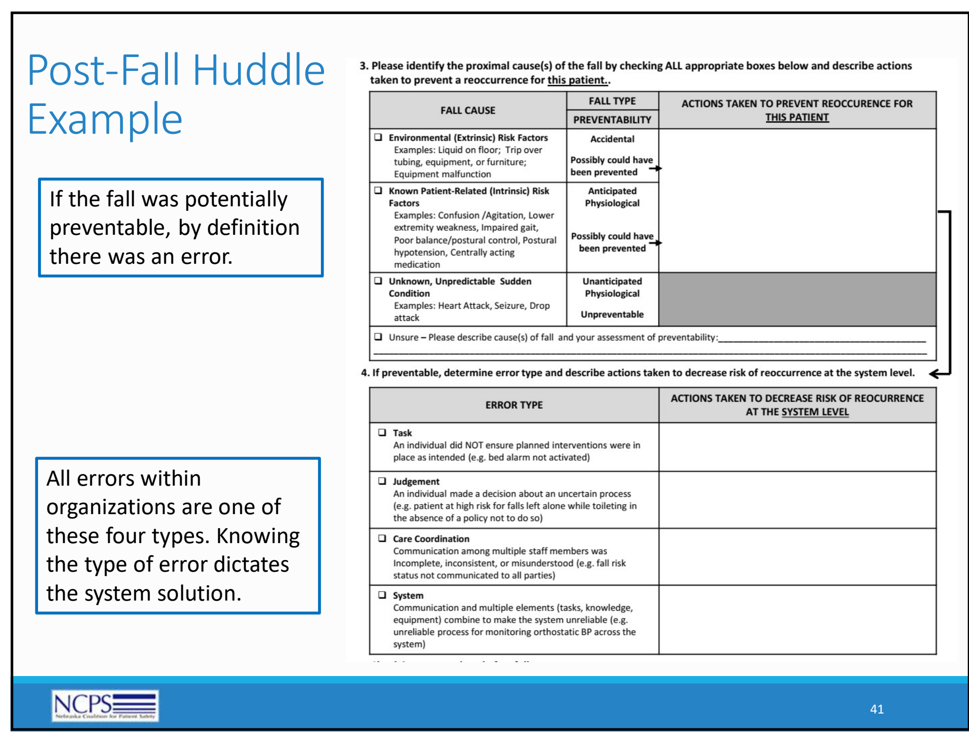
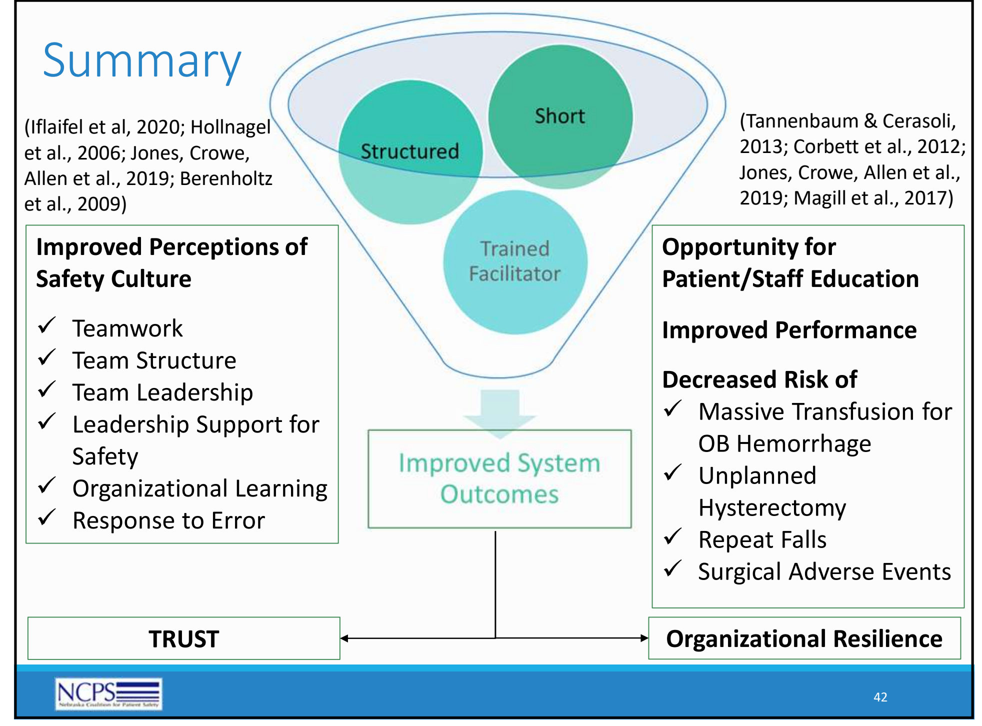


3. Please identify the proximal cause(s) of the fall by checking ALL appropriate boxes below and describe actions taken to prevent a reoccurrence for this patient..

FALL CAUSE	FALL TYPE / PREVENTABILITY	ACTIONS TAKEN TO PREVENT REOCCURENCE FOR THIS PATIENT
❑ **Environmental (Extrinsic) Risk Factors** Examples: Liquid on floor; Trip over tubing, equipment, or furniture; Equipment malfunction	**Accidental** / **Possibly could have been prevented** →	
❑ **Known Patient-Related (Intrinsic) Risk Factors** Examples: Confusion /Agitation, Lower extremity weakness, Impaired gait, Poor balance/postural control, Postural hypotension, Centrally acting medication	**Anticipated Physiological** / **Possibly could have been prevented** →	
❑ **Unknown, Unpredictable Sudden Condition** Examples: Heart Attack, Seizure, Drop attack	**Unanticipated Physiological** / **Unpreventable**	
❑ Unsure – Please describe cause(s) of fall and your assessment of preventability:________		

4. If preventable, determine error type and describe actions taken to decrease risk of reoccurrence at the system level.

ERROR TYPE	ACTIONS TAKEN TO DECREASE RISK OF REOCURRENCE AT THE SYSTEM LEVEL
❑ **Task** An individual did NOT ensure planned interventions were in place as intended (e.g. bed alarm not activated)	
❑ **Judgement** An individual made a decision about an uncertain process (e.g. patient at high risk for falls left alone while toileting in the absence of a policy not to do so)	
❑ **Care Coordination** Communication among multiple staff members was Incomplete, inconsistent, or misunderstood (e.g. fall risk status not communicated to all parties)	
❑ **System** Communication and multiple elements (tasks, knowledge, equipment) combine to make the system unreliable (e.g. unreliable process for monitoring orthostatic BP across the system)	



Putting it All Together

Implementation Step	Tools
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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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

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NCPS Debrief Toolkit

Debrief Fact Sheet to Educate Management and Leaders

Debrief Policy/Procedure

Debrief Coordinating Team Charter

Debrief Log for Facilitators

Debrief Database for Coordinating Team

Generic Debrief Pocket Guide

List of Online Videos for Training

OB Hemorrhage

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

Post-Fall Huddle

AORN Comprehensive Surgical Checklist

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

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Questions and Contact Information

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