Florida Perinatal Quality Collaborative

DEBRIEFING FOLLOWING A SEVERE INCIDENT IN PREGNANCY

The Council on Patient Safety in Women's Health Care recommends every unit establish a culture of huddles 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 needs 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 or 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 work flow in order to improve patient safety and outcomes.

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