Debriefing and feedback for critical incidents

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Symposium BAMM 25/04/24

Patient safety

WHO reports that around **1 in every 10 patients** is harmed in healthcare, more than 3 million deaths occur annually due to unsafe care

Common **sources** of patient harm include medication errors, surgical errors, health-care associated infections, sepsis, diagnostic errors, patient misidentification, etc

https://www.who.int/news-room/fact-sheets/detail/patient-safety

Patient safety

Human factors in patient harm

Human factors in patient harm include **communication errors** among healthcare workers, within healthcare teams, with patients and families, ineffective teamwork

System approach to patient safety

Requires a shift from **traditional blaming approach** to systems-based thinking

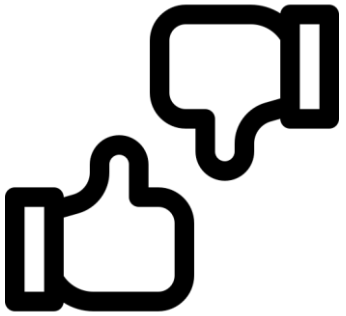
Requires building competencies of healthcare workers and **improving teamwork and communications**

https://www.who.int/news-room/fact-sheets/detail/patient-safety

Agenda

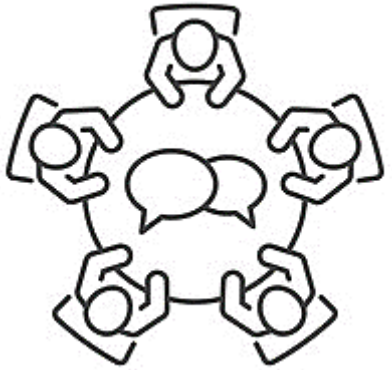
Person-centered communication strategies in **feedback**

- Effective feedback strategies for peers/team members
- Organizing a safe environment for feedback
- Dealing with feedback



Communication strategies in **debriefing**

- Tips on implementing debriefing
- Debriefing in practice



Feedback

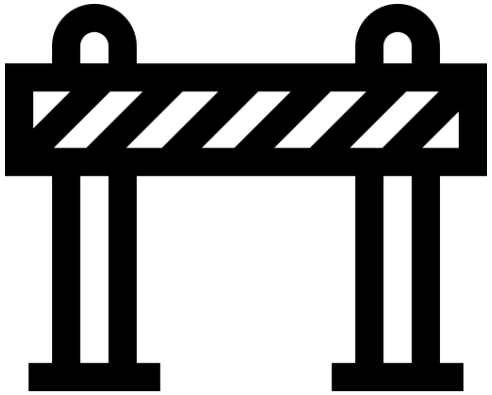
Forms of feedback

- **Informal feedback**: very frequent, often verbal, unstructured
- **Formal feedback**: part of a structured assessment, from peers or superiors
- **Formative feedback**: learning purposes, to gain insights in personal functioning, reflect and redirect, no direct impact on formal progress
- **Summative feedback**: learning measure, benchmark or standard, graded

Barriers to effective feedback

Fear of damaging professional relationships

Generalized feedback

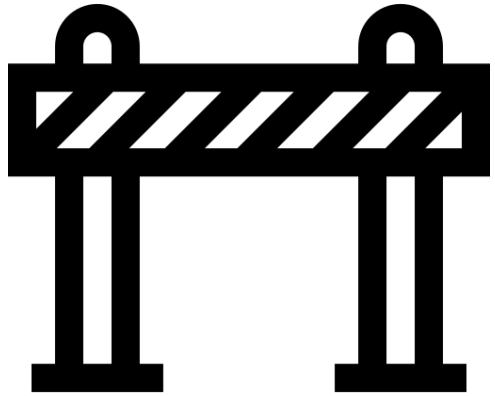


Fear of upsetting colleagues

Defensive behavior, resistance

Barriers to effective feedback

Lack of advice on how to improve



Personal agendas

Physical barriers: improper time, place, space

Lack of respect for the source

Lack of confidence

Tips for effective feedback

One-on-one feedback

Give promptly, right after event

Start gently

Be aware of non-verbal communication

Be specific

Tips for effective feedback

Plan in advance

Discussion in function of the goal

Encourage self-reflection

Self-reflect after feedback

Models for feedback

Sandwich model

Sandwich ‘negative’ feedback between ‘positive feedback’

Pendleton model

Learner centered and focusses readiness for feedback, rooted in CBT

“Chronological” model

Focusses on chronological sequence of events to guide feedback

Basic model to approach feedback

Behavior

Focus on an observed behavior, event, moment

Ideas, feelings

What feelings, what ideas, what beliefs did this trigger for you?

Consequences

What were the consequences, effects of the observed behavior?

Preferred behavior

What behavior could have been better, more appropriate?

Debriefing

Structured, formal reflection by a team or individual immediately following a critical (or clinical) **event**

Aims:

Most important -> improve care, **improve outcomes**

Also -> manage **emotional responses** (cave re-exposure)

http://www.who.int/patientsafety/research/methods_measures/human_factors/human_factors_review.pdf

Tips when implementing debriefing

When

Routine vs prompted

As soon as possible after event

Attitudes

Foster self-reflection

Quality improvement attitude

Safe environment

Suitable physical environment

Emphasize psychological safety

Tips when implementing debriefing

Local facilitators

Invest and engage local facilitators

Communication skills

Knowledge of system approaches

Structure

Adopt recognizable structure for debriefing

Limit discussion topics

Keep it short

Invest

Training

Expert support for distressed participants

Confidentiality guidelines

Coggins, *Medical Teacher* 2021

KU LEUVEN kulak

Structure for debriefing

T **Step 1: Target**
What shall we discuss to improve patient care?
Share your perspective.

A **Step 2: Analysis**
Explore your agreed target, if appropriate consider:
1. What helped or hindered...
   communication / decision making / situational awareness?
2. How can we repeat successful performances or improve?

L **Step 3: Learning Points**
What can the team learn from the experience?

K **Step 4: Key Actions**
What can we do to improve and maintain patient safety?
Who will take responsibility for actions? Who will follow up?

Diaz-Navarro, 2021

Target

Introduce debriefing session, set ground rules

Voluntary!

Ensure safe environment

Solicit initial reactions, emotions

Hold analysis

Recognize time limits (nominal group technique if needed)

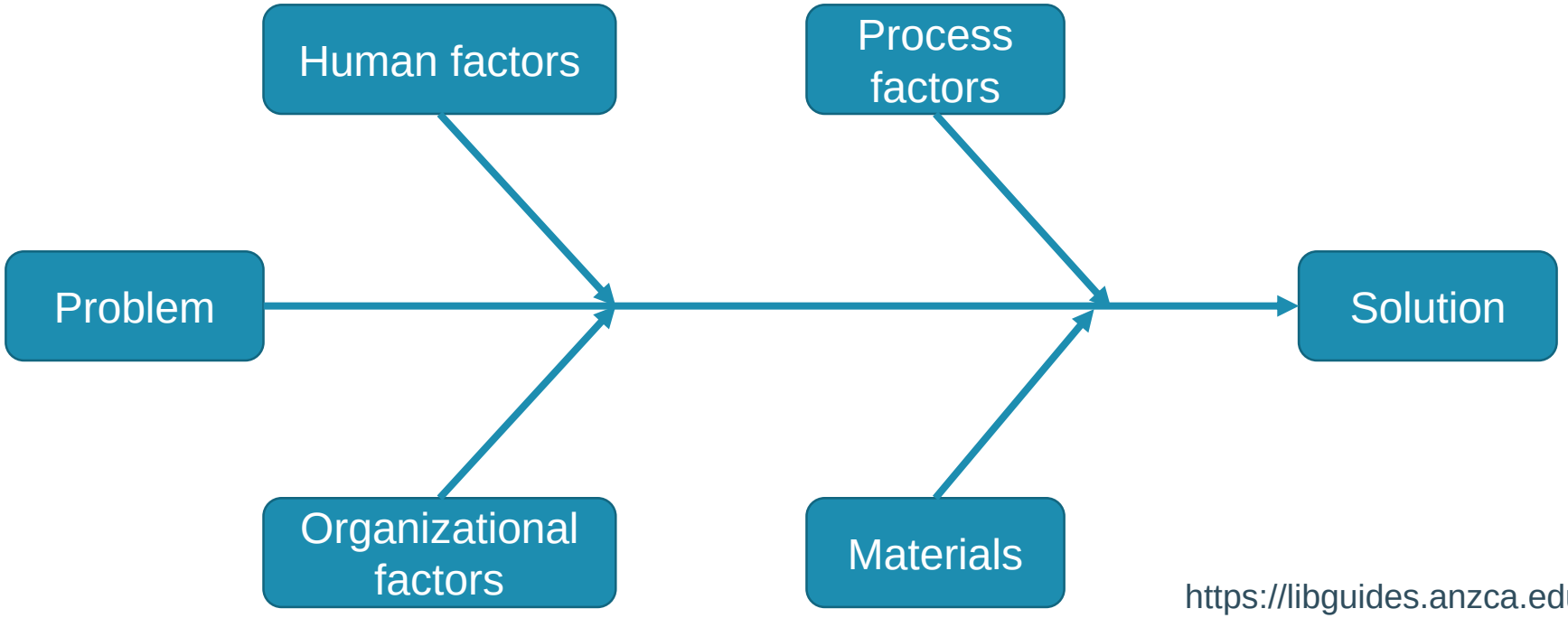
Avoid domination

https://libguides.anzca.edu.au/criticalincident/home

Analysis

Step 1: Summarize situation

Step 2: Root cause analysis



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Learning points & key actions

Summarize insights

Agree on solutions

Define responsibilities and follow-up

https://libguides.anzca.edu.au/criticalincident/home

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