

# Clinical Event Debriefing



An open access professional development module for simulationists

# How to use this module



**Module progresses from foundational concepts to advanced practice. Self direct how deep you want to go!**

**Exercises are designed to work on your own or to discuss with a friend over coffee.**



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# Clinical Event Debriefing

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## Overview :

### *What is clinical event debriefing?*

The concept of debriefing after a simulated case is a familiar one for most health care providers, as simulation-based training is already an important part of their education. Clinical Event Debriefing (CED) shares many similarities with traditional debriefing, but it has several important differences.

Clinical Event Debriefing, sometimes referred to as post-event debriefing, is a facilitated reflection on the actions and events that occurred during an actual clinical case. As opposed to simulations that occur in a protected learning environment, the focus is not on individual performance. It is on team dynamics and systems issues. It is an opportunity to reflect on the team-based care and environment to improve the care of subsequent patients. In addition, CED is often an interprofessional and multidisciplinary discussion that involves perspective gathering from many sources.

### *Why is it important?*

Teams that participate in CED regularly are more effective than those that do not<sup>(1)</sup>. Team based skills, such as high-performance CPR, and patient outcomes, such as rates of ROSC and subsequent neurological outcomes, are better in teams that conduct CED<sup>(2, 3, 4)</sup>. Because teams that routinely engage in CED are more effective, it has been incorporated into the American Heart Association's guidelines<sup>(5)</sup>.

### *What are the barriers?*

Despite the recommendation to engage in CED, many find it difficult to incorporate this in practice. In one study, approximately 25% of resuscitations had an associated debriefing<sup>(6)</sup>. Two frequently cited barriers to implementation include a perceived lack of time and facilitator discomfort or perceived lack of training.

### *Are there potential harms to it?*

The potential benefits of CED are enticing, but there are several factors to consider. These include:

- Loss of psychological safety (feeling undermined in your role in front of peers, feeling "attacked" personally for perceived mistakes in care)
- Potential for discovery (depending on the local environment, this may be a discoverable conversation)
- Responsibility for future problems (systems-based issues that are identified but not ultimately addressed (eg, malfunctioning equipment) may point back to the CED facilitator as responsible)

### *Are there "best practices" to know?*

There are several core features that must be front-of-mind when engaging in CED. These include:

- Scripted Prebriefing
- Description of the event (for a shared mental model)
- Discussion of what went well
- Discussion of systems-based issues
  - Documentation of findings and plan for escalation to resolve those issues
- Wrap up

Many teams that conduct CED use a tool to help standardize the debriefing, decrease cognitive load for facilitators who may already be stressed from the event itself, and to minimize the risk that the debriefing will devolve into one of blaming.

## Exercise 1 : Foundational Principles

Read this blog post from Life in the Fast Lane:

- [Clinical Debriefing](#)<sup>1</sup>

Read this article:

- [Debriefing in the emergency department after clinical events: a practical guide](#)<sup>2</sup>

Listen to these podcasts:

- [Debrief 2 Learn : NASA Debriefing Methods](#)<sup>3</sup>
- [Debrief 2 Learn : Clinical Debriefing](#)<sup>4</sup>

Ask yourself or discuss with a friend:

- What has been your personal experience with Clinical Event Debriefing?
- How did you feel as a participant? What kind of cases might prompt Clinical Event Debriefing in your work environment?

Retrieval practice:

- Reflect on what you know about scheduled, education-based simulation debriefing (where a simulated case is prepared for primarily educational purposes) and Clinical Event Debriefing. Use those reflections to fill out this table.

Differences between traditional, education-based debriefing and Clinical Event Debriefing			
	Education-based Debriefing	Clinical Event Debriefing	Notes
Trigger			
Location			
Timing			
Focus			
Facilitator			
Duration			

Reflect on the “what, why, and who” of CED with an interprofessional team.

- Are there certain events that should NOT undergo Clinical Event Debriefing? What would be a better way of approaching those events?
- What events should trigger an automatic CED? Are there certain factors that may prompt a CED that aren't on your list?
- Who should be invited to participate in CED? Are there any participants who should not be involved?



## Exercise 2 : Debriefing Emotion

Many debriefers express concern about debriefing events that are emotionally heightened and some people feel that CED creates a “second victim” environment, where participants feel blame and personal responsibility for a suboptimal outcome or challenging case.

### Read this article:

- [Team debriefings in healthcare: aligning intention and impact](#)<sup>5</sup>

### Ask yourself:

- Think about the CEDs you’ve experienced (or if you haven’t, experienced any, think about a clinical case that might be conducive to CED). Working through figure 1 of the Kolbe article, how would you classify the debriefing intention?

### Thorny questions:

- What debriefing practices may contribute to participants feeling blamed? What effect would it have on the team or individual if participants felt this way?
- What debriefing practices or tools may prevent participants from feeling blamed or shamed? What would the conversation look like if participants did not feel blamed during the CED?

### Proactive strategies:

The prebriefing is a critical component to creating a “safe container” for CED. It can help flatten hierarchy, encourage diverse perspectives, and minimize the perception of casting blame. This is especially important in highly charged cases (eg, an adverse outcome) or when hierarchy/power dynamics are part of the culture.

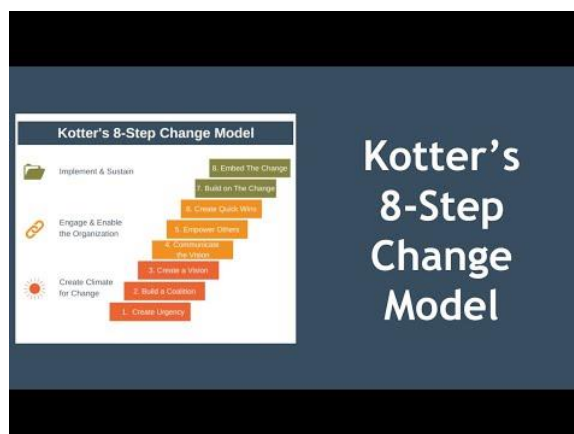
### Exercise:

- Take a moment to script a prebriefing for CED in your clinical environment.
- What items would you include to address the “thorny questions” above?
- How will you specifically address the power dynamics and cultural considerations of your work environment?

## Exercise 3 : Implementing a Clinical Event Debriefing Program

If your clinical environment does not already use CED, why do you think that is? Do you think you may be able to start doing it? If you are doing it sporadically, how could you increase the CED frequency in your workspace?

- Reflect on the barriers to implementing or increasing CED in your clinical space.
- Time can also be a barrier. Recall your reading of the Kessler paper in Exercise 1 and the discussion of “hot,” “warm,” and “cold” debriefing. Which would work better in your environment? Are there cases when an alternative timing may be more useful?
- Kotter’s principles of change management can aid your strategy when implementing a program<sup>6</sup>.



### Exercise 3 : Implementing a Clinical Event Debriefing Program

How would you use Kotter's principles of change management to start or increase CED?

Kotter's Eight Steps to Change Management :	What would this look like for you?
Establish a sense of urgency	
Form a powerful guiding coalition	
Create a vision	
Communicate the vision	
Empower others to act on the vision	
Plan for and create short-term wins	
Consolidate improvements and produce more change	
Institutionalize new approaches	

### Exercise 4 : Scripts

Discomfort or a perceived lack of experience is one of the biggest barriers to conducting a CED. To help with this, many organizations use templates with pre-written questions to keep the conversation on track. Does your organization have such a template? If not, how would you craft a template? If you need ideas, you could look at the INFO tool, the STOP5 tool, the TALK model, or the DISCERN tool.

- General overview : [Debriefing in the Clinical Environment Before, During, & After COVID-19](#)<sup>7</sup>
- INFO tool: [Charge nurse facilitated clinical debriefing in the emergency department](#)<sup>8</sup>
  - Here is a [VLOG interview](#) with the author<sup>9</sup>
- STOP5: [a hot debrief model for resuscitation cases in the emergency department](#)<sup>10</sup>
- DISCERN tool: [Implementation of an In Situ Qualitative Debriefing Tool for Resuscitations](#)<sup>11</sup>
- TALK debriefing model: [TALK Clinical Debriefing User Guide – Part 1](#)<sup>12</sup>

#### Exercise:

- Create your CED template with scripting or improve upon your previously-existing tool. You may incorporate the prebriefing you scripted in Exercise 2.

## Exercise 5 : Clinical Event Debriefing for Systems Improvement

Implementing a Clinical Event Debriefing program in your setting will require support from departmental leadership and various stakeholders. A method of defining and measuring success will help inform efforts to continuously improve and gain buy-in.

As a goal of CED is systems improvement, it is also important to have a clear mechanism of reporting latent patient safety threats that are discovered as a result of your debriefs.

### Read these articles:

- [Debriefing immediately after intubation in a children's emergency department is feasible and contributes to measurable improvements in patient safety](#)<sup>13</sup>
- [Use of a Surgical Debriefing Checklist to Achieve Higher Value Health Care](#)<sup>14</sup>

### Listen to this podcast:

- [100% Adoption. 35% Mortality Reduction. \\$7,000,000 / Year. A Talk with Michael Rose & Kate Hilton](#)<sup>15</sup>

### Reflect on:

- What are you seeking to improve by engaging in Clinical Event Debriefing? What outcomes might be of interest to you and your setting? How will you measure success?
- Consider your environment. How will data be collected from debriefs? How will data be communicated to the appropriate stakeholders?

Trust and confidentiality are critical to a robust CED program. Themes and issues that are important for quality improvement may be undermined if information from a CED is used against staff. Additional concerns arise if a case has medical-legal consequences.

### Exercise:

- Talk with your administration/risk management department about how the organization feels about CED in general. Is there already an established model for doing this within the organization? How can concerns identified in CED may be used to improve patient safety while protecting staff who were involved in care? How are staff protected in cases that may have medical-legal ramifications?
- What components are necessary at your institution to maintain the confidentiality and psychological safety of CED?

## Additional Resources

These seven articles are excellent, and familiarity with them will give you a strong foundation of knowledge about Clinical Event Debriefing:

- [Clinical event debriefing: a review of approaches and objectives](#)<sup>16</sup>
- [Debriefing in the emergency department after clinical events: a practical guide](#)<sup>17</sup>
- [Systematic Debriefing for Critical Events Facilitates Team Dynamics, Education, and Process Improvement](#)<sup>18</sup>
- [Promoting hot debriefing in an emergency department](#)<sup>19</sup>
- [Improving patient safety through better teamwork: how effective are different methods of simulation debriefing? Protocol for a pragmatic, prospective and randomised study](#)<sup>20</sup>
- [Debriefing After Critical Events: Exploring the Gap Between Principle and Reality](#)<sup>21</sup>
- [Interdisciplinary clinical debriefing in the emergency department: an observational study of learning topics and outcomes](#)<sup>22</sup>

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