

## Clarity PSO Learning Series

### Topic: The 3 D's of Debriefing: Define, Deploy, Discover

Imagine this: You work on a unit that handles a lot of emergency blood transfusions, but the blood you need from the blood bank typically takes a long time to reach your unit. You don't think about issues like this in the heat of the moment, but your team holds regular debriefing sessions, giving you the chance to reflect on the situation and to discuss the highs and lows of your processes. During your latest debriefing, one of your team members points out the timing issue of the emergency blood and you all agree something needs to be done about it in order to improve your patient care.

Discussions continue after the debriefing and a project plan is created around the blood transfusion issue. As it turns out, the blood bank is not aware of the urgency required for blood on your unit. To correct this issue, your organization develops an emergency massive transfusion protocol. The blood bank now has a way of knowing when blood products are needed immediately on your unit, ultimately improving its response time and the transfusion process.

For one healthcare organization, this was not an imaginary situation; this was a real-life scenario. We ask you to imagine it because it represents a need that is universal across healthcare settings: namely to use every situation as a learning opportunity and to consider debriefings as the powerful catalyst for the learning necessary to improve patient care and safety.

For this *PSO Learning Series Report*, we explore the elements of the debriefing process and offer ideas for how you can incorporate them into your daily operations.

### DEFINE

Debriefing is a powerful process improvement tool that can be performed quickly with few resources, while still reaping enormous rewards for individual providers and staff, organizational teams, patients' families, and patients. The practice of effective debriefing creates a sense of team amongst providers and staff, fosters team engagement, and builds a shared mental model amongst the team. Consider the goal of debriefing, "to enable members to collectively make sense of their environment and to develop a shared vision for how to proceed in the future" (Smith-Jentsch, Cannon-Bowers, Tannenbaum, & Salas, 2008, p. 303). Debriefing is a team event in which errors made are *identified*, individual and team performance is *reviewed*, best practices are *recognized*, a plan to improve is *developed*, and continuous learning and process improvement is *promoted*.

### DEPLOY

You may be thinking, "this seems great, but we don't have the time/resources and even if we did, how would we convince clinicians to make it a practice?" or "how can debriefing really impact practice?" or "how exactly does debriefing translate into practice?" To the first barrier—debriefing doesn't need to be hours long, it can take place in a matter of minutes and be initiated by the staff immediately after an event or period of time, such as a shift. To the second barrier—*staff don't want to make mistakes*,

especially mistakes that could have been avoided. Debriefing is a wonderful tool that allows staff to reflect on their work and workflow and evaluate what can be done better. Debriefing empowers staff to improve as individuals and team members, question how to be a more efficient team, and especially how to keep patients safe.

With that being said, one of the toughest parts of initiating debriefing is engaging staff in the practice. *Staff will engage, identify issues, and bring ideas for improvement when they* **1) have a safe way to debrief** (this means leadership supports and encourages a culture of safety throughout the organization, and not simply during debriefing sessions), and **2) they see changes to issues that they bring up** (this means leadership follows through with making the necessary changes).

❖ ***What are the key components any facilitator should consider when conducting a debrief?***

1. Lay the groundwork for a productive discussion:
  - a. *State the goals* of the debriefing, in the order of their importance. By prioritizing the goals, the primary intention of the debrief comes into focus, while the secondary intentions can be noted and saved for later discussions.
  - b. *Create psychological safety* (“our purpose today is to simply learn; it is not about shaming, blaming, or being punitive”).
  - c. Foster an *open and honest discussion* and emphasize the positives.
  - d. If team members present do not know each other, *make introductions* and allow the more junior members to speak first to foster their participation.
2. Begin with a chronological review of the event. It is important to note that as the team becomes increasingly well-versed in performing debriefings, consider reviewing the event based on teamwork principles such as “how did our closed-loop communication go?” The goal is to have the group perform “guided team self-correction.” This means that the facilitator should guide the group in discussion, but the group is encouraged to figure out the problems and identify the issues.
3. Use open-ended questions and ask participants to clarify.
4. When finishing the debrief, allow the participants to provide the final summary.

### ❖ *What is the discussion outline for a debrief?*

There are only three simple questions to ask and answer within a debrief:

1. What went well and why?
2. What could have gone better?
3. What could I/We do better next time?

Ultimately, these questions come down to one underlying question: *What can we learn?*

### ❖ Tips for Implementing Debriefs

- When providing feedback to participants, make that feedback specific, behaviorally focused and descriptive.
- Team leaders need to recognize behaviors and processes and need to be trained to see positive team behaviors.
- Train facilitators or leaders to perform guided correction during the debriefs to allow for team self-correction and avoid simply having the facilitator direct the discussion.

### ❖ Tips for Leaders and Facilitators

- Keep the debrief simple by focusing on the high priority and key learning points.
- Empower all participants to speak up.
- Promote process and teamwork feedback.
- Reduce the time delay between the event and the debrief.
- Record debrief conclusions for review and trending.

### ❖ Avoid Pitfalls of Debriefing

- There are many things that can turn a debrief into an ineffective meeting and cause it to stray away from its primary intentions. This can happen when participants focus on environmental limitations, clinical issues, problem-solving, ethics, policy debates, and anything that comes between your discussion and those three essential questions: “*what went well and why?*”; “*what could have gone better?*”; and “*what could I/we do better next time?*”. Other topics may be important to discuss in-depth, but those discussions should be reserved for another time.
- When the discussion veers from its core purpose, it should be gently guided back to the primary goals of the debrief, those that were identified at the beginning of the session. One way to gently redirect the conversation is to state, “This is an important issue, but let’s write it down for another time and get back to this discussion’s primary goal.”

❖ ***What do you need in order to properly implement debriefs?***

- Identify a facilitator.
- Give all team members a voice in the process.
- Treat debriefs as learning opportunities, not opportunities for assigning blame.
- Focus on process improvement and future performance.

## DISCOVER

While it is known that effective debriefing can have a significant impact, it is important to show what impact *your debriefings* have on *your organization*. Determining metrics to track your debriefings and evaluate their impact is invaluable. Some examples of effective ways to capture some metrics include: participant summary sheets; a debriefing log book for all the findings identified during various debriefings; tracking the percentage of events debriefed; Culture of Safety Surveys, etc. The specific metrics are up to your discretion. What is it that your organization will value and celebrate?

As you can see, debriefings are vital to the continuous learning and improvement that we, as providers and caregivers, have committed to and have promised our patients. Debriefings provide us with the opportunity to evaluate and close the gaps within our workflows. They empower providers and staff to engage in the process for improvement, to point out barriers and challenges, and ultimately create a workflow that propels care and patient safety to excellence. Debriefings are about us, the provider, the staff, the leadership, the family, the patient—*the team*—how we interact, what we can learn, and how we can improve.

This information on debriefing was adapted from the webinar, *The 3 D's of Debriefing: Define, Deploy, Discover*, presented by Dr. Stan Davis and Clarity PSO. Dr. Stan Davis is a board-certified obstetrician with over 20 years of clinical experience, an expert in human factors engineering, and an original faculty member for the National Implementation of TeamSTEPPS. He has worked with over 100 public, private, and military hospitals using simulation and TeamSTEPPS. He has lectured nationally and internationally with a variety of institutions including the Institute for Healthcare Improvement (IHI), the Institute for Clinical Systems Improvement (ICSI), risk management groups, and the Department of Defense (DOD), among others. He is currently working with the Research Triangle Institute (RTI) in the development of a Comprehensive Unit-Based Safety Program (CUSP) for obstetric care in the United States. For the last seven years, Dr. Davis has been an active member of the Clarity PSO Healthcare Advisory Council.

## RESOURCES

- [TeamSTEPPS](#)
- [Comprehensive Unit-based Safety Program \(CUSP\) toolkit](#)
- [AHRQ: Labor and Delivery: Debrief video](#)

## REFERENCES

- Davis, S. (2016). *The 3 D's of Debriefing: Define, Deploy, Discover: A Clarity PSO two-part webinar series* [PowerPoint slides].
- Smith-Jentsch, K. A., Cannon-Bowers, J. A., Tannenbaum, S. I., Salas, E. (2008). Guided team self-correction: Impacts on team mental models, processes, and effectiveness. *Small Group Research, 39*(3), 303-327. DOI: 10.1177/1046496408317794