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'Take 10 to talk about it': Use of a scripted, post-event debriefing tool in a neonatal intensive care unit

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Conflict of Interest

There are no competing interests in the work described.

“Take 10 to talk about it”: use of a scripted, post-event debriefing tool in a neonatal intensive care unit

Abstract

Aim

This study assessed the impact of a scripted, post-event debriefing tool in identifying logistical, procedural, personnel and performance obstacles and successes in a clinical setting. It was predicted that the debriefing tool would highlight the importance of routine debriefing following challenging clinical events.

Method

The study was conducted in a 22 bed Neonatal Intensive Care Unit at a tertiary hospital and involved all staff members in the perinatal service. The debriefing tool, a two-page form providing a structured, scripted approach, was used at the earliest opportunity after acute clinical deteriorations, emergency caesarean sections and any other critical events as decided by the neonatal team. Sessions were facilitated by either a nursing or medical member of the neonatal team. Following a two-month trial, impact was measured via comparison of before and after survey questions as well as review of a database of issues raised, subsequent actions and outcomes.

Results

Significant, positive changes were observed for survey questions specific to the frequency of debriefing, team communication, provision of learning opportunities and identification of logistical, equipment and procedural issues. Additionally, the database highlighted the significant positive impact in day-to-day practice as a result of changes initiated by the debriefing tool. All participants requested that the unit continue using the tool.

Conclusion

Scripted, post-event debriefing is achievable and valuable in the clinical setting. It encourages a supportive workplace culture and empowers team members to initiate practical change in their organisations.

Key Words

Communication; quality improvement; clinical governance: crisis intervention; patient care team

Introduction

Debriefing is an “interactive discussion or conversation after events to explore actions and thought processes, promote effective learning and identify strategies to improve future performance”.¹ There are two types: technical performance debriefing, focussing on human and system performance, and critical incident stress debriefing, which provides emotional and psychological support to those involved.^{1,2} Debriefing can be further categorised based on timing, into “hot debriefing” conducted immediately after the event, or “cold debriefing” conducted at a later stage.²

A recent meta-analysis found that post-event debriefing can improve individual and team performance by up to 25% .³ In the clinical setting, post-event debriefing has been associated with improved outcomes in cardiopulmonary resuscitation, trauma team efficiency, identification of surgical errors, and neonatal outcomes following emergent caesarean deliveries.⁴⁻⁷ Additionally, it has been linked with reduction in environmental and equipment-related problems, and improved communication and teamwork.⁴⁻⁷

Despite the proven benefits for both patients and healthcare teams, post-event debriefing remains infrequent in the clinical realm. A recent, multicentre safety audit found that only 19% of 84 neonatal intensive care units conducted post-event debriefing and only 5% had established policies.² Such scarcity of debriefing is also well documented in paediatric emergency departments.⁸ Failure to implement debriefing programs is often blamed on busy environments, where there is a perceived lack of necessary time, lack of skilled debrief facilitators and a perceived difficulty in convening members of the treating team.^{1,2,9} However, there is a lack of objective evidence in the literature to support these commonly held anecdotal beliefs.

A structured, scripted approach to debriefing can overcome many of the perceived barriers. Sessions are easily accessible, quick to complete in a busy clinical setting and simple for facilitators with variable debriefing experience to ensure a consistent approach.¹⁰ The use of a structured, scripted approach ensures consistency whilst also maintaining psychological safety for those participating in the debriefing session. The script also permits any member of the team, irrespective of profession, to act as the facilitator.¹¹ This technique upskills staff in the debriefing process and instils a habit of reflection and quality improvement in day-to-day practice.

“Hot debriefing” at the earliest opportunity is ideal, as all team members are present, the risk of recall bias is minimised and it creates the potential to quickly address identified issues.^{1,2,9} Complex issues that are identified may be beyond the scope of a short, scripted debrief and these issues can then be addressed by delayed “cold debriefing.” The post event “cold debriefing” sessions are best conducted

in an environment that is not time pressured, either in the form of a more in-depth technical performance debriefing or critical incident stress debriefing with experienced facilitators.²

The purpose of this study was to assess the impact of a scripted, post-event, “hot debriefing” tool in the Neonatal Intensive Care Unit (NICU) at Fiona Stanley Hospital; a large, 783-bed tertiary, teaching hospital in Western Australia with a 22-bed perinatal NICU. The NICU was opened in October 2014, and has undergone a strategic, step wise increase in patient acuity since opening. The debriefing tool was implemented to coincide with the progression of lowering the gestational age of patients managed at Fiona Stanley Hospital to neonates less than 30 weeks at birth. Fiona Stanley Hospital provides multidisciplinary complex care for obstetric patients from across Western Australia, with an expected delivery quota of 3000 births per annum.

We predicted that staff members in the unit would use and value the debriefing tool, that strengths in practice would be reinforced and that issues encountered in day-to-day practice would be identified and corrected.

Materials and Method

The Debriefing Tool

The debriefing tool is a two-page form that provides a structured, scripted approach to debriefing (Fig 1). It was designed to promote communication and teamwork, identify staff members in need of emotional or psychological support, reinforce strengths in practice and identify educational needs as well as to identify and fix issues encountered in day-to-day practice. The structure was adapted from a debriefing script proposed in a publication by Sawyer et al.² The debriefing script consists of:

- An introduction, establishing a shared mental model
- Discussion of positive and challenging aspects of team performance
- Summary of key learning points for future practice
- Summary of issues to be followed up
- An option for a more-in depth technical performance debriefing or critical incident stress debriefing at a later stage

In addition to the script, the debriefing tool includes areas for documentation at each stage as well as contacts for immediate psychological support, both local services and national.

Training

The neonatal unit was orientated to the debriefing tool through departmental education sessions attended by medical, nursing, allied health and administration staff. The purpose, supporting evidence and a step-by step guide with instructions for facilitators and participants were discussed. Staff members were educated about confidentiality and how to foster a safe and supportive debriefing environment. They were encouraged to focus on both positive and challenging aspects of performance to identify and reinforce successful behaviours as well as identify areas for improvement. Additionally, clinical simulation sessions were run alongside introduction of the debriefing tool to familiarise staff with the debriefing process.

Procedure

During the two months of the study, debriefing sessions were conducted at the earliest opportunity after “major clinical events”. These included acute patient deteriorations, emergency caesarean sections and any other critical events as decided by the team. Sessions were conducted in the ward clinical workroom and all team members were invited to attend; medical, nursing, midwifery, orderlies, administration staff and all other staff members involved. The neonatal consultant or nursing shift coordinator acted as facilitator and worked through the script outlined on the debriefing form, while a designated scribe recorded data at each stage. Questions were posed to the team as a group and all participants were given the opportunity to contribute. Sessions were limited to 10 minutes for practicality and to encourage participation in the busy clinical environment. Completed forms were submitted to a secure post box located in the unit. Identified issues and subsequent in-depth “cold debriefs” were followed up by senior staff in the unit within 24 hours.

Data Collection

A survey, involving all staff in the neonatal service, was conducted before and after the two-month trial period. It included questions concerning professional participants’ roles as well as the nature, timing, focus and frequency of formal debriefing opportunities following major clinical events. In addition, it included a series of questions regarding the context and impact of being involved in a debriefing session as shown in Table 1. Mann Whitney U tests were used to compare the responses collected before and after the two- month period. Significance was set at $p < 0.05$.

Results

Ten recorded debriefs occurred over a two-month period. Events that triggered a debrief included six neonatal resuscitations in the neonatal unit and operating theatre, two neonatal resuscitations in the emergency department, one transfer of a neonate and one planned withdrawal of intensive care

support. Medical, nursing and midwifery staff from the neonatal unit participated consistently, with some involvement from the emergency department, anaesthetics department and Newborn Emergency Transport Service staff. Sessions were led by both medical (consultants and registrars) and nursing staff and occurred both during and after hours. The median participant number per session was six staff members (range 4-8).

Positive aspects of performance were identified and reinforced by team members. These included:

- Early escalation to Medical Emergency Team (MET) calls
- Effective teamwork and communication during neonatal emergencies
- Good leadership and role allocation during neonatal emergencies
- Adherence to established guidelines and protocols

Senior staff (responsible consultants and the nurse unit manager) addressed challenging aspects of performance and identified issues within 24 hours. Each issue prompted a new cycle of planning for change, action and observation of the outcome with an action research approach. There were a number of improvements in clinical care that arose from acting on issues raised in the “hot debriefing” sessions with examples listed in Table 2.

48 staff members (11 medical, 29 nursing and midwifery and 2 other team members) responded to the pre-intervention survey and 28 staff members (6 medical, 21 nursing and midwifery and 1 other team member) responded to the follow-up survey. All of the follow-up survey respondents requested that the unit continue using the debriefing tool.

Significant positive changes between pre and post responses were observed for a number of survey questions (Table 3). There was no significant change in responses to survey questions regarding the existence of formal debriefing sessions in the unit, whether the formal debriefing sessions were useful in identifying gaps in knowledge or whether sessions were mainly focussed on error detection. No change occurred between pre and post responses on perceived improvements in morale, team performance or patient outcomes. Additional comments and suggestions are listed in Table 4.

Discussion

There is a common misconception that post-event debriefing is impractical due to time constraints, a lack of skilled facilitators and difficulty convening team members. This study demonstrates that with a scripted, “hot debriefing” approach, post-event debriefing is in fact achievable in busy clinical environments and results in practical change.

Use of the debriefing tool in our neonatal unit has demonstrated similar satisfaction compared to a “hot debriefing” tool used in the emergency department setting.¹¹ Rose et al demonstrated that nurse-facilitated debriefing was successfully implemented in diverse emergency departments, with 254 recorded debriefing sessions occurring over an 18-month period.¹¹ In comparison, our study assessed a different critical care environment and demonstrated similar results and similar ease of implementation despite both being recognised as some of the busiest and fast-paced units in hospital.

Overall, the debriefing tool was well-received. All follow-up survey respondents requested that the unit continue using it and there were improvements in a number of areas. These included frequency of debriefing, team communication, provision of learning opportunities as well as identification of logistical, equipment and procedural issues. Additionally, use of the debriefing tool empowered team members to raise areas for improvement in workplace practices and the clinical environment. Some of these issues had been recognised by individual staff members on previous occasions and use the debriefing tool provided a platform to raise and correct them, resulting in positive, practical change (Table 2).

One of the other major benefits of the debriefing tool was the early identification and triggering of “cold debriefing” opportunities at a later stage. Anecdotally, there are many major instances in the hospital setting where “cold debriefing” would be beneficial but is either never considered or organised. The debriefing tool was not intended to replace “cold debriefing” but has been a useful trigger for teams to stop and consider the opportunity for more in-depth technical performance or clinical incident stress debriefing at a later stage. An example of this followed its use after withdrawal of intensive care support for a neonate, where a formal clinical incident stress debriefing was triggered for staff members affected by the case through existing support services. This drew attention to the mental health and wellbeing of team members, leading to timely emotional and psychological support for those involved.

However, post survey responses did not demonstrate perceived improvements in morale, team performance or patient outcomes. A likely explanation is that the study period was relatively short; morale and culture-changes take time and it would be unrealistic to expect this to occur over a two-month period. Similarly, team performance and impact on future patient outcomes would require a longer study period to assess.

There has been a recent trend towards promoting open discussion in healthcare, with a focus on improving performance and patient outcomes. This is a practice that does not come naturally, perhaps due to a “culture of blame” in healthcare and a general fear of being persecuted for mistakes.¹² It is

the hope that by learning to use the debriefing tool, participants develop important skills to debrief openly about strengths as well as areas for improvement in a safe and supportive environment with a focus on celebrating successes, improving performance and keeping in mind the mental health and wellbeing of others. These are skills that can be translated to all areas of clinical practice and it is the hope that this gradual change in behaviour will result in culture change over time.

Following completion of the study period, the debriefing tool has been incorporated into “business as usual” in the NICU. Given the positive, practical outcomes, the Newborn Emergency Transport Service is adopting the debriefing tool after participating in a debriefing session while retrieving a neonate. Additionally, there are steps towards implementing a generic version of this debriefing tool with an accompanying instructional video in many departments at the hospital, including the cardiology department, mental health unit and post-anaesthetic care unit, demonstrating its utility in promoting clinical governance in other areas of medicine. The debriefing tool is also being adapted into an easily accessible, electronic version with plans for use by the hospital Medical Emergency Team following MET calls for deteriorating patients. The initial positive trends highlight the need for future research evaluating its effectiveness on a larger scale, over a longer duration and in a variety of clinical areas.

Brief Points

What is already known on this topic:

1. Post-event debriefing is associated with improved team performance and patient outcomes
2. Post-event debriefing rarely occurs in the clinical setting

What this paper adds:

1. A simple and practical approach to post-event debriefing
2. Evidence that post-event debriefing is achievable and valuable in the clinical setting with a scripted, “hot debriefing” approach

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Tables

Table 1: Survey Questions
Pre-Intervention Survey
<p>1. What is your role in the neonatal unit?</p> <ul style="list-style-type: none"> • Doctor / Nurse / Allied health <p>2. Is there a formal process in place for debriefing in the neonatal unit?</p> <ul style="list-style-type: none"> • Yes/ No <p>3. Following major clinical events in the neonatal unit, how often have you been involved in debriefing?</p> <ul style="list-style-type: none"> • Always / Usually / Sometimes / Rarely / Never <p>4. How soon after major clinical events does debriefing occur?</p> <ul style="list-style-type: none"> • Immediately after / Within one week / After one week <p>5. Who usually leads debriefing sessions?</p> <ul style="list-style-type: none"> • Consultant / Registrar / Nurse or Midwife / Other (please specify) <p>6. What is the usual focus of debriefing sessions?</p> <ul style="list-style-type: none"> • Performance (what happened and why) / Staff wellbeing / Both of the above • Other (please specify) <p>7. When I have experienced debriefing in the neonatal unit, it has...</p> <p><i>(Likert Scale used to grade responses)</i></p> <ul style="list-style-type: none"> • Occurred in a safe and supportive environment • Provided me with learning opportunities • Allowed me to work through the stress of major clinical events • Identified logistical issues (e.g. environmental problems, staffing issues) • Identified equipment issues • Identified procedural issues (e.g. use of or access to protocols and guidelines) • Identified knowledge gaps and training needs • Mainly focussed on errors and how they occurred • Helped to reinforce positive actions and how to repeat them • Improved staff morale • Improved team performance • Improved team communication • Improved patient outcomes
Post- Intervention Survey
All pre-intervention questions were included, in addition to the following questions.

1. Have you used the Neonatal Unit Debriefing Tool since it was introduced?

- Yes / No

2. Do you feel the unit should continue to use the Neonatal Unit Debriefing Tool?

- Yes / No

3. Why do you feel the unit should continue using this tool? (You can select more than one response)

- Improved team communication
- Improved team performance
- Reinforced positive behaviours
- Identified areas for improvement
- Improved staff morale
- Improved patient outcomes
- Other (Please specify)

4. Why do you feel the unit should stop using the tool? (You can select more than one response)

- Time constraints in the unit
- Lack of skilled facilitators
- Lack of an appropriate setting for debrief
- Threat of litigation
- Other (Please specify)

5. Do you have any suggestions to improve the Neonatal Unit Debriefing Tool or its use?

Table 2: Issues identified in debriefing sessions, actions and outcomes

Issue	Action	Outcome
The neonatal resuscitation cot and equipment were positioned impractically in the emergency department	The cot and equipment were repositioned to a safer and more accessible location	Positive reception when trialled during an interdepartmental perinatal simulation in ED
The paediatrics registrar was not receiving neonatal MET call notifications despite being a valuable resource	The communications department was notified and added the paediatrics registrar to the neonatal MET call list	Both paediatrics and neonatal registrars now attend neonatal MET calls
Neonatal team members were not easily identifiable during crowded resuscitations	Fluorescent pink arm bands were produced for members of the neonatal resuscitation team for easy identification	Neonatal resuscitation team members now wear pink armbands
Team members needed emotional and psychological support following palliation of a neonate	A formal critical incident stress debrief was arranged through the hospital support service	Team members involved attended the debrief and were followed up by the hospital support service

Table 3. Post survey questions showing a significant, positive change in ratings		
Survey Question	z value for pre to post-survey comparisons	Significance
Increasing the frequency of involvement in debriefing after major events	-6.987	P = 0.000
Reducing the time elapsed between the event and the debriefing session	-2.703	P=0.007
Involving professionals other than consultants leading the session	-2.497	P= 0.013
Instigating a change from focus on errors in the session	-4.321	P= 0.000
Improving the professional safety of the debriefing environment	-3.933	P = 0.000
Provision of additional learning opportunities	-3.117	P= 0.002
Providing opportunities to work through stress	-3.213	P = 0.001
Providing a forum to identify logistical issues	-2.090	P = 0.037
Providing a forum to identify issues with equipment	-3.068	P = 0.002
Providing a forum to identify procedural issues	-2.625	P =0.009
Improving team communication	-2.716	P = 0.007

Note:

1. Mann- Whitney U Test was used for all pre to post-survey comparisons.
2. $p < 0.05$ was considered significant.

Table 4: Pre and post survey comments and suggestions

Pre- Intervention Survey	
Positive Reception	Negative Experiences
<ul style="list-style-type: none">• Looking forward to a more formalised opportunity to have debrief discussions in the neonatal unit• Would be fantastic and a great learning experience to have a more formal process in the unit	<ul style="list-style-type: none">• Most debriefing sessions I have attended have been a negative experience• Focus usually ends up on blame
Post- Intervention Survey	
Positive Reception	Suggestions for Improvement
<ul style="list-style-type: none">• Why would we not continue to use it?!• Enables debriefing to actually happen in a structured and timely fashion• Great tool and great idea - only takes a few minutes to discuss a case and very useful for continued clinical improvement and ensuring the follow up of staff wellbeing	<ul style="list-style-type: none">• Please create an electronic version• Please make sure all team members are included in the sessions

Neonatal Unit Debriefing Tool

Please use this form to debrief **following major clinical events** in the neonatal unit (including all neonatal MET calls, category 1 LSCS and any other major neonatal clinical events). **Please note this should not replace formal clinical incident reporting and escalation to the line manager.**

Introduction and shared mental model		
Debrief facilitator: _____	Debrief Scribe: _____	Date: _____
Staff members (Optional): _____ <small>(Please include names and he numbers if a more formal debrief is required)</small>		
Trigger for debrief:	Neonatal MET / Cat 1 LSCS / Other (specify): _____	
Major clinical event:	_____	
Extent of resuscitation:	CPAP / IPPV / Intubation / Adrenaline / Cooling / ECM	
Outcome of event:	Admit NICU / Admit other clinical area / Deceased	

What went well and what was challenging ('plus/delta')?		
	Positive +	Challenging Δ
Logistical (e.g. clinical environment- include location- and staffing)		
Equipment (e.g. equipment availability and functionality)		
Procedural (e.g. use of and access to protocols and guidelines)		
Personnel (e.g. clinical knowledge, teamwork, use of CRM principles and training needs)		

What is to be replicated (positive performance) or changed for future events?

Are there identified issues to be followed up?		
1. <u>Logistical</u>	Y/N (circle)	Specify: _____
2. <u>Equipment</u>	Y/N	Specify: _____
3. <u>Procedural</u>	Y/N	Specify: _____
4. <u>Personnel</u>	Y/N	Specify: _____

Will a more thorough technical performance debriefing be required? Y/N (circle)
Will critical incident stress debriefing be required (emotional/psychological support for people involved)? Y/N

Debriefing Script

Introduction and shared mental model
“We are going to do a quick debrief of that event. It should take only a few minutes. The goal is to improve our performance as a team and the care we provide. Let’s start with a description of the key clinical events.”
• <i>Review the clinical events and establish a shared mental model of what happened.</i>

What went well and what was challenging ('plus/delta')?
“Okay team, let’s talk about our performance. What went well and what was challenging?”
• <i>Were there any issues with the clinical work environment or staffing? If so, what?</i>
• <i>Were there any issues with availability or functionality of equipment? If so, what?</i>
• <i>Did the team follow established guidelines and protocols? If not, why?</i>
• <i>What positive actions helped to optimise team performance?</i>
• <i>Were staff involved up to date with best practice? Are there any identified training needs?</i>

What is to be replicated (positive performance) or changed for future events?
• <i>Discuss aspects of team performance that will be implemented in the future based on discussion above.</i>

Are there identified issues to be followed up?
• <i>Record issues to be followed up (logistical, equipment, procedural and personnel).</i>
• <i>Is there need for a more thorough technical performance debriefing or critical incident stress debriefing?</i>

Conclusion
“Thank you for taking time to participate in this technical performance debriefing.”
If you have any further questions about this form or need support during office hours, contact the Medical Education Unit (Ph: 6152 3634). If support is needed after hours, Converge International (Ph: 1800 687 327, www.convergeinternational.com.au) and Optum (Ph: 1300 361 008, www.optum.com.au) offer professional, independent and confidential services 24/7.