



Healthcare Risk Professionals Impact, Influence, Innovate

Debriefing: Purpose, Practice, and Patient Safety

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Please refer to the Presenters' Bios available on the table and online for more information



Debrief



Clinical/Patient Safety



Why Debrief?

“Define and discuss gaps in medical knowledge, clinical performance, and behaviors that directly relate to patient care”

-Mullen, Kessler, & Cheng, 2014

Why is this important?

- 50% of centers doing in-situ simulation reported formal error reporting
- 23% reported at least 1 unresolved serious unsafe condition that went on to cause **Actual Patient Harm**¹



Evidence-based

- Pediatric ED: 90 sims found 73 unsafe conditions $(0.8/\text{sim})^2$
- NICU: 16 sims found 29 unsafe conditions $(1.8/\text{sim})^3$
- Testing New ED facility: 2 sims found 37 LSTs $(18.5/\text{sim})^4$



Opportunities for Debriefing

Coaching

Healthcare
Simulation

Clinical
Debriefing



Relationship to Risk Management

- Improve patient outcomes
- Increase efficiency
- Identification of errors & latent safety threats
- Enhances a culture of safety
- Strengthen relationships with the clinical team

Clinical/Patient Safety



Healthcare Risk Professionals Impact, Influence, Innovate

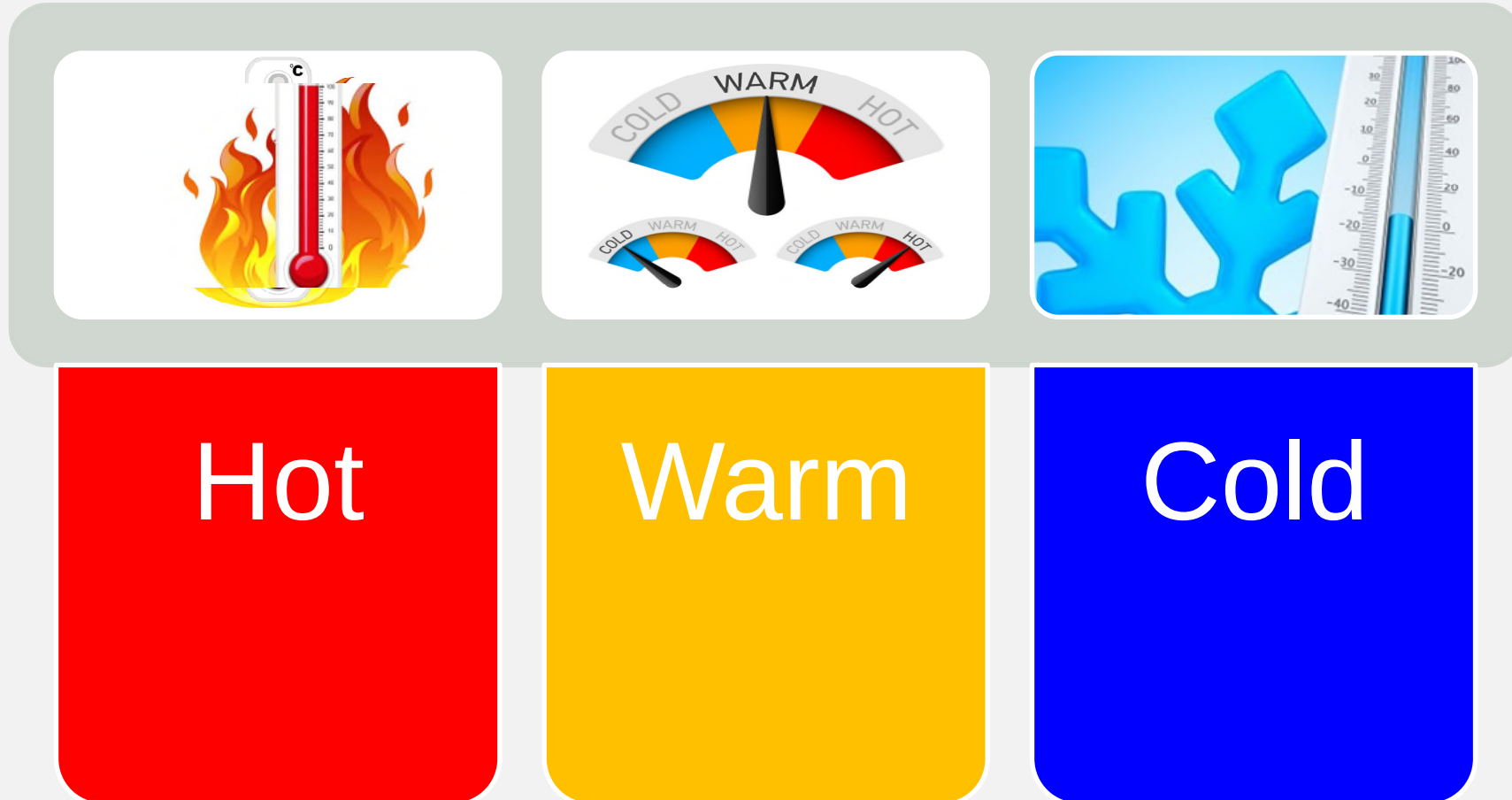
What to Debrief

- Low frequency/High risk events
- Intra-operative team communication
- Handoff communication
- Resuscitations
- Code responses
- New skill acquisition

Clinical/Patient Safety



When to Debrief



Clinical/Patient Safety



Methods of Debriefing

Some methods really are better!



Judgmental Debriefing

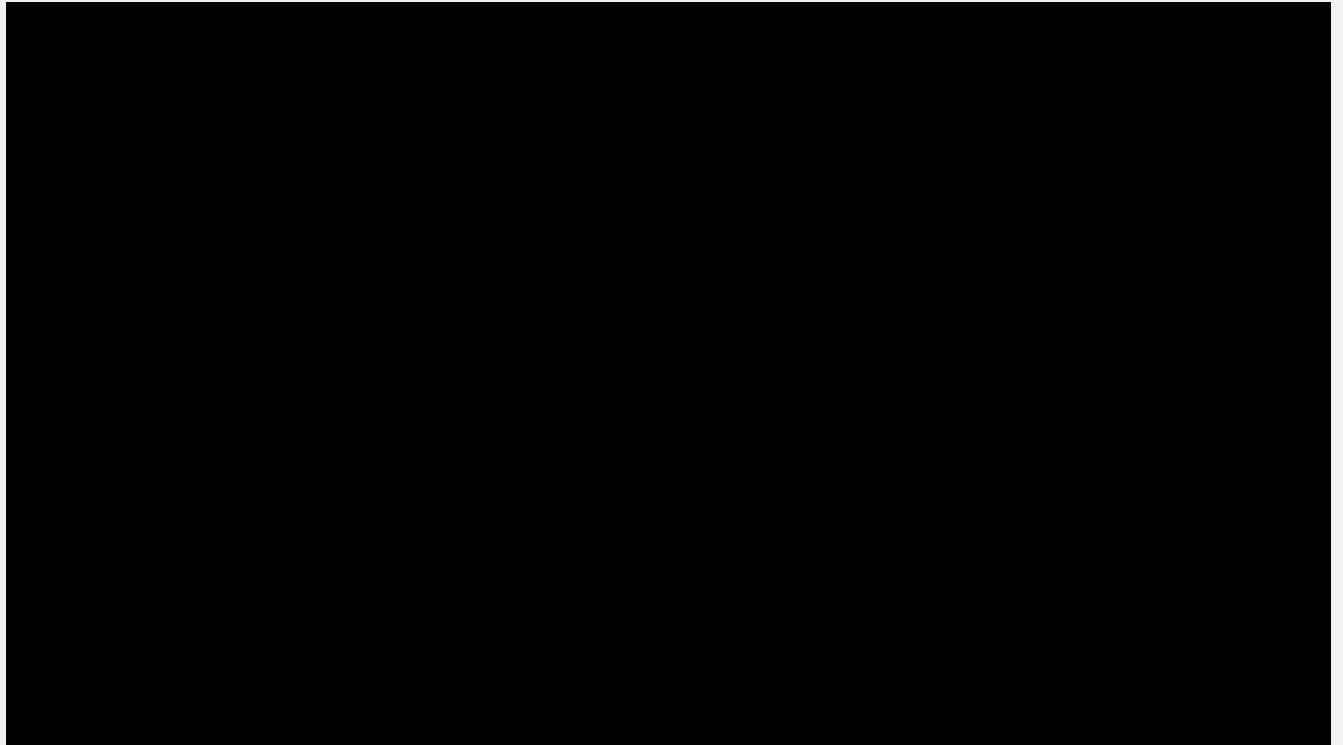
Pros: At least you are discussing the event?

Cons: humiliation, reluctance to participate or ask questions in the future, decreases motivation, creates a culture of blame

Judgmental Debriefing

Guessing game: “Can you guess what I am thinking?”

Critical: “Can anyone tell me what went wrong?”



Non-Judgmental Debriefing

Socratic Questions

- Pros: Learner uncovers answer
- Cons: Frustrating

Feedback Sandwich

- Pros: Non-confrontational
- Cons: Confusing



Non-Judgmental Debriefing

Example:

You did a great job identifying that the patient was deteriorating.

I thought you should have given Epinephrine earlier.

Overall, you did a great job of managing the situation.”

Ask-Tell-Ask Framework

Ask Learner to assess own performance

Tell What you observed

Ask Clarify understanding of opportunities for improvement, add your suggestions, commit to improvement together

Debriefing with Good Judgment

- Focus on actions and meanings behind actions
- Use of Advocacy/Inquiry
- Promotes a safe learning environment



Debriefing with Good Judgment

Example

“I noticed that you began chest compressions approximately 1 minute after the code was called.”

“When I have a patient that has lost pulses, I know it is important to start chest compressions right away.”

“Can you walk me through what happened between the point at which the patient lost pulses, and the time chest compressions began?”



SIMULATION

- How did that feel?
- What happened?
- What went well?
- What could have been improved upon?
- What should we do differently?



PEARLS FRAMEWORK

Reaction

Description

Analysis

Summary

PEARLS

Reaction Phase

- *“How are you feeling?”*
- *“How does the team feel right now?”*



PEARLS

Description Phase

- *“Can someone summarize what occurred from a clinical perspective?”*
- *“What occurred next?”*



PEARLS

Analysis Phase

- *“What aspects were managed well?”*
- *“What opportunities for improvement were identified?”*



PEARLS

Summary Phase

- *“I would like each of you to describe an action you will take away from this debriefing”*
- *“What will you do differently?”*
- *“The key learning points are...”*



Let's Have Some Fun!

In pairs or small groups-Please select your character:
This will be the “learner” that you will be debriefing



Oscar



Michael

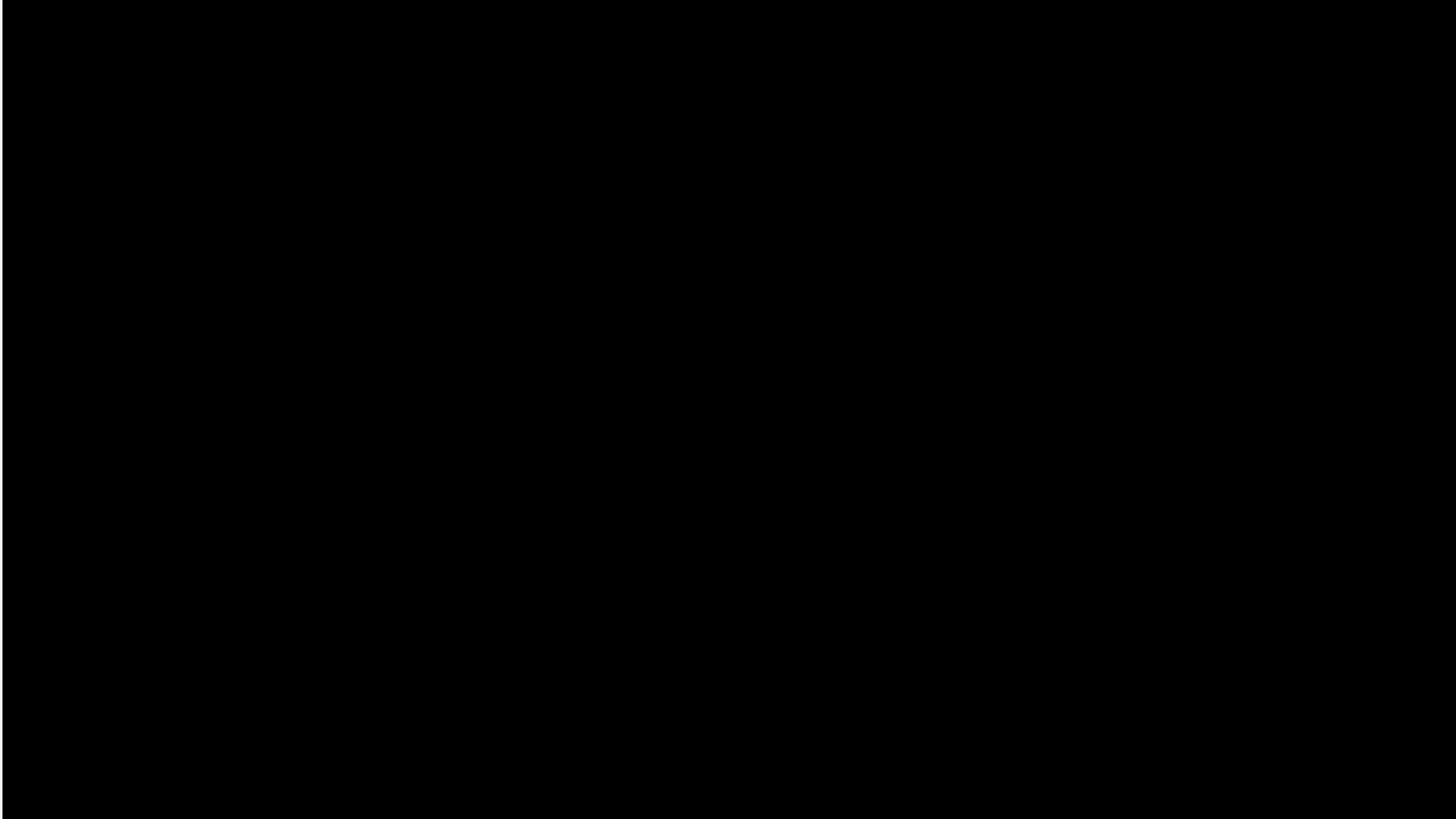


Angela



Kevin

Fire Drill



Let's Debrief

Reaction

Description

Analysis

Summary

In Summary

Debriefing:

- Release emotions following event
- Discuss opportunities for improvement
- Psychologically safe learning environment
- Actionable take-aways
- Action planning

Questions?!



Thank you!



References

- Bajaj, Komal MD, MS-HPed; Meguerdichian, Michael MD, MSHPE; Thoma, Brent MD, MA, MSc; Huang, Simon MSc; Eppich, Walter MD, MEd; Cheng, Adam MD. The PEARLS Healthcare Debriefing Tool. Academic Medicine 93(2):p 336, February 2018.
- Kessler DO, Cheng A, Mullan PC. Debriefing in the emergency department after clinical events: a practical guide. Ann Emerg Med. 2015;65(6):690-698. doi:10.1016/j.annemergmed.2014.10.019
- Rudolph JW, Simon R, Rivard P, Dufresne RL, Raemer DB. Debriefing with good judgment: combining rigorous feedback with genuine inquiry. Anesthesiol Clin. 2007;25(2):361-376.



References

- Auerbach M, Kessler D, Patterson M. BMJ Stel 2015;0:1–6. doi:10.1136/bmjstel-2015-000037 – accepted October 2015
- Wetzel, E. A., Lang, T. R., Pendergrass, T. L., Taylor, R. G., & Geis, G. L. (2013). Identification of latent safety threats using high-fidelity simulation-based training with multidisciplinary neonatology teams. Joint Commission Journal on Quality and Patient Safety, 39(6), 268-268.
- Geis, G. L., Pio, B., Pendergrass, T. L., Moyer, M. R., & Patterson, M. D. (2011). Simulation to assess the safety of new healthcare teams and new facilities. Simulation in Healthcare, 6(3), 125-133.
- Patterson, M. D., Geis, G. L., Falcone, R. A., LeMaster, T., & Wears, R. L. (2013). In situ simulation: detection of safety threats and teamwork training in a high risk emergency department. BMJ quality & safety, 22(6), 468-477.

