Coming to the Table: Debriefing for Patient Safety

NYSPQC Educational Webinar
April 24, 2013

Christine Arnold, RNC, MS
Rita Dadiz, DO
Joanne Weinschreider, RN, MS
Faculty

Christine Arnold, RNC, MS
Project Director, Center for OB/GYN Simulation
Department of Obstetrics & Gynecology

Rita Dadiz, DO
Assistant Professor of Pediatrics
Director, Simulation-Based Emergency and Safety Training Program
Division of Neonatology

Joanne Weinschreider, RN, MS
Nursing Simulation Lab Director, School of Nursing
Saint John Fisher College
Disclosures

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

• This webinar was made possible by the NY State Perinatal Quality Collaborative and the Health Resources and Services Administration (grant # T21MC18129-03-00).
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

[Graph showing annual deaths in the United States categorized into AIDS, Motor Vehicle Accidents, Breast Cancer, and Medical Errors.]

- AIDS: 20,000
- Motor Vehicle Accidents: 40,000
- Breast Cancer: 60,000
- Medical Errors: 80,000

Root Causes: Perinatal Deaths & Injuries

- Human Factors
- Communication
- Assessment
- Leadership
- Information Management
- Physical Environment
- Medication Use
- Operative Care

% 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

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

Crew Resource
Analysis & Evaluation
Line Operations

Emotions
Analysis
Application
Summary

Gather
Analyze
Summarize

3D Model
Diffusing
Discovering
Deepening
Summary

Reactions
Understanding
Summary
## Elements of Debriefing Models

<table>
<thead>
<tr>
<th>Emotions</th>
<th>• How did staff feel about the patient event?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analysis</td>
<td>• What was done well?</td>
</tr>
<tr>
<td></td>
<td>• What are some areas for improvement?</td>
</tr>
<tr>
<td>Application</td>
<td>• How can patient care be improved next time?</td>
</tr>
<tr>
<td>Summary</td>
<td>• What are the main take away points?</td>
</tr>
</tbody>
</table>
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
Facilitator

- Assists
- Co-learner
- Same level
- Flexible
- Staff-centered

Instructor

- Provides
- All-knowing
- Hierarchical
- Inflexible
- Teacher-centered

Role in learning

Knowledge

Relationship to staff

Structure

Focus
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>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Role of the facilitator</th>
<th>Judgmental</th>
<th>Debriefing with Good Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides directed feedback with the intention to change behavior</td>
<td>Tries to understand frames and creates a context for learning and change</td>
<td></td>
</tr>
</tbody>
</table>

<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>

Polling Question #1

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

- Identify case
- Notify facilitators
- Identify participants / teams involved
- Secure time, location & personnel
- Debrief
- Capture opportunities for improvement
- 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.

- Educational: 24%
- Systems-Based: 35%
- Teamwork & Communication: 41%
### 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>
<tbody>
<tr>
<td><strong>Obstetric team:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organize emergency</td>
<td>L&amp;D nurse leader</td>
<td>• Secure funds for new cart</td>
<td>4/1/10</td>
<td>• Use by staff</td>
</tr>
<tr>
<td>cesarean section tote</td>
<td></td>
<td>• Purchase new cart</td>
<td></td>
<td>• Feedback from staff about the cart</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stock cart</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Educate staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NICU team:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarify who and how</td>
<td>NICU nurse manager</td>
<td>• Check current policy</td>
<td>4/1/10</td>
<td>• Staff who respond to overhead pages</td>
</tr>
<tr>
<td>many people should</td>
<td></td>
<td>• Obtain consensus from delivery room team</td>
<td></td>
<td>• Feedback from staff</td>
</tr>
<tr>
<td>respond to an overhead</td>
<td></td>
<td>• Inform all NICU staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STAT delivery page</td>
<td></td>
<td>• Revise policy, if needed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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!

Christine_Arnold@URMC.Rochester.edu
Rita_Dadiz@URMC.Rochester.edu
JWeinschreider@SJFC.edu