Debriefing Skills:
Coming Together to Support Perinatal Teams and Improve Patient Safety

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Learning Objectives

- Define the role and goals of debriefing
- Identify best practices for facilitating a successful debriefing
- Discuss evaluation and strategies for sustaining debriefing

What is Debriefing?

- Debriefing, also known as debrief or after-action review, provides an opportunity for individuals experiencing an event to reflect, make sense of what happened, and uncover lessons learned
- Debriefing has been utilized in the military and aviation industries, as well as in psychology and education

Why Debrief?

- Identify ways to improve patient care and outcomes.
- Learning is relevant and timely, focused on actual patient care events.
- Debriefing elicits learner-centered feedback.
  - Self-reflection and discovery.
  - Enhanced retention of learned ideas.
- Process feelings and provide education about coping with stress

Driskell JE and Adams RJ (1992). FAA Handbook.

Most Frequently Identified Root Causes of Sentinel Events Reviewed by The Joint Commission by Year

The majority of events have multiple root causes
(Please refer to subcategories listed on slides 5-7)

2012 (N=901)		2013 (N=887)		2014 (N=7)	
Human Factors	614	Human Factors	635	Human Factors	547
Leadership	557	Communication	563	Leadership	517
Communication	532	Leadership	547	Communication	489
Assessment	482	Assessment	505	Assessment	392
Information Management	203	Information Management	155	Physical Environment	115
Physical Environment	150	Physical Environment	138	Information Management	72
Continuum of Care	95	Care Planning	103	Care Planning	72
Operative Care	93	Continuum of Care	97	Health information technology-related	59
Medication Use	91	Medication Use	77	Operative Care	58
Care Planning	81	Operative Care	76	Continuum of Care	57

The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these root cause data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of root causes or trends in root causes over time.

11 Tenets of a Safety Culture


Identify opportunity to debrief
Interdisciplinary team debrief
Capture, implement and track action items
Improve systems, communication and education
Building a culture of safety

Debriefing Models

- **C**rew Resource
- **A**nalysis & Evaluation
- **L**ine Operations

- **Emotions**
- **Analysis**
- **Application**
- **Summary**

3D Model

- **D**iffusing
- **D**iscovering
- **D**eepening
- **S**ummary

American Heart Association®

- **G**ather
- **A**nalyze
- **S**ummarize

Plus	Delta
What was done well?	What are some areas for improvement?

CENTER FOR MEDICAL SIMULATION

- **R**eactions
- **U**nderstanding
- **S**ummary

Plus-Delta Model in Action

https://youtu.be/4jB6ISx0SFc

When to Debrief?

- Suggestions
  - After any emergency
  - After any unexpected event
  - After a near-miss
  - When the team requests a debriefing
  - Routine event

Facilitation Skills During Debriefing

- **Active listening**
  - Paraphrasing
  - Reflecting feelings
  - Mirroring
  - Summarizing

- **Probing**

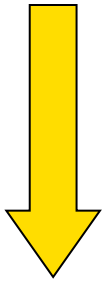
- **Keeping on track**
  - Content
  - Time

- **Maximizing participation**
  - Silence
  - Learners' body language
  - Balancing

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

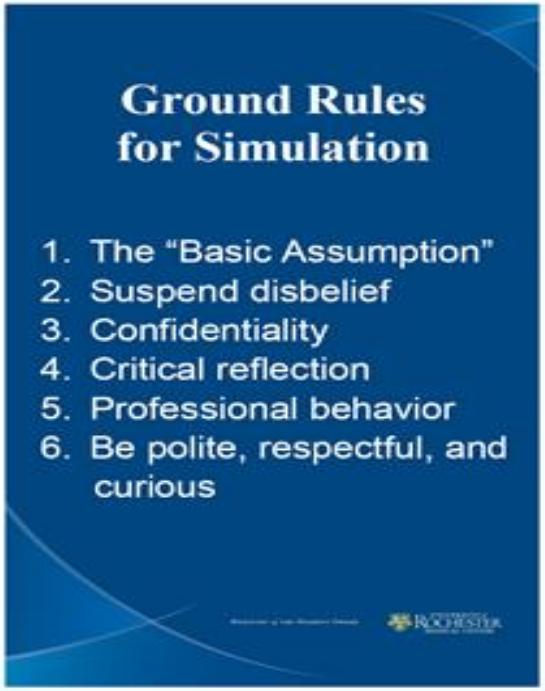
Strategies for Successful Debriefing

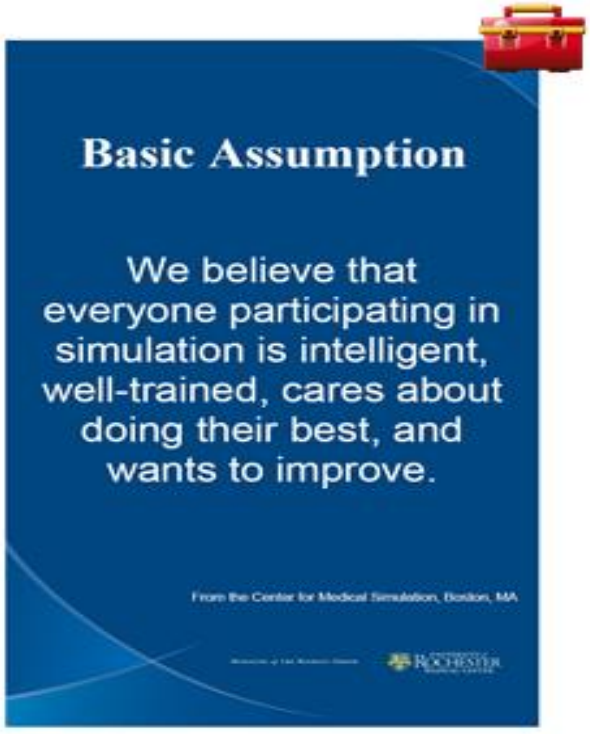
- Prepare yourself before the debriefing
- Prepare participants at the beginning of the debriefing
- Ask questions to facilitate discussion on different aspect of patient care
- Bring the debriefing to closure

Handout: OB-GYN Service Patient Quality Debriefing Form

Briefing- Prepare

- Set up safe environment- Thank everyone for participating
- Explain purpose for debriefing and how long you anticipate debrief will last
- Share ground rules for engagement
- Ask people to introduce themselves and their role in event.
- Start with a description of key clinical events





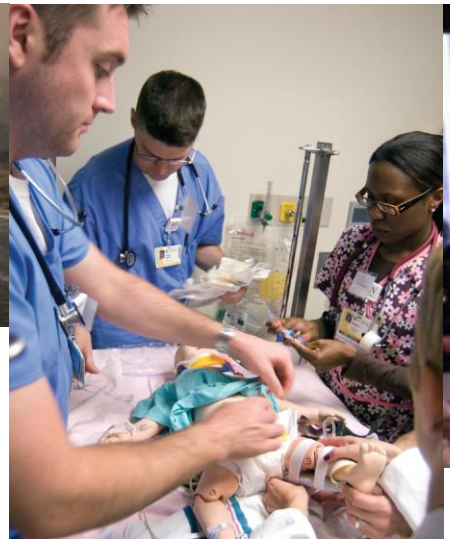
Debriefing- Analysis and Application

Active listening/ Questions to facilitate discussion

- **Patient care:** *Can you tell more about what happened then? At what point did we realize we needed more resources? How well did we follow the phases of care for managing obstetric hemorrhage?*
- **Technical skills:** *How did the caesarean section go?*
- **Resources:** *Who was present ? What additional resources did you need?*
- **Teamwork:** *How well did the team work together? How can we better support each other?*
- **Communication:** *What did we know about the patient? What information would have helped you? How was the communication with the family and the other teams involved?*

Summary - Closure

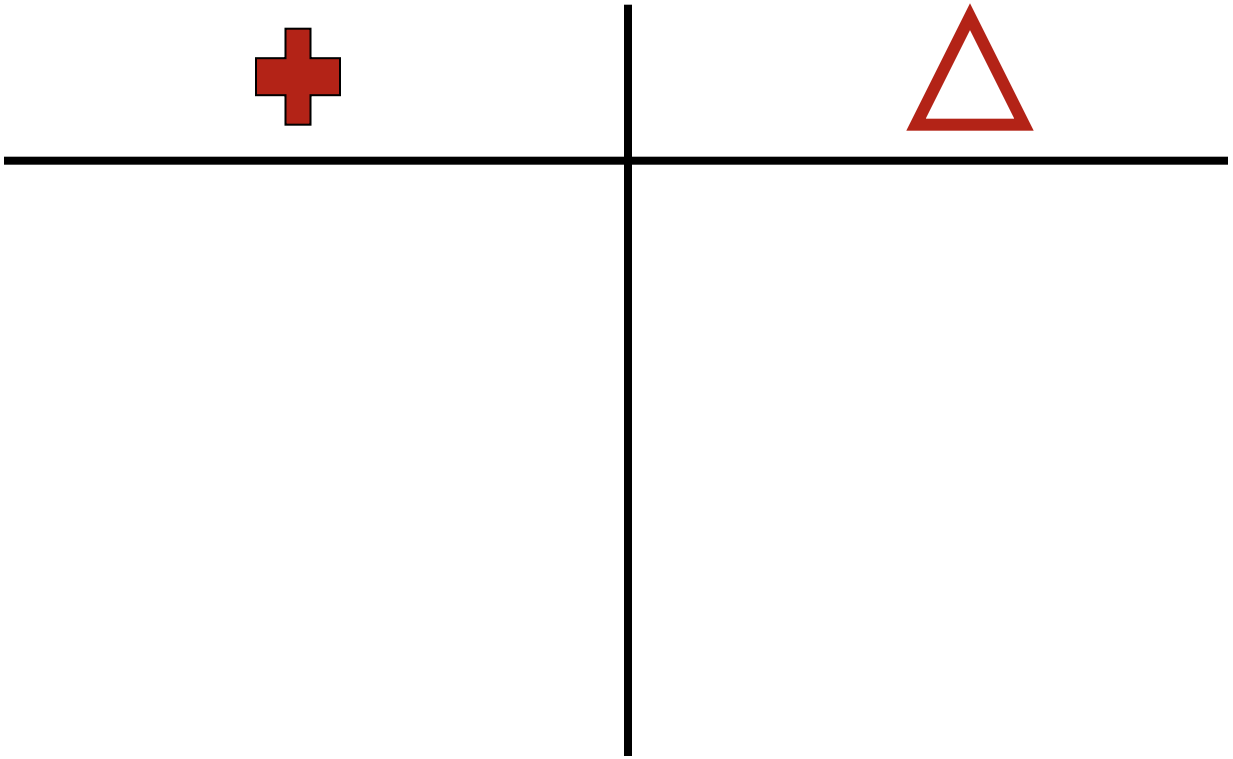
- Thank everyone for participating
- Summarize take away points if time allows
- Let staff know who they can contact for any further discussion
- Remind Staff about EAP if the debrief was emotional



Evaluation, Tracking & Follow-Up

Identified Opportunity	Point Person	Plan of Action	Date Started	Tracking
Obstetric team: Organize emergency cesarean section tote	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
NICU team: Clarify who and how many people should respond to an overhead STAT delivery page	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

Debrief the Facilitator



Debrief the Facilitator

https://youtu.be/DyO2kS7ajqY

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