Coming to the Table: Debriefing for Patient Safety

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Disclosures

• The presenters have no financial relationships to disclose or conflicts of interest to resolve.

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Learning Objectives

• Discuss the significance of establishing a debriefing program in healthcare
• Present different debriefing models and potential applications in obstetrics and neonatology
• Identify the key components of a debriefing program
• Describe the process for tracking opportunities for improvement after debriefing
• Identify strategies to overcome barriers when establishing a debriefing program
Patient Safety Movement

Joint Commission National Patient Safety Goals

Patient Safety and Quality Improvement Act

Adapted from: www.ahrq.gov.teamsteppstools/instructor/fundamentals/module1/jgintro.htm
Annual Deaths in the United States

- AIDS
- Motor Vehicle Accidents
- Breast Cancer
- Medical Errors

Root Causes: Perinatal Deaths & Injuries

- Human Factors: 70%
- Communication: 65%
- Assessment: 60%
- Leadership: 55%
- Information Management: 25%
- Physical Environment: 20%
- Medication Use: 10%
- Operative Care: 5%

% of Sentinel Events

www.jointcommission.org (2004-First Quarter 2012)
AHRQ Hospital Safety Scores

Nonpunitive Response to Error
Handoffs & Transitions
Teamwork Across Units
Open Communication
Overall Perception of Patient Safety

% of Positive Responses

Debriefing

From left to right: www.PSQH.com; www.defense-update.com; www.sales-getters.com;
Why Debrief?

1. Staff identify ways to improve patient care and outcomes.
   - **Crew Resource Management**: Blend technical and human skills to support safe and efficient patient care.

2. Learning is relevant and timely, focused on actual patient care events.

3. Debriefing elicits learner-centered feedback.
   - Self-reflection and discovery.
   - Enhanced retention of learned ideas.

Debriefing Models: Structured and Supported Debriefing
### Plus-Delta Model

<table>
<thead>
<tr>
<th>Plus</th>
<th>Delta</th>
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</thead>
<tbody>
<tr>
<td>What was done well?</td>
<td>What are some areas for improvement?</td>
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Elements of Debriefing Models

- **Emotions**
  - How did staff feel about the patient event?

- **Analysis**
  - What was done well?
  - What are some areas for improvement?

- **Application**
  - How can patient care be improved next time?

- **Summary**
  - What are the main take away points?
Feedback
Giving information or input to an individual or team with the intention of modifying future behavior

INSTRUCTOR,
SUPERVISOR, etc.

STAFF

Debriefing
Facilitating a structured form of feedback that allows individual and team reflection to understand issues and discuss areas for improvement

FACILITATOR

STAFF
<table>
<thead>
<tr>
<th>Facilitator</th>
<th>Instructor</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assists</td>
<td>• Provides</td>
</tr>
<tr>
<td>• Co-learner</td>
<td>• All-knowing</td>
</tr>
<tr>
<td>• Same level</td>
<td>• Hierarchical</td>
</tr>
<tr>
<td>• Flexible</td>
<td>• Inflexible</td>
</tr>
<tr>
<td>• Staff-centered</td>
<td>• Teacher-centered</td>
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- **Role in learning**: Instruction vs. facilitation
- **Knowledge**: All-knowing vs. hierarchical
- **Relationship to staff**: Same level vs. hierarchical
- **Structure**: Flexible vs. inflexible
- **Focus**: Staff-centered vs. teacher-centered
Roles and Traits of the Facilitator

• Establishes ground rules for debriefing
• Creates a safe debriefing environment for staff
• Stays focused on primary goals & objectives
• Suspends own opinions and biases
• Engages in active listening
• Clarifies or elaborates on discussion points
• Ensures balanced staff participation
• Asks open-ended questions
Assessing Frames to Reveal Improvement Opportunities

Debriefing with Good Judgment

<table>
<thead>
<tr>
<th>How facilitator views staff</th>
<th>Judgmental</th>
<th>Debriefing with Good Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff makes mistakes</td>
<td>Staff takes certain actions based on knowledge and assumptions</td>
<td></td>
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</table>

| Role of the facilitator    | Provides directed feedback with the intention to change behavior | Tries to understand frames and creates a context for learning and change |

<table>
<thead>
<tr>
<th>Typical message of debriefing</th>
<th>Judgmental</th>
<th>Debriefing with Good Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Here’s how you messed up.”</td>
<td>“I noticed X. I was concerned with that because of Y. Tell me what you were thinking at that time.”</td>
<td></td>
</tr>
<tr>
<td>“What do you think you could have done better?”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
When does your staff debrief on your unit?
Please check all responses that apply.

a. We have not had the opportunity to debrief
b. After a sentinel event (e.g. a maternal or infant death)
c. After an unexpected emergency (e.g. shoulder dystocia, post-partum hemorrhage, etc.)
d. After extensive neonatal resuscitation
e. After medical errors or near misses
f. After most uncomplicated deliveries or patient events
Steps in Building a Debriefing Program

1. Obtain leadership buy-in
2. Secure frontline champions
3. Create a safe environment
4. Introduce the concept
   - Simulation
   - Team training education
5. Secure and train debriefing facilitators
6. Roll-out the program

Building a culture of safety

- Identify opportunity to debrief
- Interdisciplinary team debrief
- Capture, implement and track action items
- Improve systems, communication and education
Setting Up A Debriefing

1. Identify case
2. Notify facilitators
3. Identify participants / teams involved
4. Secure time, location & personnel
5. Debrief
6. Capture opportunities for improvement
7. Share, implement & track opportunities
Quality Improvement Opportunities

- Clarify with nursing and residents when to institute chain of command.
- Improve organization of emergency c-section cart.
- Educate staff on implementing team huddles for high-risk patients.

Pie chart:
- Teamwork & Communication: 41%
- Systems-Based: 35%
- Educational: 24%
## Tracking Tool

<table>
<thead>
<tr>
<th>Identified Opportunity</th>
<th>Point Person</th>
<th>Plan of Action</th>
<th>Date Started</th>
<th>Tracking</th>
</tr>
</thead>
</table>
| **Obstetric team:**    | L&D nurse leader | • Secure funds for new cart  
• Purchase new cart  
• Stock cart  
• Educate staff | 4/1/10 | • Use by staff  
• Feedback from staff about the cart |
| Organize emergency cesarean section tote | | | | |

| **NICU team:** | NICU nurse manager | • Check current policy  
• Obtain consensus from delivery room team  
• Inform all NICU staff  
• Revise policy, if needed | 4/1/10 | • Staff who respond to overhead pages  
• Feedback from staff |
| Clarify who and how many people should respond to an overhead STAT delivery page | | | | |
Polling Question #2

What do you see as the most important barrier to establishing a debriefing program in your unit/department? Please select up to 3 choices.

a. Establishing buy-in from administrators & staff
b. Finding time for staff to debrief because of patient care duties
c. Alleviating staff anxiety of being evaluated or blamed
d. Addressing the presence of inter-professional conflict
e. Identifying and training facilitators
Establishing Buy-In

General principles:

• Start small
• Identify what success looks like
• Be clear about the goals of the debriefing program
• Share identified areas for improvement and changes implemented with frontline staff and hospital leadership
• Celebrate small wins
Establishing Buy-In

From administrators & unit leaders:

• Create a sense of urgency
• Compile data from institutional safety surveys, events reporting, root cause analyses and malpractice claims
• Identify potential patient safety outcomes
• Discuss cost benefit analysis
• Draw from experiences of other units and institutions
Establishing Buy-In

From staff:

• Empower staff to influence change
• Create a safe learning environment
  o Introduce debriefing during educational programs or simulation-based training exercises
  o Reassure staff that purpose is to improve patient safety rather than focus on any individual
• Ask nursing and physician leaders to participate during debriefings
Making Time to Debrief

• Identify a point person to set-up the debriefing
• Ask nurse leaders or physician supervisors to provide temporary patient coverage
• Give core participants time to decompress, stabilize patients and hand-off patient care
• Establish a length of time for debriefing, alert staff and stick to it
• If timing is right, build it into scheduled staff meetings
• Keep it short and simple
Alleviating Staff Anxiety

• Establish a safe debriefing environment
• Reassure staff that purpose is for quality improvement, rather than be punitive
• Reassure staff that discussions during debriefings are not discoverable
Addressing Inter-Professional Conflicts

• Establish “ground rules” of debriefing at beginning
• Acknowledge known internal conflicts
• Redirect focus/purpose of debriefing to patient safety, rather than to individuals
• Highlighting the importance of individual contribution to the team
• Highlight “ground rules” to promote effective debriefing
• Speak to individuals separately
Identifying & Training Facilitators

• Start by identifying champions
  o Safety nurse, nurse or physician educators

• Train several individuals to become facilitators
  o Identify individuals from day and night shifts
  o Tie debriefing to work responsibility and clinical advancement
  o Enroll individuals in training courses

• Keep the debriefing simple
  o Script debriefings with key questions
Summary

• Establishing a debriefing program is an effective method to identify opportunities for improvement.

• Implementing changes identified during debriefings can improve patient safety.

• Debriefing improves interprofessional collaboration and communication, which leads to a team culture that further promotes patient safety.
Future Webinars... Coming Soon!

• June 28, 2013
  Improving Team Function through Simulation-Based Learning

• October 29, 2013
  Linking Simulation and Debriefing to Quality Improvement
Thank You!

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