Debriefing Clinical Events: Improving Team Communication and Collaboration

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I have no financial disclosures or conflict of interest relevant to this talk
Goals and Objectives

• **Goal:** Bring simulation debriefing skills to obstetric events

• **Objectives:**
  – Discuss the benefits of debriefing in the clinical environment
  – Compare different methods of debriefing in the clinical environment
  – Provide tools to assist with implementing debriefing in your clinical environment
Why Debrief?

- A meta-analysis of team based debriefings after clinical events, showed organizations can improve individual and team performance by 20-25% by using properly conducted debriefs. ¹
- Clinical debriefing has been associated with improved CPR outcomes, trauma team efficiency, identification of surgical errors, and neonatal outcomes following emergent cesarean deliveries. ²
Why Debrief?

• **The Need:** Opportunity for continuous team performance improvement.

• **The Benefits:**
  – Opportunity to defuse emotions and tension after clinical events
  – Opportunity to identify latent safety threats in hospital systems and environments
  – Improves interdisciplinary open communication.
  – Staff feel safer to speak up
Qualitative vs. Quantitative Debriefing

• Quantitative debriefing:
  – Data: bedside CPR devices, patient monitors, records
  – Typically occurs days to weeks after event
  – Wider audience than event members

• Qualitative debriefing:
  – Limited data - relies on participant recall of events, interactions, and thought processes
  – Minutes to hours after event
  – Event members
Clinical Debriefing …

• How:
  – Plus/delta
  – Scripted debrief
  – Checklist

• Who:
  – Entire team invited
  – Led by *trained debriefers – can be physicians/charge nurses/both

• What:
  – All adverse events
  – Specific pre-identified events
Clinical Debriefing …

• **When:**
  – Hot (minutes)
  – Warm (hours) - pre-shift departures
  – Cold (within a week)

• **Where:**
  – Quiet or isolated place if possible

• **Post-debriefing:**
  – Improvement ideas to quality and department leaders
  – Group feedback to department on changes by staff meetings and emails
Debriefing: Basic Structure

• Three parts to an effective debrief:
  – Beginning: Reactions Phase
  – Middle: Analysis Phase
  – Ending: Summary Phase
Basic Critical Debriefing Elements

• Beginning: Reactions phase – create a safe environment
  – Thank members for being present
  – All information discussed in the debriefing is confidential
  – The purpose of debriefing is for education, quality improvement, & emotional processing.
  – We are not here to assess or evaluate personal performance
  – Everyone’s participation is welcome and encouraged.
Basic Critical Debriefing Elements

• Middle: Analysis Phase
  – Briefly review the patient’s summary
  – All members are encouraged to participate in general plus/delta or can have targeted open ended questions
  – Help participants identify performance gaps and close them

• Ending: Summary Phase
  – Ask members what they would do differently next time (if anything)
  – Start and end on time (aim 10 minutes)
  – Provide employee assistance counseling info if appropriate
Introduction and shared mental model
“We are going to do a quick debrief of that event. It should only take a few minutes. The goal is to improve our performance as a team and the care we provide. We are not here to evaluate individual performance. Let’s start with a description of the key clinical events.”
• Review the clinical events and establish a shared mental model of what happened.

What went well, and what did not (‘plus/delta’)
“OK team, let’s talk about our performance. What went well, and what didn’t go so well?”
• Did the team follow established guidelines and protocols? If not, why?
• Were there any technical, equipment, or procedural issues? If so, what?
• Discuss 2 to 3 key behavioral skills relevant to the situation. How was team performance in these areas?
What will the team do differently next time?

“How can we do better next time?”

- Discuss changes in team performance that will be implemented in the future, based on discussion above.
- Identify the individual(s) responsible to follow up on issues discussed.

Follow up on issues?

“What issues, if any, should be deferred for a more in depth discussion at a later time?”

- Record issues to be followed up later.

Conclusion

“Thank you for taking time to participate in this debriefing”
Psychological safety and debriefing

• Debriefers should be formally trained
  – Team members need to feel safe to participate without the fear of being shamed, humiliated, or belittled
  – When one feels safe they feel they will be viewed positively, even if they have made a mistake
  – Psychological safety necessary in order to freely ask questions, understand the desired behavior, and to achieve lasting change.
By understanding the frame from which a learner performed, you can figure out what type of teaching point to make to try and change the frame which can lead to changes in actions and therefore outcomes for the patient/clinical situation.
I’m curious how you saw the situation at the time...

Tell me more....

What was your thought process??

Can you expand on that?

Anyone else have a thought?
# Texas Children’s Hospital - Debriefing In Situ Conversation in Emergency Room Now (DISCERN) Form

This info is privileged and confidential pursuant to TX Health & Safety Sections 161.031-033, TX Occupations Code Section 160.007 &/or TRCP 192.5

## ALL patients need this section completed - NURSE must decide with the doctor whether a debrief is necessary for EVERY

<table>
<thead>
<tr>
<th>Place Patient Sticker Here</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### 1. Date (MM/DD/YY)

### 2. Physician Team Leader

### 3. "I/\* Nurse filling this out:

### 4. If team leader & 1/\* nurse together decide not to do a care issue to make time debriefing, state reasoning:

### 5. Resuscitation Type (check all that apply):

<table>
<thead>
<tr>
<th>Respiratory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical (includes seizure)</td>
</tr>
<tr>
<td>Trauma</td>
</tr>
<tr>
<td>Pulseless</td>
</tr>
</tbody>
</table>

### 6. Interventions (check all that apply):

<table>
<thead>
<tr>
<th>Intubation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defibrillation</td>
</tr>
<tr>
<td>Code 3 Trauma Activation CPR</td>
</tr>
</tbody>
</table>

### 7. Time Rescue Ended

<table>
<thead>
<tr>
<th>(Either &quot;time of death&quot; or &quot;time left EC&quot;, whichever was last)</th>
</tr>
</thead>
</table>

### 8. Patient outcome

<table>
<thead>
<tr>
<th>Alive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expired</td>
</tr>
</tbody>
</table>

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### Advice for Running A Team Debriefing

1. Pick a quiet or isolated space if possible - start by thanking members for being present & encouraging all members to participate.
2. State: "The purpose of debriefing is for education, quality improvement, & emotional processing; it is not a blaming session. Everyone’s participation is welcome & encouraged."
3. State: "These debriefings usually take several minutes and if you have urgent issues to attend to, you are welcome to leave at any time."
4. State: "I will briefly review the patient's summary and then we as an entire team can discuss what went well and what could have gone better. Please feel free to ask any questions."
5. Proceed as team leader with a brief summary of the patient’s course (<1 minute) and then proceed to the group discussion. Documenter (not team leader) records on this form.

* If anyone needs or requests referral for free counseling, call the appropriate institution at 832-824-3327 (TCH) or 713-500-3327 (BCM) Updated 2/3/2012

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### Fill out this section only if debriefing occurs

1. Members Present (*X* box if present during debriefing)

   | Chaplain |
   | Charge Nurse |
   | Child Life |
   | Family Advocate |
   | Pediatric Emer. Medicine Fellow |
   | Pharmacist |
   | Physician Team Leader |
   | Primary/Documenting Nurse |
   | Resident |
   | Respiratory Therapist |
   | Secondary Nurse |
   | Other: |

2. Debriefing Physician, Team Leader Name:

3. Debriefing Documenter Name (NOT same as #2 above, can be RN or Dr.):

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### Fill out this section during the debriefing (Person writing not the person leading debriefing) (Write on the back of form if there is not enough space)

1. Time Debriefing Started: ____________________________

2. What went well during our care for the patient?

   ____________________________

3. What could have gone better during our care for the patient (ADD potential solutions if applicable)?

   ____________________________

4. Was the Physician Team Leader (PTL) the only doctor calling out medication orders? YES __________ NO

5. Was anyone confused at any time during the resuscitation about who was the PTL? YES __________ NO

6. Time Debriefing Ended: ____________________________

7. State: "If anyone wants counseling support, please see referral numbers at the bottom of this form."

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*Texas Children’s Hospital*
Identified the:

- lack of established debriefing tool for perinatal critical events
- absence of published studies on routine use of debriefing in perinatal units for critical events or related to performance improvement
- link between benefits and improved outcomes resulting from debriefing real-time events
California Maternal Quality Care Collaborative

- Targeted debriefing tools for:
  - Term infant with apgar 6 or fewer at 5 minutes
  - Intrapartum fetal demise
  - Emergency CD
  - PPH
  - 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 NICU
<table>
<thead>
<tr>
<th>Team Attendance</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Help arrived in a timely manner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Team members assumed or were assigned roles.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Adequate help was present</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication Administration</th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>1. Medications arrived in a timely manner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Medications were given in accordance of policy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Adequate volume and type of meds were in room</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Device Placement</th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Foley</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Intrauterine balloon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluid &amp; Blood Administration</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----</td>
<td>----</td>
<td>----------</td>
</tr>
<tr>
<td>1. Second IV was started in a timely manner</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>2. Was any type of blood administered</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>3. Blood arrived in a timely manner</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>4. Was MTP policy activated</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>5. Was rapid transfuser used?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>6. Rapid transfuser was used effectively and according to procedure?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>7. Adequate amount of blood was available</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Surgical Treatment</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Operating room ready in a timely manner</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Adequate staff for procedure</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. Appropriate supplies were readily available</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Other issues to report
### Advocacy - Identify Performance Gaps and Desired Actions

- I noticed that we did/ did not....
- I saw that we did/ did not....
- I heard you/someone say that...
- I was concerned to see that we did/did not....
- I was impressed by how we did/ did not....

**Where did debrief occur?**
- LDR/OR at bedside
- Hallway
- NICU bedside
- Elevator/Transit
- Other: ____________

**When did debrief occur?**
- Prior to handoff to LDR/NICU team
- After handoff to LDR/NICU team (< 1hr)
- After handoff to LDR/NICU team (> 1hr)

**Was the family present during the debrief?**
- Yes
- No

### Identify Specific Critical Behaviors During a Resuscitation

- Evaluate Team Performance: 0- Not Done, 1- Done Sometimes, 2- Done Consistently

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gather all necessary equipment before delivery?</td>
<td></td>
</tr>
<tr>
<td>Follow the NRP algorithm?</td>
<td></td>
</tr>
<tr>
<td><strong>Use Effective Communication</strong></td>
<td>Score</td>
</tr>
<tr>
<td>Remain calm &amp; professional</td>
<td></td>
</tr>
<tr>
<td>Use closed loop communication</td>
<td></td>
</tr>
<tr>
<td>Share information &amp; critical events</td>
<td></td>
</tr>
<tr>
<td>Share the plan &amp; next steps in care</td>
<td></td>
</tr>
<tr>
<td>Use the Two Challenge Rule when disagreement with plan arose</td>
<td></td>
</tr>
<tr>
<td><strong>Utilize Resources Well</strong></td>
<td>Score</td>
</tr>
<tr>
<td>Call for help early</td>
<td></td>
</tr>
<tr>
<td>Distribute workload optimally (no multitasking)</td>
<td></td>
</tr>
<tr>
<td><strong>Establish Role Clarity</strong></td>
<td>Score</td>
</tr>
<tr>
<td>Team Leader identified</td>
<td></td>
</tr>
<tr>
<td>Team member roles and tasks identified</td>
<td></td>
</tr>
<tr>
<td><strong>Use Effective Situational Awareness</strong></td>
<td>Score</td>
</tr>
<tr>
<td>Obtain &amp; utilize all available information</td>
<td></td>
</tr>
<tr>
<td>Anticipate and plan ahead for crises</td>
<td></td>
</tr>
<tr>
<td>Use effective mental modeling to review expected care plan, ask for suggestions, &amp; get team on same page</td>
<td></td>
</tr>
</tbody>
</table>

### Inquiry: Questions for Reflection

- How did you/we see it?
- I was wondering what your/our thoughts are?
- What were you/we thinking at the time?
- Help me understand how you/we decided that?
- How could you/we have done that differently?
- How could you/we have improved?
List any systems issues identified during the debrief that may interfere with safe and effective patient care: (Please turn in to _________________ for improvement):

- **Resource issues** related to personnel, medication, and equipment—whether missing, malfunctioned, or an inability to use secondary to provider unfamiliarity with the device.
- **Systems issues** related to process, policies, or procedures that do not work as well as anticipated in the clinical setting.
- **Facility or space set up** concerns that are not conducive to effective, efficient, and safe patient care.

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**List any systems issues identified during the debrief that may interfere with safe and effective patient care:**

- Resource issues: _______________________________________
  _______________________________________
  _______________________________________

- Systems issues: _______________________________________
  _______________________________________
  _______________________________________

- Space Set Up Issues: _______________________________________
  _______________________________________
  _______________________________________
<table>
<thead>
<tr>
<th>Objective</th>
<th>Task</th>
<th>Sample Phrases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting the Scene</td>
<td>Create a safe context for learning</td>
<td>State the goal of debriefing, articulate the basic assumption*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;Let's spend X minutes debriefing. Our goal is to improve how we work together and care for our patients.&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;Everyone here is intelligent and wants to improve.&quot;</td>
</tr>
<tr>
<td>Reactions</td>
<td>Explore feelings</td>
<td>Solicit initial reactions &amp; emotions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;How are you feeling?&quot;</td>
</tr>
<tr>
<td>Description</td>
<td>Clarify facts</td>
<td>Develop shared understanding of case</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;What was the working diagnosis? Does everyone agree?&quot;</td>
</tr>
<tr>
<td>Analysis</td>
<td>Explore variety of performance domains</td>
<td>See backside of card for more details</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(Use to introduce new topic)</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;At this point, I’d like to spend some time talking about [insert topic here] because [insert rationale here]*</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Mini Summary</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;That was great discussion. Are there any additional comments related to [insert performance gap here]?&quot;</td>
</tr>
</tbody>
</table>

**Any Outstanding Issues/Concerns?**

| Application/Summary | Identify take-aways | Learner centered                                                                 | "What are some take-aways from this discussion for our clinical practice?" |
|                     |                     | Instructor centered                                                            | "The key learning points for the case were [insert learning points here]." |

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The Analysis Phase

Performance Domains

The analysis phase can be used to explore a variety of performance domains:

- Decision Making
- Technical Skills
- Communication
- Resource Utilization
- Leadership
- Situational Awareness
- Teamwork

Three Approaches

1. Learner Self-Assessment
   Promote reflection by asking learners to assess their own performance

2. Focused Facilitation
   Probe deeper on key aspects of performance

3. Provide Information
   Teach to close clear knowledge gaps as they emerge and provide directive feedback as needed

Sample Phrases

- What aspects were managed well and why?
- What aspects do you want to change and why?
- Advocacy: I saw [observation], I think [your point-of-view].
- Inquiry: How do you see it? What were your thoughts at the time?
- I noticed [behavior]. Next time you may want to consider [suggested behavior], because [rationale].
Resources:

lamcmull@texaschildrens.org