Hypertension in Pregnancy (HIP) Initiative

July 2016 Learning Session: Debriefing

Partnering to Improve Health Care Quality for Mothers and Babies
Welcome!

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• If you have a question, please enter it in the Question box or Raise your hand to be un-muted.

• This webinar is being recorded.

• Please provide feedback on our post-webinar survey.
Agenda
July 21, 2016

HIP Initiative Announcements

Debriefing After Adverse Outcomes: Opportunities to Improve Quality and Patient Safety - Peter S. Bernstein, MD, MPH

Florida HIP Hospital experiences

Q&A
Resources

- Website: [http://health.usf.edu/publichealth/chiles/fpqc/hip](http://health.usf.edu/publichealth/chiles/fpqc/hip)


- Grand Rounds

- Site Visits

- Clinical Questions/Technical Assistance – send us your questions any time [fpqc@health.usf.edu](mailto:fpqc@health.usf.edu)
Resources Available!

English/Spanish Tear Pads and Posters

Limited number per hospital at no cost

Contact FPQC@health.usf.edu to request
Peter S. Bernstein, MD, MPH

Professor of Clinical Obstetrics and Gynecology and Women’s Health
Maternal Fetal Medicine Division Director
Einstein College of Medicine
Montefiore University Hospital
New York
Debriefing After Adverse Outcomes: Opportunities to Improve Quality & Patient Safety

Peter S. Bernstein, MD, MPH
Professor of Clinical Obstetrics & Gynecology and Women’s Health
Maternal Fetal Medicine Division Director
Conflict of Interest Statement

• No conflicts of interest to report
Learning Objectives

• Describe debriefing background

• Identify key strategies for debriefing in various settings: healthcare in general, simulation, clinical obstetrics

• Discuss implementation of debriefing in Obstetrics
Definitions

• **Debriefing** is defined as:
  – Brief, informal exchange and feedback session
  – Occurs after an event
  – Designed to improve teamwork skills and outcomes
  • An accurate reconstruction of key events
  • Analysis of why the event occurred
  • What should be done differently next time
Debriefing background

• Military
  – Individuals returning from a mission would discuss and describe their experiences in order to learn and receive psychological support after traumatic events.

• Commercial aviation
  – Adopted Crew Resource Management in the late 1970’s as a way to change the culture from one of hierarchy to one of high reliability and increased safety.
Debriefing in Medical Simulation

• Role is to:
  – facilitate transfer of new knowledge, skills, and attitudes to the clinical domain
  – primarily through enactment of the relocation stage of experiential learning
  – and providing the opportunity for the experimentation aspect of adult learning.

• Debriefing Assessment for Simulation in Healthcare (DASH)
  – published, validated tool used to assess performance leading a simulated debriefing
Debriefing in Healthcare

Institute of Medicine, “To Err is Human”, 1999

Healthcare organizations looked to other industries for strategies to begin the journey to high reliability.

High reliability organizations (HROs) are those which have systems in place allowing them to consistently accomplish goals while avoiding potentially catastrophic error.
High Reliability: TeamSTEPPS

- 4 domains-
  - communication,
  - situation monitoring
  - mutual support
  - leadership

- Teams are provided tools and strategies to assist members in becoming more effective and highly functional.
- **Debriefing** is a key strategy within the leadership domain.
Characteristics of HROs

- Safety-oriented culture
- Operations are a team effort
- Communications are highly valued and rewarded
- Emergencies rehearsed and unexpected is practiced
- “Top brass” devotes appropriate resources to safety training
- Members always consider “what can go wrong.”
Principles Underlying HROs

According to Weick and Sutcliffe, the principles underlying the performance of highly reliable organizations are:

- Preoccupation with failure
- Reluctance to simplify
- Sensitivity to operations
- Commitment to resilience
- Deference to expertise

Managing the Unexpected
Weick and Sutcliffe (2007)
## Team STEPPS™

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Tools and Strategies**</th>
<th>Outcomes</th>
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</thead>
<tbody>
<tr>
<td>Inconsistency in team membership</td>
<td>Brief</td>
<td>Shared Mental Model</td>
</tr>
<tr>
<td>Lack of time</td>
<td>Huddle</td>
<td>Adaptability</td>
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<td>Lack of information sharing</td>
<td><strong>Debrief</strong></td>
<td>Team Orientation</td>
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<td>Hierarchy</td>
<td>STEP</td>
<td>Mutual trust</td>
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<td>Defensiveness</td>
<td>I’M SAFE</td>
<td>Team performance</td>
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<tr>
<td>Conventional thinking</td>
<td>Cross monitoring</td>
<td>Patient Safety</td>
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<td>Complacency</td>
<td>Feedback</td>
<td></td>
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<tr>
<td>Varying communication styles</td>
<td>Advocacy and Assertion</td>
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<tr>
<td>Conflict</td>
<td>Two-challenge Rule</td>
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<tr>
<td>Lack of coordination and follow-up with coworkers</td>
<td>CUS</td>
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<td>Distractions</td>
<td>DESC Script</td>
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<tr>
<td>Fatigue</td>
<td>Collaboration</td>
<td></td>
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<td>Workload</td>
<td>SBAR</td>
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<td>Misinterpretation of cues</td>
<td>Call-out</td>
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<tr>
<td>Lack of role clarity</td>
<td>Check-back</td>
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<td></td>
<td>Handoff</td>
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<td>Task Assistance</td>
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Debriefing can be a first step to identify critical areas of focus from front line team members involved in major events which can guide further review.
Debriefing Guidance & Pitfalls

Key elements of good debriefing:

- Empathetic, non-blaming, non-threatening
- Conversational
- Consider sandwich technique
- Pair advocacy with inquiry

Avoid:

- When asking questions, do not grill.
  - “Don’t you know...?”
  - “Did it occur to you...?”
  - “Why didn’t you double check?”
  - Guess what I am thinking...
Debriefing Techniques

- Non-judgmental debriefing
- Debriefing with good judgment
- Plus-delta
- “Sandwich technique”
  - What went well?
  - What did not go well?
  - What are lessons learned for future?
Debriefing in Obstetrics

• Who?
  – Entire interdisciplinary team (obstetrics, nursing, pediatrics, and anesthesia)
  – Social Work: most severe events

• What?
  – All deliveries vs. just certain trigger events

• When?
  – As close to an event as possible to maximize the potential for information gathering and identification of systems issues

• Where?
  – Safe space where participants feel comfortable enough to express opinions and offer suggestions.

• Why?
  – To help the team identify opportunities for improvement in teamwork, skills, and outcomes.
  – Emotional well-being.

• How?
  – Trained debriefers
  – Use of a debriefing guide
Debriefing in Obstetrics - Triggers?

- **Maternal Events:**
  - Maternal Death
  - Unanticipated hysterectomy on nulliparous patient
  - Unanticipated admission to ICU

- **Neonatal Events:**
  - Unanticipated fetal/neonatal death
  - Neonatal significant injury (brain cooling/ neonatal code)
Debriefing in Obstetrics - Tools

APPENDIX C: DEBRIEFING TOOL

Directions: Form is to be completed immediately after patient situation by the designated team member. After completion, the form is given to ______________ (designated by hospitals). After the debrief, team members who want to provide additional input are encouraged to complete an incident report.

Goal: Allow team a debrief mechanism to talk immediately about a patient care situation to capture what went well, what could have been done better and what prevented the team from caring for the patient effectively.

Patient Name: __________________________ Form completed by: __________________________

Date: __________________________ Time: __________________________

Team members attending debriefing (Print Names):

<table>
<thead>
<tr>
<th>Team Attendance</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Help arrived in a timely manner</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>2. Teams members assigned or were assigned needed roles</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>3. Teams members stayed in role through situation</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>4. Adequate help was present</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

Medication Administration: Yes No Comments

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medications arrived in a timely manner</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>2. Medications were given in accordance with policy</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>3. Adequate volume and type of medications were in room</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

Device Placement: Yes No Comments

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Device was placed correctly</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>2. More than one device was used</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

Debriefing in Obstetrics-Tools

Kilpatrick et al. Obstet Gynecol 2014

<table>
<thead>
<tr>
<th>Obstetric Team Debriefing Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remember: Debriefing is meant to be a learning experience and a way to address both human factors and systems issues to improve the response for next time. There is to be no blaming/finger-pointing.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of event:</th>
<th>Date of event:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location of event:</td>
<td>Person completing form:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Members of team present (circle all that apply)</th>
<th>Primary RN</th>
<th>Primary MD</th>
<th>Charge RN</th>
<th>Resident(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia personnel</td>
<td>Neonatology personnel</td>
<td>MFM leader</td>
<td>Other RNs</td>
<td></td>
</tr>
<tr>
<td>Nurse Manager</td>
<td>OB/Surgical tech</td>
<td>Unit Clerk</td>
<td>Patient Safety Officer</td>
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</tr>
<tr>
<td>Anesthetist (RNs, PA, Fellow, Resident)</td>
<td></td>
<td></td>
<td>Antepartum team</td>
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</tbody>
</table>

Thinking about how the obstetric event was managed...

Identify what went well (Check if yes)
- Communication
- Role clarity (leadership/supporting roles identified and assigned)
- Teamwork
- Situational awareness
- Decision-making
- Other:

Identify opportunities for improvement: “human factors” (Check if yes)
- Communication
- Role clarity
- Teamwork
- Situational awareness
- Decision-making
- Human error
- Other:

Identify opportunities for improvement: “systems issue” (Check if yes)
- Communication
- Role clarity
- Teamwork
- Situational awareness
- Decision-making
- Human error
- Other:

For identified issues, please fill in the table below...

<table>
<thead>
<tr>
<th>Issue</th>
<th>Actions to be Taken</th>
<th>Person Responsible</th>
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<tbody>
<tr>
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</table>

DO NOT place any patient identification on this form.
Start with what went well...

Identify what went well (Check if yes)

☐ Communication

☐ Role clarity (leader/supporting roles identified and assigned)

☐ Teamwork

☐ Situational awareness

☐ Decision-making

☐ Other: ___________________________
Opportunities for improvement: human factors....

Identify opportunities for improvement: “human factors”? (Check if yes)

- Communication
- Role clarity
- Teamwork
- Situational awareness
- Decision-making
- Human error
- Other: ________________________
Opportunities for improvement: systems factors....

Identify opportunities for improvement: “systems issues”? (Check if yes)

☐ Equipment/supplies/accessibility
☐ Medications
☐ Blood products availability
☐ Inadequate support (in unit or other areas of the hospital)
☐ Delays in transporting the patient (within hospital or to another facility)
☐ Staffing
☐ Other: ________________________________
Debriefing in Obstetrics - Benefits

• Real time identification of opportunities for improvement in:
  – Teamwork
  – Knowledge/skills
  – Systems

• “Emotional debriefing”:
  – Team members feel empowered, supported and heard
  – Allows identification of potential “second victims”
Emotional Debriefing

Critical Incident Stress Management (CISM)

– Comprehensive package of interventions intended to:
  • mitigate impact of a traumatic event
  • facilitate recovery of individuals having normal reactions to traumatic event
  • restore adaptive function for individuals, communities, or organizations
  • identify individuals who could benefit from additional support services or referrals for further evaluation and treatment

– May take precedence over “fact-finding” debriefing after most severe events (death or serious injury)

https://www.icisf.org/a-primer-on-critical-incident-stress-management-cism/
Medicolegal Considerations

• Are debriefings legally protected?
  – Variations in state laws make this difficult to answer

• To help ensure success of debriefing please make certain that any possible protections are in place.
  – Collaborate and coordinate within existing quality and patient safety structures
  – Work closely with legal and risk management
Final Thoughts…

• Incorporating debriefing into obstetrical care has the potential to transform:
  – the way teams function
  – the way systems issues are identified and corrected
  – our care for future patients
  – our well-being as providers

• Low cost, low resource tools:
  – exist
  – can be easily incorporated
  – provide valuable data
Questions?
References

- Issenberg SB, McGaghie WC, Petrusa ER, Gordon DL, Scalese RJ. What are the features and uses of high-fidelity medical simulations that lead to most effective learning: a BEME systematic review. *Med Teach* 2005; 27:10-12.
References

Joanne Tanner, RN, C-EFM

Clinical Leader, Labor and Delivery
UF Health Shands
Gainesville
POST-TREATMENT DEBRIEFING TOOL

JOANNE TANNER, RN, C-EFM
CLINICAL LEADER, L&D
UF HEALTH SHANDS
POST-TREATMENT DEBRIEFING TOOL

- Debriefing tool added to existing GHTN documentation tool
BENEFITS OF DEBRIEFING TOOL

- Data point to run chart audits from
- Reduce the amount of free text notes
- Captures the physician’s name
- Available to Triage, L&D, and Postpartum Nurses
- Increased compliance with documentation of debriefing
Debriefing Following a Severe Incident in Pregnancy

The Council on Patient Safety in Women's Health Care recommends every unit establish a culture of hurdles for high-risk patients and post-event debriefs to identify successes and opportunities.

What is Debriefing?
- A process of information exchange and feedback conducted after a severe or emergent event to improve teamwork skills and outcomes.
- Conducting a debriefing provides the team with the opportunity to decompress while identifying areas for improvement.
- Debriefing after simulations provides immediate feedback, increases learner engagement, enhances retention of information, and results in a higher level of staff preparedness and confidence, contributing to optimal performance when emergencies arise.

How is it Done?
- A debrief begins with a recap of the situation, background, and key events that occurred. Reconstruction of the events, analysis of why the event occurred, what worked, and what did not work results in discussions of lessons learned and what should be done differently in the future.
- Have someone outline the process for the team and assist as a resource and note taker to ensure the objectives are met as the participants debrief themselves.
- The debriefing should provide the opportunity for all participants to be heard.
- Effective debriefs allow participants to see the process as a learning opportunity and not a punitive one.

Practical Application
- Can be impromptu or planned, and adapted to meet local needs and conditions.
- Helps find answers: What did we do well? What did not go so well? What can we improve upon in the future?
- A simple checklist can be created to help aid the process for both the note taker and the participants.

Some promising practices facilities have utilized include the following:
1. Adapt the debrief form to include only those items deemed to be most helpful to the team. Always ask if there was something that was not on the form that needed to be reviewed and include that in notes from the debriefing.
2. Debriefs can take as little as 5 minutes once the process is streamlined.
3. Some places have established a conference line for debriefing so that participants across departments can be included. The # and time is handed out and coordinated on pre-printed business cards once the event is over or the patient stable.
4. When the obstetric provider or other team members are not able to gather for full team debriefs, conduct an immediate nursing debrief or debrief at shift change. This information should be recorded and shared with the obstetric provider for their additional feedback at the next face to face encounter via phone or email. Alternatively, a form can be created in house for those unable to stay, this can be used by the nurses in their shift-change debrief regarding what went well and what needed improvement. Personal input is always best but if all are not available, gathering all perspectives can still occur.
5. Gather information from all severe/emergent cases and consolidate the information in a de-identified format. At obstetric staff meetings review the information and solicit feedback.
6. Utilize the findings from the debrief process to make small tests of change to practices or workflow in order to improve patient safety and outcomes.

Sample debrief forms are available in the FPQC HIP online Tool Box.
DISCUSSION

If you have a question, please enter it in the Question box or Raise your hand to be un-muted.

We can only unmute you if you have dialed your Audio PIN (shown on the GoToWebinar side bar).
FAQ

Disseminating information to OB offices – who and how?

Start with the providers practicing in your facility by sharing your plan and steps in implementation and provide a short hand-out that they could share with their nursing staff at the office.

Your local Healthy Start Coalition could assist with sharing the information. FPQC will be working with the coalitions at the statewide level.