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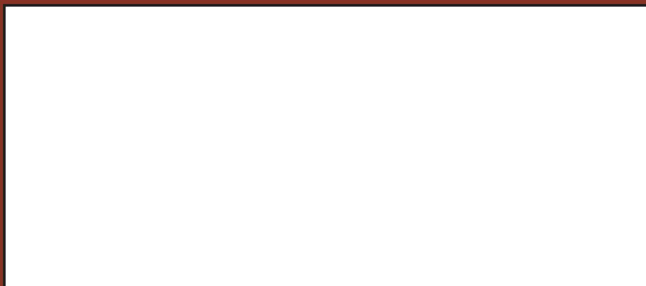

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Debriefing for PATIENT SAFETY

"If only I could do it all over again…"

By Scott H. Turner and Walter D. Kurtz

When sentinel events and near misses occur, the risk manager investigating the event often hears these types of statements from the people involved: "I didn't mean to…," "I thought *you* were…," or often, "If only I could do it all over again…"

Nobody in your organization deliberately makes a mistake. In fact, it's human nature to avoid things that will harm you or someone else. Still, people commit errors that lead to tragic results. There are two reasons why people make mistakes. The first involves poor technical expertise. Think about it; it's easy to make a mistake when you're spending 100% of your time struggling to do your job. A famous comedy routine from the television show *I Love Lucy* illustrates this point. It's Lucy's first day working at the candy factory. All she has to do is put candy in a box as it moves past her on the conveyor belt. We all know what happens next: as the conveyor belt increases speed, Lucy ends up putting candy everywhere except in the box. It's an extremely funny skit, and it highlights the importance of being technically proficient and working in a supportive work environment. The second reason people make mistakes is a breakdown in teamwork. That's why during accident investigations you often have everyone pointing fingers in different directions.

People make mistakes for different reasons.

Every individual and team is psychologically different. We all have different strengths and weaknesses. For instance, some people may excel at planning but are poor communicators. Other team members may make great decisions but don't prioritize their actions effectively. Teams and individuals normally make mistakes in those areas where they are weak. We can limit an individual's or team's propensity to make a mistake only if *they* recognize and understand where *they* tend to commit errors.

Debriefing is the key.

Debriefing simply means getting everyone who was involved in an occurrence together for a few minutes after the procedure or event to discuss in a non-threatening manner what the team did right and to identify those areas where the team needs to improve.

Dr. Gabriel J. Hauser, the director of Georgetown University Hospital's Pediatric Intensive Care Unit, debriefs with his team.

Photo by Scott H. Turner

Highly successful organizations such as professional athletic teams, aviation crews, and military units debrief everything. Effective debriefing is the key to long-term sustainable improvements in patient safety and care. It is only through debriefing that an organization, team, or individual will improve consistently over time.

Avoid outcome-based debriefings.

Supervisors and team leaders must avoid relying on outcome-based debriefings. People and teams commit errors even when they succeed. Even when an event or task has a favorable outcome, there is always room for improvement. When would you rather correct an inherent problem or procedure in your organization: at the end of a successful course of action or after experiencing a sentinel event? The answer is obvious. You can identify systemic root-cause problems and avoid future sentinel events by debriefing normal, successful day-to-day procedures.

Follow these rules for successful debriefing.

If you're completely honest, you'll acknowledge that debriefing makes a lot of people uncomfortable. That's precisely why most organizations don't do it. The thought of debriefing usually prompts an eye roll, as participants wait for a supervisor to walk through the door. Even the word "debrief" stirs up an image of people asking themselves who's responsible while pondering the consequences.

The debriefing process must be user friendly. A few simple guidelines can turn this once dreaded activity into an honest learning experience. Specifically, debriefings must be confidential, non-threatening, structured, and timely.

- ***Debriefings must be confidential***. Each participant must understand and trust that what is discussed in the debriefing stays in the debriefing. The only reason to share the results of a debriefing is when other people in the organization can benefit and learn from the results. Even in that situation, the results should be shared in a nameless, faceless manner to protect the identity of the debriefing participants. Of course if the debrief highlights an individual or team's exceptional performance, why not get the word out? Everyone needs to know.
- ***Debriefings must be non-threatening.*** The quickest way to shut down communication in a debriefing is to foster a hostile environment. Make sure everyone understands that his or her opinion counts. Always start the debriefing with the most junior member of the group and work your way to the more senior. This simple action encourages team members to give their input without any pressure to agree with the more senior members of the team.
- ***Successful debriefings are structured.*** You can't have everyone talking at the same time; there has to be a structured approach to identifying "what happened" and "why" the event occurred. It is the responsibility of the debrief facilitator (team leader) to keep the debriefing process on track, so everyone involved can reach a consensus decision. The best facilitators provide a disciplined and structured debriefing environment with a minimal speaking role for themselves.
- ***Debriefings must be timely.*** Debriefings must be timely in two ways. First it's important the debriefing take place as soon as practical, relative to when the incident actually occurred. This makes it easy to reconstruct details while the "event" is still fresh in the participants' minds. Second, debriefings should never be long and drawn out. Even when debriefing the most complicated event, it's possible to determine "lessons

learned" in just a few minutes. There is no reason for a debriefing to exceed 15 minutes; in fact, most debriefings should only take 2 to 3 minutes. Additionally, if your team is moving rapidly from one procedure to the next, you can still accomplish a 60-second debriefing by asking your team these simple questions: "We were successful during this procedure. Was there something we could have done differently or better?"

Before you start, it's important you recognize that the reason you debrief *is not* to tell everyone what *they* did wrong. Everyone who participated in the event already knows what they could have done better or should have done. With this fact in mind, focus your debriefing on letting the participants identify *on their own* those areas where they think they did well or need to improve. You can accomplish this task in a non-threatening manner using three simple steps:

- ***Step 1: Determine what happened.*** The first and most important facet of every debriefing involves identifying and agreeing on "what happened." You should accomplish this without assigning responsibility or implying cause. For example, we can all agree that the Titanic hit an iceberg, sank, and is now lying on the bottom of the ocean. At this point in the debriefing, why the ship is on the bottom of the ocean is irrelevant.

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Start your debriefing by asking the most junior member of the team simply to describe what they saw. Tell him or her to describe the event using "just the facts," like Joe Friday from the TV series *Dragnet.* Make sure everyone understands they are not allowed to use opinion-based adjectives or adverbs. These kinds of words imply judgment and are purely subjective in nature. For example: "I saw John *quickly* attempt to…" versus "I saw John pick up the…."

As a debriefing facilitator, you can lead the discussion by asking these questions:

- What were you doing before the event occurred? (This establishes a start point.)
- What was the event?
- What did you do and what did you see everyone else do?
- What was the end result?

As you engage each subsequent person on the team, ask them to add only pertinent facts that the previous member did not discuss or of which they were unaware. Normally, you'll establish "what happened" after the first two or three team members tell what they saw. Once the team identifies what happened, make sure everyone agrees. The facilitator needs to ensure buy-in by asking each person if they agree with the facts. "Do we all agree that the Titanic hit an iceberg, sank, and is now on the bottom of the ocean?" Buy-in is critical; you can't proceed without it.

- ***Step 2: Identify why the event happened.*** The most important rule applicable to this debriefing step is: *Don't use the word "why."* If you say to one of your team members, "Why did you...," you'll immediately put them on the defensive, and they won't tell you anything. Instead, start with the most junior member of the team and ask them this simple question: "If you could do this event all over again… what would YOU do differently?" This will enable you and everyone else on the team to identify why the event happened without putting anyone on the defensive or placing blame.

  This technique is also important because each personality on the team is different. Each individual has different strengths and weaknesses, and you want to make sure they leave the debriefing recognizing where *they* tend to make mistakes or do well. This is the key to improving future behavior and performance.

  Once everyone has the opportunity to explain what they would have done differently, you can finish the "Why it happened" step by quickly asking each team member this question: "If the team had the chance to do this all over again, what do you think *we* could have done differently?" This question is important because the team's leadership, structure, and organization may be the reason individuals on the team make mistakes or do well.

- ***Step 3: Pinpoint lessons learned.*** This is the final step and the most applicable to improving future performance. Individuals should identify what they think they learned from the event. Additionally, the team should identify "lessons learned" that apply to both the team and organization. This step is especially important because you may identify a systemic problem that impacts everyone. In that case, everyone in the organization needs to know.

Will all of my debriefings be easy?

No. It would be less than honest to say that you won't encounter difficulties or bumps along the way to productive debriefings. Just think of the personalities you deal with on a daily basis. Some will be cynical, some critical, and some will not want to be involved in the process at all. That's okay. Debriefing is not an all-or-nothing proposition. Even in the worst-case scenario, when one of the team members refuses to be involved, the rest of the team will still benefit from the debriefing. Debriefing is about proactively engaging the environment you work in. Focus on what you can do with what you have and identify how you can improve patient safety and care.

Debriefing really works!

Two healthcare organizations located just 60 miles apart decided to train their personnel on how to debrief—but for completely different reasons.

MediCorp Health System

Medicorp's motivation to teach frontline caregivers how to debrief was the result of Virginia's changing legal climate. The Virginia Supreme Court ruled in *Johnson v. Riverside* that incident reports containing factual information about an incident were admissible in court. Based on this ruling, MediCorp's leadership recognized that their staff would be less than enthusiastic about reporting mistakes. Even with the best incident and accident reporting system, they would now only be able to capture a fraction of the incidents and errors. Jina Haikey, vice president of regulatory affairs, summed it up, saying, "With the change in the legal climate in our state and a desire for our staff to learn from each other and from incidents as they occur, we made a conscious decision to focus on situation awareness training and frontline staff debriefing. Debriefing provides us with the best opportunity to apply our lessons learned to patient safety and quality of care."

The program is working. To date, MediCorp has trained more than 2,000 clinical and nonclinical staff in situation awareness and debriefing. Additionally, MediCorp has instituted a customized recurrent training and mandatory new-hire program. David E. Pearce, RN, BSN, regulatory affairs and risk management, described MediCorp's approach: "Our objective in adding a customized, 4-hour version of situation awareness and debriefing training was to help further ingrain the concept and practice of these skills into the daily culture of our healthcare system."

Georgetown University Medical Center

Georgetown was looking for a way to improve patient safety. Initially they planned on only one training session involving key personnel, but based on the participants' reaction they decided to train more than 1,000 frontline staff and doctors. Initially some staff members were skeptical that applying military and aviation principles to healthcare would work. But, thanks to the leadership of some astute physicians, they began to brief prior to and after operating room procedures. They found this to be an effective tool that not only improved patient safety and care, but also unexpectedly helped to eliminate inefficiency within the organization. Dr. Richard Goldberg, vice president of medical affairs and chief medical officer at Georgetown puts it this way, "What we initially thought was a focus on patient safety also became a mechanism to eliminate inefficiency. Enhanced communication and teamwork is a win-win situation."

What is the bottom line?

A common aphorism says, "Those who fail to learn from the mistakes of the past are doomed to repeat them."

We must all recognize that despite our best efforts, mistakes happen. Your goal must be to minimize mistakes by recognizing errors when they occur and correcting them in a timely manner. Debriefing "events," especially in a non-threatening environment, enables individuals to identify where they and their team tend to make mistakes. This information is critical to minimizing errors and enhancing future performance. The bottom line is that debriefing is your key to improving patient safety and care. PSQH

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