Quality Academy Knowledge & Evidence Team

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| **Your request for evidence:**  Best practice for debriefing after an incidentBottom of Form | **Date of literature search: 27/03/2020**  **Search conducted by:** Ramona Naicker  **Contact details:** [ramona.naicker@nhs.net](mailto:ramona.naicker@nhs.net) x5338 |
| **In Summary:**   * **Suggested best practice for debriefing structures: overview of purpose and clearing the air from judgement; discussion of facts of the event; analysis and identifying points for improvement; finishing with a summary and take-home points.**   4 of the resources recommend best practice debriefing structures1-4 and these tend to be divided into 3 or 4 phases including:   * **A preparation phase** where the team can get organised, the air can be cleared from judgement and the stage is set for learning; * **A dialogue phase** where members explore what happened, what went well and what didn’t; * **An analysis phase** where the team discuss why aspects may or may not have gone well and indicate key points for improvement; * **A summary phase** where take-home points are indicated.   I’ve included a collection of various debriefing forms which may be useful to look at. In general, the forms display roughly the same structure for debriefing: **Description; Analysis; Planning for Future; Summary.5**  UCL structured their debrief (or after-action reviews) into 4 main questions with additional sub-questions: **what was expected to happen; what did happen; was there a difference; what can be learnt?6**  Though Royal College of Physisicans’ section on debriefing in their ’Improving Teams in Healthcare’ resource focuses on questions that could be asked during the **analysis phase**, rather than the structre of the debrief, I thought these may be helpful. For example: **were there adequate resources; was there clear communication; was workload distributed evenly?7**  One of the key features about a debrief is that members **should be informed at the beginning that debrief occurs in a safe zone** and is not an investigation, and the lessons are being captured for the sake of l**earning and improvement, not punishment**.1,2,6,7 An evaluation conducted in Northumberland, Tyne and Wear found that embarrassment was a main barrier to successful debriefing and that If there was **no pre-existing positive relationship with the person facilitating the debrief or providing the support, all participants were generally more reluctant to engage**.8  As **the act of debriefing has been adapted from the military and aviation industry**,1 I’ve included the debriefing standards for the Civil Aviation Authority of what constitutes a basic, good and very good debrief.9 Included in the numerous standards are: **debrief starts with an introduction; limits debrief to 3 or 4 main points, plus 3 or 4 minor ones; staff leave with clear and concise learning points; debrief holds the agenda**.9 | |

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| **No.** | **Key information** | **Document** |
| 1. | Gardner, 2013. **Introduction to debriefing**. *Semin Perinatol*;37: 166-74.  **Key finding:**   * **A refined 3 step model of debriefing developed by experts consists of a reactions phase, and understanding the event phase, and a reviewing phase.**   Process of debriefing  Fanning and Gaba\* reviewed several models of debriefing, not specific to simulation in a medical context, as having anywhere from three to seven steps. Leading experts at the Center for Medical Simulation in Cambridge, Massachusetts,\*\* have developed and refined a three-step model of debriefing with a reactions phase, an understanding phase and a summary phase:    Factors that facilitate effective debriefing include **building an open environment, focusing on key learning objectives, acknowledging the value of each participant and the importance of self-reflection, reassuring participants that debriefing is confidential and managing time constraints**. Keys to building an open environment include:   * Ensuring staff have a ‘‘**zone of safety,**’’ a psychologically safe and private area for open discussion. * Acknowledging the value of staff input, the importance of **reflection and analysis of their teamwork** and other skills for better managing an event. * Making it clear debriefing is **confidential**.   \*Fanning et al., 2007. The role of debriefing in simulationbased learning. Simulation Healthc; 2(2): 115–125.  \*\*Rudolph et al., 2008. Debriefing as formative assessment: closing performance gaps in medical education. Acad Emerg Med; 15(11): 1010–1016. | Available to read online [here](https://pdfs.semanticscholar.org/fcae/5bd0b8a3bcb6d893dd36a17cc264d4761f8b.pdf?_ga=2.140986610.1500115131.1585299931-1152688286.1585299931) |
| 2. | Kessler et al., 2014. **Debriefing in the Emergency Department After Clinical Events: A Practical Guide**. *Ann Emerg Med*; :1-9.  **Key finding:**   * **Debriefing in any high-risk industry includes 3 general phases: description, analysis, and application to future events.**   Although there is no single criterion standard for what phases should be part of a clinical debriefing, most sessions will generally include:   * An **overview of the purpose** of the debriefing * The format and **ground rules** needed to establish a **psychologically safe** environment * Discussion of **content** relevant to the **objectives** * **Review** of actual **actions** * Discussion of **what went well and what did not** * Discussion of **how to improve** in the future * A **summary of take-home points**.   Other notes:   * Debriefing should include **a friendly atmosphere**, open-ended questions, honest dialogue, and identification of behaviours or perceptions that lead to improved outcomes. * **Debriefing tools or scripts** may help guide facilitators and teams through a specific method of debriefing. * When feasible, some form of debriefing should be conducted **as soon as possible after an event**. | A copy of this paper can be obtained upon request |
| 3. | Cant et al., 2011. **The benefits of debriefing as formative feedback in nurse education.** *Aus J Adv Nurs*; 29(1)  **Key finding:**   * **Key requirements of a debrief involve preparation for the debrief, describing and analysis of the event (application of “sandwiching” negative performance points with positive points) a final summary and take-home message.**   The features of debriefing that are indicative of best practice:  Key requirements include a teaching plan, attention to the physical environment, setting the mood for the learner, managing the dialogue, and implementing a succinct summary and closure. A learner’s reflection on their actions is key to their learning experience, **being guided (not driven) by the facilitator**.    The clinical impact on patient care of debriefing as learning for nurses has not been measured to date. To this end, further research is warranted to fully establish educational applications and the short‑term and long‑term effect of the educational approach. | Available to read online [here](https://www.ajan.com.au/archive/Vol29/29-1_Cant.pdf) |
| 4. | Perry et al., 2015. **Reducing perioperative harm in New Zealand: the WHO Surgical Safety Checklist, briefings and debriefings, and venous thromboembolism prophylaxis**. *NZMJ*; 128(1424).  **Key finding:**   * **Provides a simple, recommended structure for debriefings, which can be tailored to individual local practice and context:** |  |
| 5. | Association AH. **Hot debriefing form examples – Get With The Guidelines® – resuscitation clinical tools**.  **A collection of various post-incident debriefing forms** which in most cases shows that debriefing follows the same structure:   * Description * Analysis * Planning for Future * Summary | Available to read online [here](http://www.heart.org/idc/groups/heart-public/@wcm/@hcm/@gwtg/documents/downloadable/ucm_486571.pdf) |
| 6. | University College London Hospitals NHS Foundation Trust. **Resource A; Part 3 – Check Debrief Template**.  **Key finding:**   * **There are four main questions to ask in a debrief: what was expected to happen; what did happen; was there a difference; what can be learnt?**   The debrief should focus in learning; no hierarchy, no blame, no assumptions.  The after-action review (AAR) is constructed of **4 main questions**, broken down into further questions:  **1. What was expected to happen?**  This question is asked to the group for their discussion. The following sub questions could  be utilised (if suitable) to aide group discussion:   * Was there a planned response? * What was the planned response? * What was your personal expectation to happen in this type of incident * What was the expected timeline?   **2. What actually occurred?**  This question is asked to the group for their discussion. The following sub questions could  be utilised (if suitable) to aide group discussion:   * Each participant should describe - what they did, saw or experienced, during the * incident. * The participants should not be discussing what was good or bad at this stage.   **3. Was there a difference?**  This question is asked to the group for their discussion. The following sub questions could  be utilised (if suitable) to aide group discussion:   * Was there a difference between what was expected and what actually happened? * What were the good points and what didn't work so well?   **4. What can be learned or identified?**  This question is asked to the group for their discussion. The following sub questions could  be utilised (if suitable) to aide group discussion:   * With the benefit of hindsight - what could have been done differently/better? * Does anything need to be changed to improve future responses?   **Closing the AAR** - The key learning points should be summarised from the discussion held, focussing on what lessons have been identified.  Inform participants of what are the next steps i.e. report writing. If actions have arisen in the AAR, it is the responsibility of the AAR participants to take the actions forward and ensure they are brought into the existing reporting mechanisms within their organisation.  **Sharing the Report** - Once the report has been completed share it with members of the AAR and ask if the group are happy to share the lessons identified. | Available to read online [here](https://www.england.nhs.uk/wp-content/uploads/2016/03/prt4-act-resrc-a-debrief-temp.pdf) |
| 7. | Royal College of Physicians, 2017. **Improving teams in healthcare**.  **Key finding:**   * **Provides questions that should be asked after the event, e.g. what went well/didn’t; were there adequate resources; was there clear communication?**   Team Debrief  Ideally debriefing should occur upon completion of any team activity, but especially after a difficult or challenging event. It allows teams to discuss actions and thought processes involved in a care situation, encourages reflection, and facilitates actions for improvements in future performance. Most importantly it provides a support mechanism for the members of the team.  **Debriefs are conducted in ‘safe environments’ where honest mistakes are viewed as learning opportunities** with no assignment of blame or failure to an individual. | A copy of this paper can be obtained upon request |
| 8. | Burman, 2018. **Debrief and post-incident support: views of staff, patients and carers.** *Nursing Times*; 114: 9, 63-66.  **Key finding**   * **A quiet space and a facilitator with whom all have a good relationship are conducive to debrief and post-incident support. Barriers to debrief include embarrassment, cultural attitudes and low staffing levels or a lack of staff time.**   Data comprised of:   * An evaluation conducted on five wards in a mental health trust explored perceptions and experiences among a group of 44 staff, patients and carers. Northumberland, Tyne and Wear Foundation Trust.   Barriers to debriefing:   * **Embarrassment** * **Work culture** where debrief was ‘just not the done thing’ and where **incidents were considered inevitable** due to ‘the nature of the job’. Debrief was **not always prioritised** by coordinating staff * Low **staffing levels** * Too much **paperwork**   If there was no pre-existing positive relationship with the person facilitating the debrief or providing the support, all participants were generally more reluctant to engage, but they would usually **be happy to engage with anyone they had a positive relationship with.** | Available to read online [here](https://www.nursingtimes.net/roles/mental-health-nurses/debrief-and-post-incident-support-views-of-staff-patients-and-carers-28-08-2018/) |
| 9. | Civil Aviation Authority, 2014. **Flight-crew human factors handbook**.  **Key finding:**   * **Standards of successful debriefing are outlined in the table below**  |  |  |  |  | | --- | --- | --- | --- | | Civil Aviation Authority Debriefing Standards | | | | | 1. Requiring Improvement | 2. Basic Standard | 3. Good | 4. Very Good | | Chronological  No prioritisation of faults  Does not identify root causes  Little opportunity for crew to review their own performance  ‘Nit-picking’  Cursory review of the flight...or  Debriefs for an excessively long time | Prioritises areas for improvement  Holds the agenda  Some use of facilitation  Encourages crew to provide their views  Supporrts company SOPs  Limits debrief to 3 or 4 main points, plus 3 or 4 minor ones  Debriefs good aspects as well as the faults  Compares individual performance against the objectives  Generates a brief summary  Gives preparatory work for the next lesson  Produces a written training report | **As per 2 plus:**  Starts with an introduction  At ease with facilitation to move the debrief in the required direction  Draws common faults together – perceptive to root causes  Balances praise and criticism  Concise and informative report writing | **As per 2 & 3 plus:**  Allows the crew drive the agenda but with the instructor controlling it  Achieves crew consensus  Crew leave with clear and concise learning points | | Available to read online [here](https://publicapps.caa.co.uk/docs/33/CAP%20737%20DEC16.pdf) |

**Search Strategy:** *debrief*\***AND** *inciden***\* OR** *death\** **OR** *adverse\** **OR** *crisis\** **OR** *critical* **OR** *hospital\** **OR** *ward\** **OR** *heathcare* **OR** *“health care”* **OR** *clinc\**

**Sources searched:** AMED, BNI, CINAHL, EMBASE, HMIC, Medline, NICE, NICE Evidence Search, UpToDate, Cochrane, BMJ, TRIP, advanced Google search