Implementing and Sustaining Effective Debriefs: Support Call 1

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President, NCPS Board of Directors

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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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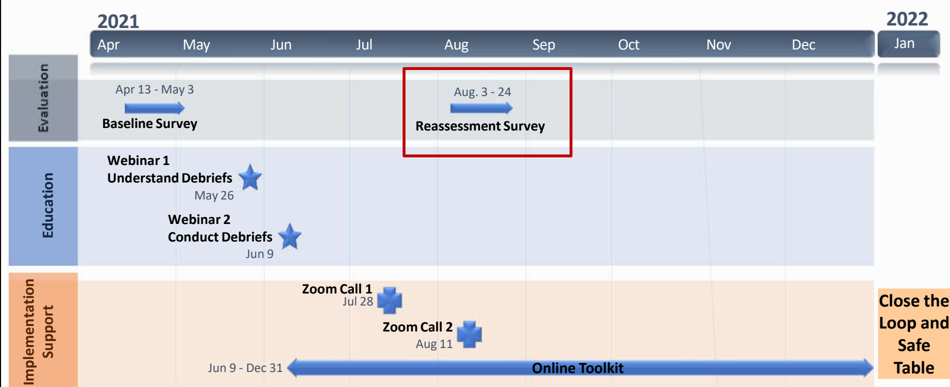
Debrief Collaborative Timeline



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
2. Review structure needed to implement strategy
3. Review typical barriers encountered when implementing debriefs
4. Share your barriers and successes implementing debriefs
5. Identify shared needs for overcoming barriers
6. Share what's new in the literature about debriefs

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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)

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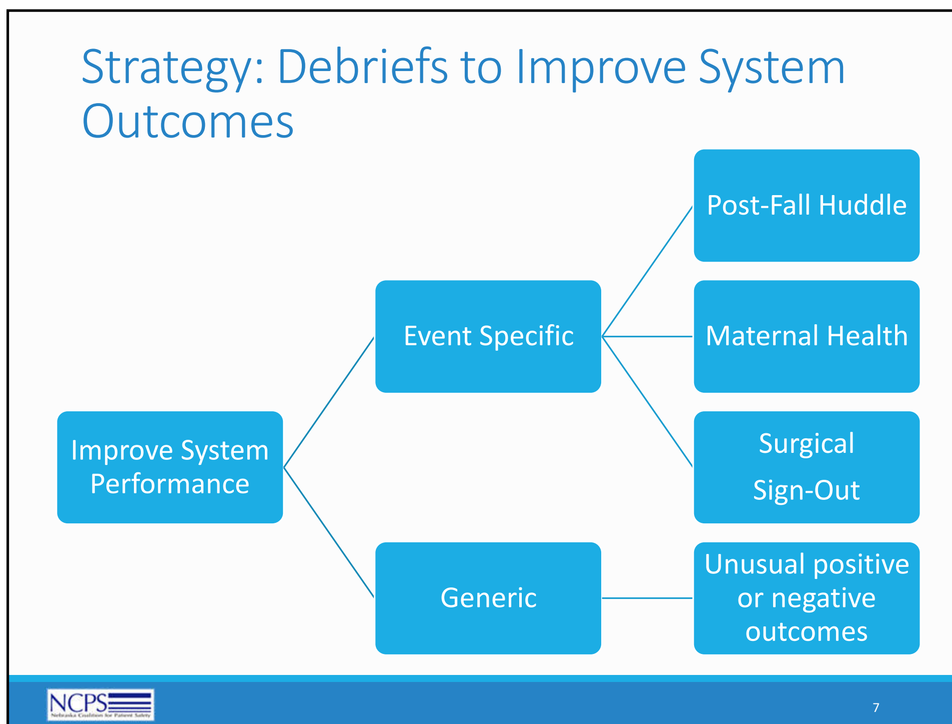

Strategy: Debriefs to Improve System Outcomes
Improve System Performance
Event Specific
Generic
Post-Fall Huddle
Maternal Health
Surgical Sign-Out
Unusual positive or negative outcomes
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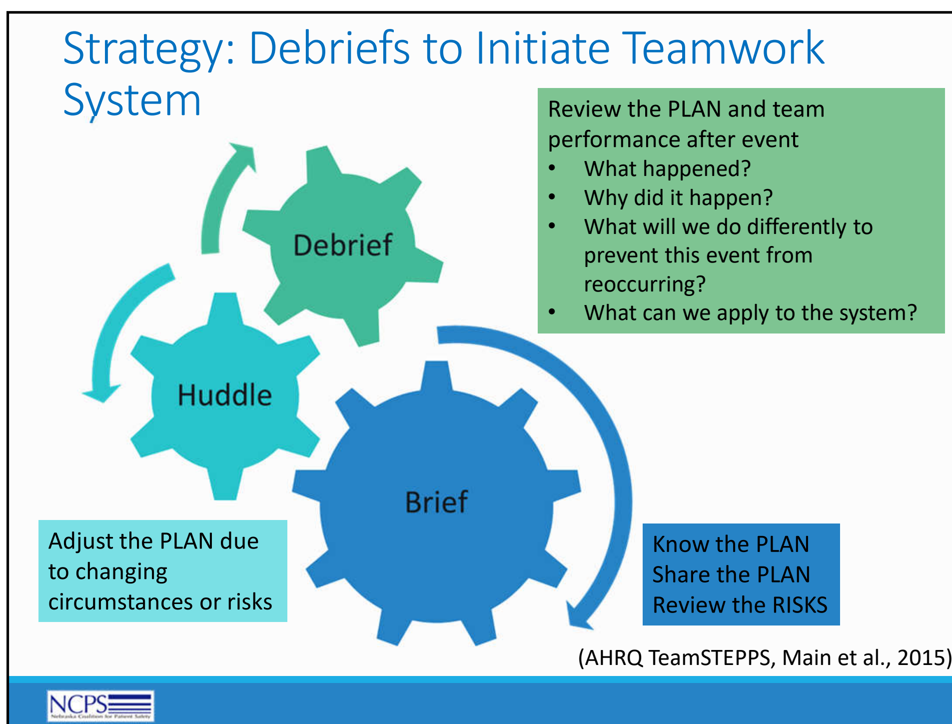

Strategy: Debriefs to Initiate Teamwork System
Review the PLAN and team performance after event
• What happened?
• Why did it happen?
• What will we do differently to prevent this event from reoccurring?
• What can we apply to the system?
Debrief
Huddle
Brief
Adjust the PLAN due to changing circumstances or risks
Know the PLAN
Share the PLAN
Review the RISKS
(AHRQ TeamSTEPPS, Main et al., 2015)
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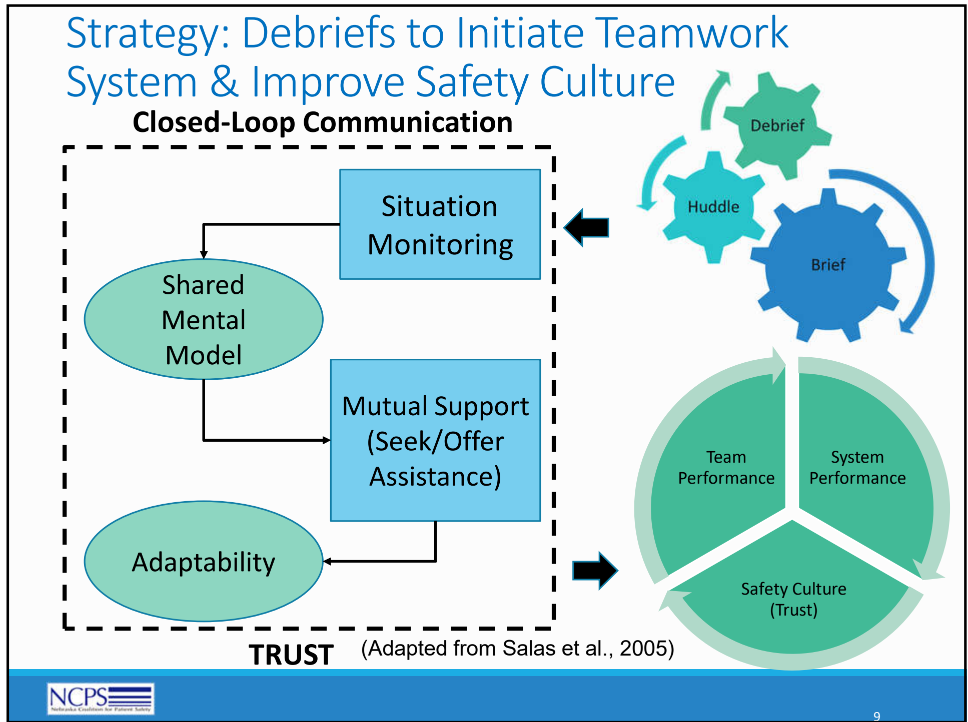
Strategy: Debriefs to Initiate Teamwork System & Improve Safety Culture
Closed-Loop Communication
Situation Monitoring
Shared Mental Model
Mutual Support (Seek/Offer Assistance)
Adaptability
TRUST
(Adapted from Salas et al., 2005)
Debrief
Huddle
Brief
Team Performance
System Performance
Safety Culture (Trust)
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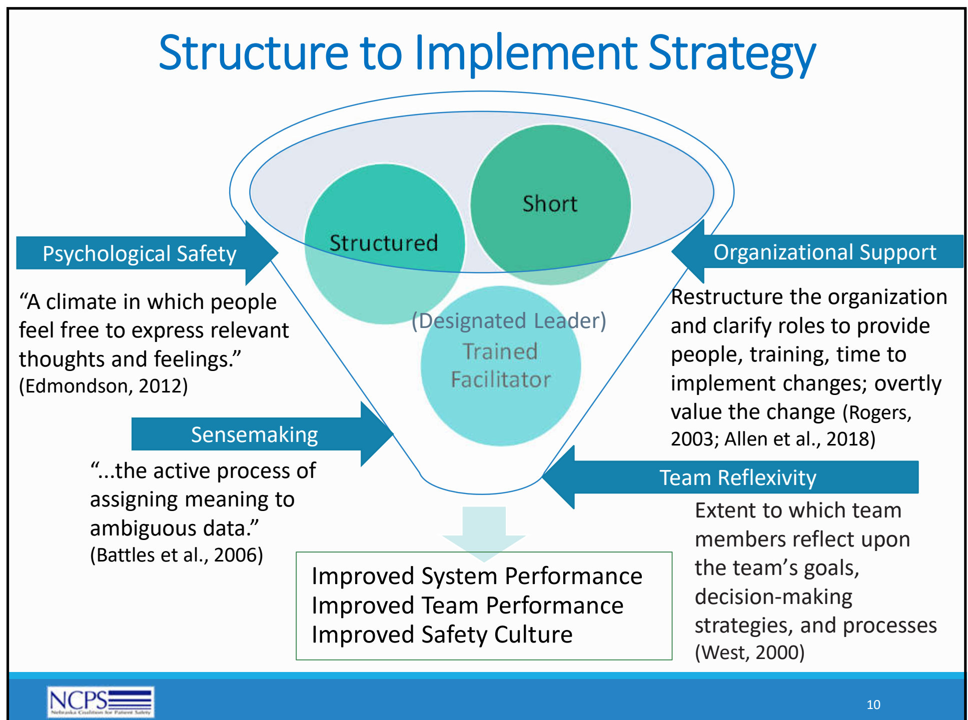
Structure to Implement Strategy
Short
Structured
(Designated Leader) Trained Facilitator
Psychological Safety
"A climate in which people feel free to express relevant thoughts and feelings." (Edmondson, 2012)
Sensemaking
"…the active process of assigning meaning to ambiguous data." (Battles et al., 2006)
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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Structure: Debrief Pocket Guide

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

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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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Explain How and Why Debriefs Work

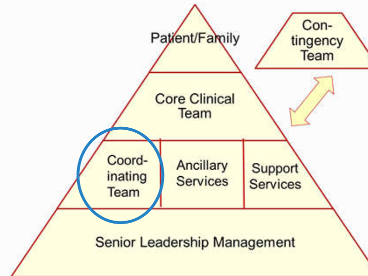
How care is delivered and organized (people, tools, environment):	**Tasks performed (what is done with structures):**	**System Changes:**
Debrief Coordinating Team • Debrief Policy/Procedure • Debrief Facilitator Training • Structured Debrief Guides • Database of Debrief Outcomes	Standardize and plan 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) >Shift charge nurse (PFHs) >Circulating nurse (OR) >Code lead/recorder >ED Shift Lead **Must be designated!**	1. Use structured debrief guides • Establish psychological safety • Guide team sensemaking about event • Guide team reflection 2. Complete debrief log	

(Donabedian, 2003; Jones, Skinner et al., 2019; Jones, Crowe et al., 2019)

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)

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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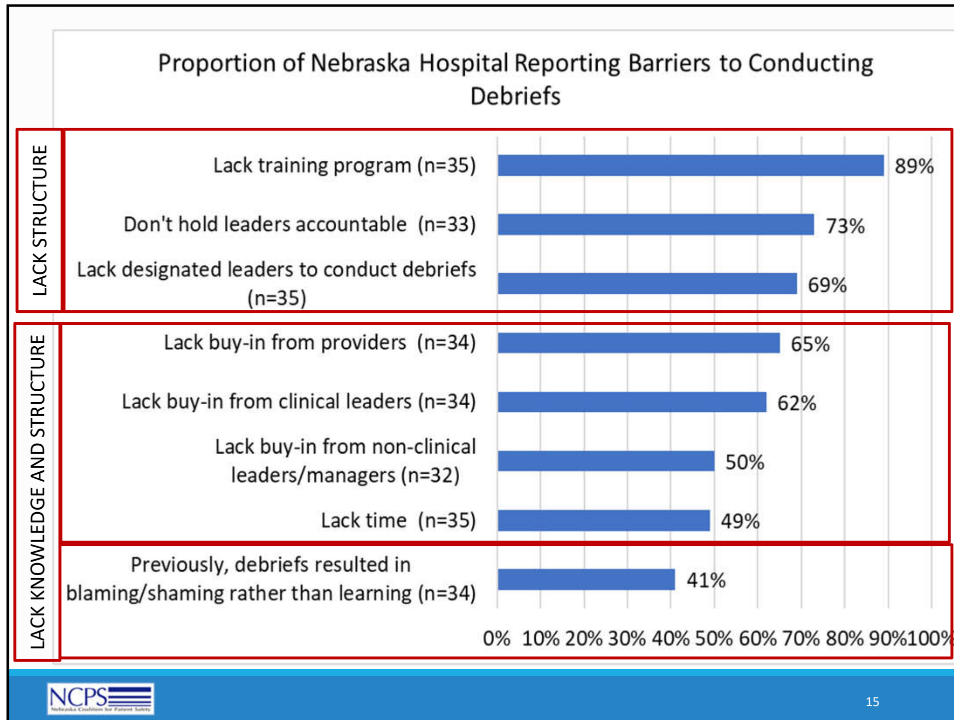

Barrier	Strategy
Lack training program	✓ Debrief Fact Sheet ✓ Pocket Guide ✓ Videos referenced in Webinar 1
Lack of accountability	✓ Include conducting debriefs in relevant job descriptions ✓ Senior clinical and administrative leaders communicate importance of debriefs as a strategy to improve system outcomes
Lack of designated leaders	✓ Designate leaders to be trained in policy/procedure ✓ Integrate conducting debriefs into relevant job descriptions
Lack of buy-in	✓ Debrief Fact Sheet
Lack of time	✓ Compare benefits of conducting debriefs to time required to investigate events that conducting debriefs may prevent
History of debriefs resulting in blame/shame	✓ Train designated leaders to conduct structured, short debriefs consistent with Debrief Fact Sheet

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Share Barriers

1. Post-fall huddles have not been routinized as a sensemaking conversation due to:
   1) Previous perception that main goal of activity is to gather data rather than to ensure front-line staff learn and develop a plan to decrease risk of future falls for the patient. STRATEGY: Train charge nurses that conducting the post-fall huddle as a sensemaking conversation is consistent with their role as a designated leader, with front-line learning about this specific patient's fall risk factors, and with how the organization's fall risk reduction interventions are intended to be used.
   2) Lack of clarity regarding charge nurse's role in conducting the post-fall huddle as a sensemaking conversation. STRATEGY: Clarify charge nurse's role in post-fall huddles, integrate this role into the job description, and include it in performance appraisals.
2. Key stakeholders leave without participating in debriefs. STRAGEGY: Invite these stakeholders to share their experiences first and then close the loop with them about lessons learned during the debrief using reminder emails.

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Share Successes

1. Post-code and post rapid-response debriefs are becoming hard-wired in one organization. The code recorder can lead the debrief by referring to their notes. However, there may be room for improvement in aggregating, analyzing, and sharing the lessons learned due to lack of a database and lack of an established procedure to share what was learned.
2. Organizations shared success stories of using debriefs to learn from:
   1. fall events and serious safety events with an emphasis on closing the loop with the front-line about lessons learned.
   2. Tornado response.
   3. Post-partum hemorrhage.
   4. Behavioral Health Code 10 in which security is recognized as a key part of the team and logs of the debriefs are reviewed by management.

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What’s in the Literature?

Arriaga AF, Szyld D, Pian-Smith. Real-Time Debriefing After Critical Events: Exploring the Gap Between Principle and Reality. Aneshthesiol Clin. 2020; 38:801-820.

✓Debriefing after perioperative critical events potentially benefits the individual, team, environment, and overall health care system.

✓In studies of actual critical events across medical disciplines, debriefing only takes place a fraction of the time.

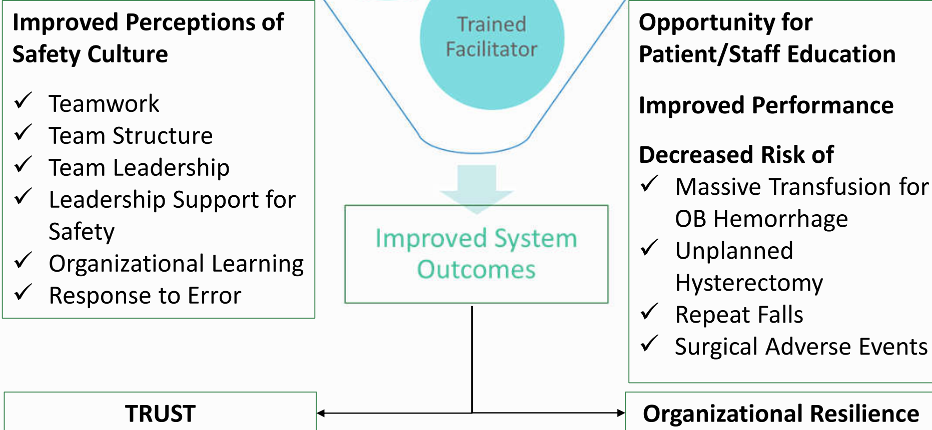
✓The implementation sciences, as well as recent implementation research pertaining to patient safety interventions, may provide insight toward closing the gap between principle and reality.

- Needs assessment
- Build capacity (e.g. develop tools such as those in the toolkit)
- Train staff
- Create implementation team (e.g. Debrief Coordinating Team)
- Provide technical assistance, coaching, and feedback (e.g. Debrief Coordinating Team provides feedback after receiving Debrief Log)

Summary

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

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



Improved Perceptions of Safety Culture

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

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

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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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. 11: Attend implementation support call
- Aug 3 – 24: Respond to Reassessment Survey
- Nov. 10: TeamSTEPPS Primer at NHA Rural QI Pre-Conference 1-5 pm, Kearney, NE

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Questions and Contact Information

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