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

A Clarity PSO Webinar Series

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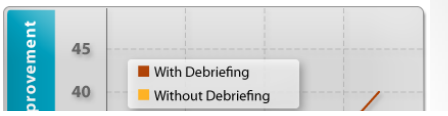
Why Debrief ?

- Debriefing is arguably the most powerful tool in process improvement.
- Debriefing is readily available to all, yet remains underutilized.
- Debriefing is powerful in creating a sense of team and heightened team engagement.
- This webinar will focus on how to efficiently conduct debriefings to maximize its effectiveness in improving patient care and safety.

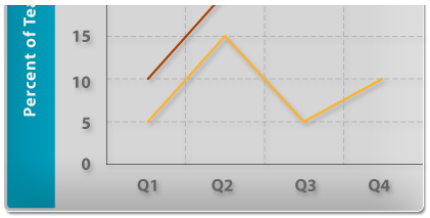
Why Debrief?

- Teams that debrief are able to uncover and identify problems earlier than other teams



Reflection!

- Teams that debrief effectively build shared mental models



Smith-Jentsch, et al., 2008

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Why Debrief ?

Joint Commission (TJC) Report
2004 - 2014

Communication failures were a root cause in:

- 48 percent of US maternal sentinel events
- 70 percent of US perinatal sentinel events

Fair Process: Managing in the Knowledge Economy

(Kim and Mauborgne)
"Best of Harvard Business Review, 1997"

"When employees don't trust managers to make good decisions or to behave with integrity, their motivation is seriously compromised. Their distrust and its attendant lack of engagement is a huge, unrecognized problem in most organizations."

"This issue has always mattered, but it matters now more than ever, because knowledge-based organizations are totally dependent on the commitment and ideas of their employees."

Why Debrief ?

Suburban Hospital

Obstetricians	81
L&D Nurses	50
Anesthesiologists	16
NNPs	12
Scrub Techs	14
CRNAs	35

How many C/S teams are possible with these staff numbers?

381 Million

Debriefs are team events used to:

Identify errors made

Review individual and team performance

Recognize best practices

Develop a plan to improve

Promote continuous learning and process improvement

The Goal of Every Debriefing…

"enable members to collectively make sense of their environment and to develop a shared vision for how to proceed in the future."

Guided Team Self-Correction
Impacts on Team Mental Models, Processes, and Effectiveness
Smith-Jentsch, et al., 2008
Small Group Research
Volume 39 Number 3 June 2008 303-327

Remind people of the goals…
Remind people of the goals…
Remind people of the goals…

TeamSTEPPS™

Team Skills to Understand/Utilize

Briefing

Huddle

Debriefing

Handoff's

Individual Communication & Teamwork Skills

Situational Awareness	"Me"
Standardized Language (ex: SBAR)	"You"
Closed-Loop Communication	"You"
Shared Mental Model	"US"

Please Use CUS Words

but *only* when appropriate!

Opportunities for Team Debriefs

- Change of Shift
  - Scheduled staff sharing of information
- After Critical Events
  - Codes, rapid responses, resuscitations, patient morbidity/ mortality
  - Following team simulation events
- Post-procedure or at patient discharge
- Ad-hoc or Informal
  - Any unscheduled opportunity for team learning

Debrief Tool for Performance Improvement

Debrief Checklist
Communication clear?
Roles and responsibilities understood?
Situation awareness maintained?
Workload distribution?
Did we ask for or offer assistance?
Were errors made or avoided?
What went well, what should change, what can improve?

Key Elements of a (formal) Debriefing

1) Brief the Debriefing (goals)!

   Create psychological safety…
   "this is a learning process, not shame and blame"
   Open and frank discussion "accentuate the positive".

2) Introductions (allow junior members to speak first)

3) Chronological review of event…

   As the team gets better review the event based on teamwork principles.*

4) Use open ended questions, ask participants to clarify

5) Final summary by the participants

   Remember…it is the participant's debriefing.

* "Guided team self-correction" is the ideal.

Our Conversation Today….

Communication and Teamwork

Process Improvement

Clinical Issues

"Simisms"

…and their order of importance!

Only 3 Questions!

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

Tips for Leaders and Facilitators

- Don't overwhelm learners or observers — **Keep it simple**
  - People can integrate only a few key learning points from an event.
- Empower all members to **speak up** during the debrief.
- Promote **process** and teamwork **feedback**.
- **Reduce the time** delay between the event and the debrief.
- Record debrief conclusions for **review and trending**.

"Debrief the Debriefing"

Tips for Implementing Debriefs

- Telling someone they did well is not good enough.

  They need diagnostic feedback:

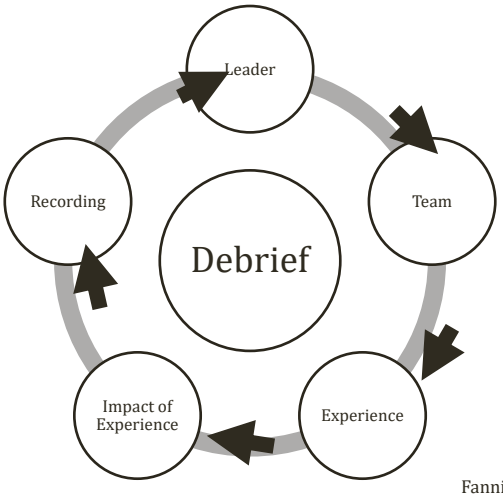
  - Specific
  - Behaviorally focused
  - Descriptive

- Train team leaders to recognize **positive** team behaviors
  - Ensure leaders are attentive to behaviors and processes
- Train leaders or facilitators to provide **guided correction**
  - Create a checklist of goals and objectives for the debrief

Things that Can Blow-up Your Debriefing:

- Losing Sight of the Goal
- Concentrating on Environmental Limitations
- Problem-Solving
- Ethics
- Policy Debate

Team Debrief Process



Fanning & Gaba, 2007

Metrics

- Participant Summary Sheet
- Findings:
  ex: Debriefing log "glitch book"
- Percentage of events debriefed
- Yes/No
- COS survey

Identified Findings

(A partial list of findings from 10 simulations at one hospital)

- No formalized code process
- OB/GYN and Pediatrician not on code c-section paging list
- Unable to access resuscitation supplies
- Infant resuscitation supplies not in the OR
- Unclear role definition
- Orders were not clear and concise
- Extra staff members needed to handle emergency situation
- No documentation
- CPR stopped to assemble equipment
- Hierarchy
- Unclear communication
- Patient Information wasn't shared
- Not enough space for staff to resuscitate the baby
- Staff unsure about where to go when a code c/s is called
- Lack of trust with in the team
- Locked out of the OR

- Orders/Tasks being called out to the air, not directed to someone
- Entire team needs to understand sterile technique
- Didn't have the help needed as code was not called
- Unable to apply suprapubic pressure as no step stool was accessible
- Team members didn't have the same understanding of spoken words
- Importance of Armband
- Code blue call system didn't work in the OR
- Telephone system not working in the OR
- Team did not have the same understanding of the situation
- CPR not being done correctly
- Ceiling light fell during surgery
- Unable to hear call system when in another room
- Lack of defined leadership
- Unsure of who everyone was and what their role was
- Inability to get emergency blood products

Improvements/Solutions

- Identical Newborn Resuscitation Carts now in OR and Nursery
- Pediatrician and Obstetrician added to the code c/section paging list
- Standardized language developed and implemented
- Orientation to the OR
- Mocked codes moved to a regular basis
- Code Blue system fixed in the OR
- Telephone system fixed
- Defined roles now included in policy/ procedure
- Newborn Code Blue Resuscitation Policy created and implemented
- Newborn Code Blue documentation form created and implemented
- Respiratory Therapists now encouraged to have NRP
- Code process formalized
- Step stools added to every labor and delivery room
- Closed Loop Communication being utilized
- Emergency Release of Blood Products Policy/ Procedure implemented
- Shared mental models being discussed
- Utilization of briefing/ huddles/ debriefing used to improve patient care
- Concise documentation forms for obstetrical emergencies being utilized
- Teams verbalized improved trust in their units
- Verbalized change culture within the unit

Implementation *for Success*

What will it take to implement debriefs with your team?

- 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.**

Have a sustainment PLAN!

Sustainment *for Success*

1) It's an **Expectation.**

2) Make it clear the point is to **develop the team**.
(not to criticize individual abilities or critique clinical technique)*

3) Develop **coaches** for the point of patient-care:
"Can I get an SBAR" or "Closed-loop?"

4) **Showcase** the changes that came from staff ideas.
(share at monthly meetings, newsletter, morning brief)

Celebrate team input and team change!

* best done at another time/place.

Barriers *against Success*

…pretty much everything.

Time

You will be more efficient.

Fear

It doesn't have to be perfect.

Loathing

Show people value.

Confucius

"the only thing
required
for learning…
…is humility"

Questions to think about…

- Are you debriefing?
- If so, after what type of events?
- Is there a formal format?
- Are the debriefings done with a routine schedule or ad-hoc?
- What percentage of the scheduled events are debriefed?
- Who leads the debriefing? Per policy?
- Are the debriefing findings documented?
- If so, who coordinates these findings with process improvement measures?
- Are the findings codified? If so, how? (what categories?)
- What have been your greatest successes with debriefing? Stumbles?
- Are the participants engaged in the debriefing process?
- How does the debriefing begin/flow?
- Are findings shared with the rest of the work force?
- If debriefers are trained, do they train others?
- Any interesting catches with debriefing?

Human Factors Tools or "Does Your Hospital Do This?"

- Standardized briefing? Debriefing? Review role definitions?
- Cross monitoring plan in place?
- Have a "stop the line" phrase? "I need clarity"
- Use a two challenge rule? SBAR?
- Program for using closed-loop communication?
- Standardized handoffs?
- Coaching for Sustainment?