After compression, time for decompression: debriefing after significant clinical events

Debriefing is rarely carried out in clinical practice but it has huge benefits to patient safety, quality of care and staff morale. This article explores what debriefing is and how techniques learnt through a simulation training programme can positively impact on care and staff in the neonatal unit.

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Key points

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1. Debriefing should occur after any significant clinical incident to help support staff, improve quality of care and improve patient safety.
2. A debrief needs to have a leader to ensure that key points are discussed and taken forward.
3. Debriefing should consider the 'lessons learnt' so that training can be developed accordingly.
4. Debriefing immediately after an event captures the 'heat of the moment'; debriefing a few days later enables wider team involvement.
5. Debriefing need not be a one-off process; an ongoing regular programme may benefit the neonatal unit.

The resuscitation of an infant on the labour ward or neonatal unit often occurs without warning and emotions run high for parents and healthcare professionals alike. Debriefing offers a chance to highlight emotional stressors and develop strategies to deal with them, while also presenting an opportunity for further training. Debriefing is a well-used educational tool to use with adult learners after they have taken part in a simulated scenario. More and more members of medical and nursing staff are learning the skills of debriefing through recognised Resuscitation Council UK courses, other formal training courses and also informally through the development of simulation training. Anecdotally it seems that debriefing is rarely carried out in clinical practice for a range of reasons.

What is a debrief?

Most experienced debriefers would argue that debriefing after significant events can also:

1. Improve patient outcomes
2. Identify training needs
3. Identify process snags
4. Improve staff morale and sickness rates.

All of which are of great interest and relevance to the NHS of 2014.

What do other industries do?

Health care is often aligned to other high-risk industries such as the police and the military. Both of these industries have formalised strategies in place to debrief after major incidents. The police have set criteria for incidents after which there needs to be a documented debrief. In these debriefs they focus on those involved but they also look wider at their processes including administration, information gathering and the logistics of responding to the incident. They consider any communication issues and discuss the role of human rights in the incident.

In the military, personnel returning from areas of conflict spend some time in a designated compulsory camp en route home. Here they have the opportunity to relax and discuss what they have been through in the presence of padres and psychologists to debrief or 'decompress' their experiences. This, it's felt, helps them adapt better to life back at home. It also helps the professionals identify those who may be in need of emotional support. Every member and rank of personnel takes part.

Why should we debrief?

Adults need to talk through their experiences to get a deeper understanding of a situation. But a good debrief takes time and therefore involves staff being away from their clinical duties. The debrief could simply happen over a cup of tea at break time. This lack of formality may encourage some staff to open up but may not result in any tangible benefits. However a more formal debriefing process will lead to benefits in four key areas:

1. Improve patient outcomes

This is always a challenge to demonstrate; an improvement in patient outcomes in any clinical situation is invariably multifactorial. There is evidence from adult practice that regular debriefing of the team can improve patient outcomes. A system where trauma teams review videos of their

resuscitations in formal team meetings has been established[1]. Here, key areas such as leadership, team working and adherence to guidelines are discussed, resulting in an improvement in the time it takes from the commencement of the resuscitation efforts to the patient receiving definitive care across a wide range of ages and injuries[1].

If formal debriefing occurs after an event particularly focusing on team working and leadership then hopefully this will translate into clinical practice and improve patient outcomes.

2. Identify training needs

Often in a simulation training programme much of the debriefing following a scenario is actually spent delivering training on disease processes, guidelines and equipment. By watching staff perform and then discussing their performance with them, it is possible to uncover all sorts of training needs that may be otherwise difficult to identify.

Real life cardiac arrest events were evaluated using both a CPR technique evaluation system and filming of the event. The resuscitation team was then debriefed with both pieces of evidence, specifically focusing on team working and leadership. In this cohort, the rates of return of spontaneous circulation were improved from 44.6% to 59.4%[2].

It is very easy to set up an in-house training programme around a set curriculum but by debriefing real events it is possible to design a training programme around the actual needs of staff.

3. Identify process snags

It is well recognised that in around 30% of in-hospital cardiac arrests, there is some process failure that contributed to the outcome. Staff are often aware of practical issues within their work environment but do not know how to escalate these concerns within their organisation.

Through *in situ* simulated scenarios, issues with process are regularly uncovered for example: emergency bags that are impossible to use or an inappropriate recommendation to use a transport incubator to transport an infant from the labour ward. By running scenarios and then debriefing the 'process' side of the situation, issues can be identified and solutions found with the team who will use them. At Leeds Children's Hospital, the issues identified in the risk management meetings are discussed and processes are changed accordingly.

4. Improve sickness rates and staff morale

There are various examples from other high-risk professions showing that instigating a formal debriefing process within an organisation can improve staff morale as it gives staff an outlet for their emotions and enables them to ask questions following an incident, allowing closure on their experience. The improvements in sickness rates have been quoted as up to 60%[3].

Around 30% of NHS staff report being stressed at work. Those who take time off from work spend an average of 31 days out of the work place. This is costing the NHS around £300-400 million per year[4,5]. Debriefing challenging situations would go some way to help alleviate these figures.

Why don't we debrief more often?

There are many barriers. Firstly, getting staff to 'buy in'; some staff may struggle to see any tangible benefits from the process. For staff not regularly exposed to the technique of debriefing there is a fear as to what is involved, specifically will it expose failures in practice? Many staff are not comfortable in opening up alongside peers and showing emotion. There is always an issue of time constraint and the practicality of getting all staff involved together in the same room at the same time.

There is a perception that no one knows how to lead an effective debrief, although many staff are trained in a range of teaching and debriefing techniques that are

FIGURE 1 A debriefing event. The debrief needs to be held in a private space where all involved feel safe to speak openly and honestly.

used primarily with an educational purpose but can be easily translated into the clinical environment.

How can we approach it?

When?

A 'hot' debrief is performed straight after the event. The benefits are obvious; the event is fresh in everyone's mind, the team is there and it will help check that everyone is in a satisfactory physical and mental state following the event.

If the debrief is delayed by a few days, it is known as a cold debrief however this allows staff some time for their emotions to settle and for them to rationalise what has happened. Here staff may be more receptive to the debrief process, although a large drawback of this is getting the right staff back together at a convenient time.

Debriefing need not be a one off process; an ongoing regular programme may benefit the neonatal unit. Indeed another unit known to the author, holds a monthly debrief at which critical incidents and challenging events are discussed with a psychologist. It is hoped that a debriefing team will be established on the Leeds' neonatal unit later in 2014.

Where?

The debrief needs to be held in a private place where all involved feel safe to speak openly and honestly about what has happened.

Who?

The team involved need to be present (**FIGURE 1**). If the incident involved a delivery, the midwife looking after the parents should be included as well. There could be a role for senior nursing/medical staff to add some training value to the session. They can also be crucial in taking forward any key process issues that need resolving.

If establishing a formal debriefing team, there is a benefit to having a psychologist involved to provide additional support for staff. A culture of openness needs to be developed but a clear leader who can direct the discussions and move things forward is necessary.

A debrief example

It may be useful to consider an actual scenario that occurred at Leeds involving the care of a complex preterm infant with a range of medical issues. After a few weeks it became clear that ongoing intensive care was not appropriate for this infant and so discussions took place with the family regarding this. This process took over a week, as there were many cultural hurdles for the team to consider. Eventually the baby died, surrounded by the family and their friends. He was immediately taken for burial in accordance with the family's religious beliefs.

As he had been in the neonatal unit for a few weeks, many staff had been involved in his care and the discussions with the family. All levels of the team wanted the opportunity to talk through the case from their perspective. Many had felt troubled about the family's reticence to opt for reorientation to palliative care, some struggled with the idea that funeral plans were in place before he had died and many staff simply wanted an opportunity to gain a deeper understanding of all of his medical issues.

A team meeting to discuss all of these issues took place around two weeks after his death. The consultant in charge of his care led the debrief but everyone was free to talk. The discussion started with some education about his complex medical needs and then moved onto the more psychological side of the case. Holding the debrief after two weeks gave time to make all team members aware of the planned meeting so that they could attend if they wanted, including staff at the neighbouring unit. It also enabled the chaplain to attend to explain the cultural issues surrounding the infant's death.

All staff involved appreciated the opportunity to talk about the case and openly discuss the parts they found challenging. It gave everyone a greater appreciation of the cultural issues involved.

Conclusion

There are challenges to running a debrief after significant events but it is worth the effort for the sake of improving patient outcomes, identifying training needs, improving patient safety and for the psychological well-being of staff.

References

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