Debriefing: An Expert Panel's How-to Guide

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ANNALS CASE

We've all been there. A patient dies. A case goes badly. Bad news is delivered. And then we check the list, and guess what? New patients are waiting. At that moment, we, and likely the rest of the team, might be internally processing what just occurred and contemplating what could have gone better. Do we have another option besides burying our whirring thoughts and emotions in order to function in the emergency department (ED)? One option might be postresuscitation debriefing (PRD). Turns out, facilitated discussion after an event is beneficial in assimilating improved behaviors into practice.[1,2] PRD has been associated with improved performance measures such as improved cardiopulmonary resuscitation (CPR) quality and better neurologic outcome,[3] as well as decreased provider stress.[4] Although the article by Mullan et al[5] in this month's *Annals of Emergency Medicine* evaluates the accuracy of PRD, we wanted to provide practical advice on how to institute PRD in your busy ED. Our expert panel (Appendix), with experience instituting ED PRD programs, is here to help.

What are your triggers for debriefing?

Our experts agreed that major resuscitation events such as CPR, intubations, and trauma activations should trigger PRDs. Their value, though, may not be limited to major resuscitations. Dr. Kessler recommends debriefing after difficult situations such as dealing with an angry parent. Dr. Zinns debriefs after "psychosocial events [use of restraints], difficult family dynamics, and new diagnoses." PRDs may have high educational value for high-risk but rare events, even if they go well. Examples according to Dr. Rose include vaginal delivery and posttonsillectomy bleeding. Although events such as CPR and intubations are a starting point for building a culture of debriefing, Dr. Mullan noted that, although CPR and intubations were a starting point for building a culture of debriefing because they have "highest odds of successful buy-in for providers to stop their work flow momentarily to debrief. However, once we implemented the tool, and teams valued the process, they started using it at their own discretion for other scenarios like septic shock, upset parents, altered mental status, status epilepticus, and others." Simply put, debriefing may be beneficial in a much broader application than resuscitations.

How is a PRD conducted?

First, there must be a PRD facilitator, which our experts report is typically a physician or nurse team leader. Dr. Mullan recommends the nurse resuscitation documenter as the best choice: "Given that the majority of people present at a resuscitation and a debriefing tend to be nurses, and the primary goal of debriefing is to note performance deficiencies that can be improved in future events, you want the primary facilitator to be the one most likely to get the crowd to speak openly. Given the hierarchy in medicine that unfortunately exists even in quality improvement activities like debriefing, this person tends to be a nurse." Dr. Rose added that "after a high-stakes or unexpected event occurs, any member of the professional team can request a PRD." Panel members described doing both "hot" debriefings (within an hour of the event) and "cold" debriefings (days to weeks later by video analysis). Ms. Brown stated, "We announce the time for debriefing overhead just like we do for med alerts, and everyone that participated in the crisis is strongly encouraged to attend." Dr. Rose added, "The sooner it can be done, the greater the chances are that it will happen." The panel generally follows a "plus-delta" model, which involves discussing what went right (the "plus"), and what can be improved (the "delta"). A scripted form is commonly used. Ms. Brown gave specific examples: "We ask yes and no

questions [about] measurable goals. For example, for CPR or intubation, were the AED [automated external defibrillator] pads placed on the patient within 2 minutes of CPR? Were there pauses that lasted greater than 10 seconds between compressions? Were there any desaturations to less than 90% during the intubation?" As with any feedback, the goal is to improve future performance. Focus on uncovering what interfered with optimal performance and how to improve for the next case rather than on assigning blame.

What obstacles did you have to overcome in implementation and maintenance of the PRD program and how did you address them?

The entire panel agreed that the primary obstacle to PRD is a busy ED. The first step to PRD is departmental support of an established PRD system by a multidisciplinary team. At Ms. Brown's program, she recruited nurses, technicians, and other ancillary staff first. Then she provided training, followed by gathering and addressing feedback. She explained, "[When we] started performing PRDs, feedback was encouraged from the participants and some changes were made to the form to make things easier for the staff. Once we had nursing buy-in, it was easier to get the physicians on board because physicians and nurses have a mutual respect for each other. We value each other's opinion." In addition, the panel recommended limiting the PRD time to 10 minutes or less. Drs. Zinns and Mullan noted the importance of giving feedback to providers on the positive changes resulting from PRDs: "The addressing by ED leadership of the follow-up issues identified by PRD has been the number one buy-in factor for ED teams to increase the proportion of resuscitations that are debriefed, as teams can see the value of their time investment in a debriefing."

Do you have any form of simulation training program for your PRD?

Because PRD is a new modality for many providers, simulation training has been described to help in both the implementation and improvement of a PRD program. Dr. Kessler described how simulation training is used at his program: "Each week, we meet for 30 to 45 minutes for a mock code. Usual attendees are nurses, physicians, child life specialists, ED technicians, and unit assistants." Pediatric emergency medicine fellows, under an attending physician mentor, write the simulation cases. Dr. Kessler explained that the "sim[ulation] center provides tech, manikin, and expertise as needed for the scenario. [The] supply center sends us a mock code crash cart each week. This has led to a large cross-section of our physician and nursing staff who are trained in debriefing. In addition, when we identify latent safety threats in the environment, we enter them into our error reporting system as 'unsafe conditions found via sim' for follow-up through that mechanism." Dr. Mullan added that a physician leads the postsimulation debriefing "with the same debriefing tool that we use after clinical events. This helped to increase ED provider familiarity with the form, as well as improve the quality of debriefing discussions. [The physician] would coach teams through the debriefing process if they were either silent on a particular issue or digressing off course on tangent discussions."[6]

What are some actual examples of system or resuscitation performance issues that were identified and corrected through the use of PRD?

Dr. Kessler recalled an infant with acute respiratory distress from an upper airway foreign body. "We were able to maintain oxygenation and normocapnia without invasive intervention long enough to have a conversation with both ENT [ear, nose, throat] and anesthesia [consultants], who arrived in the room," he stated. "The PRD led to a multidisciplinary task force revising our threatened and crash-airway algorithms to focus on subspecialty disposition. We were then able to test the new process, and train using simulation." Dr. Zinns's team discovered that monitor connection problems were leading to end tidal CO_2 malfunctions. Ms. Brown's PRD system revealed that intubation blade sterilization time was suboptimal, as well as costly and inefficient. As a result, the department changed the sterilization process.

How would you respond to the physician who tells you, "Our ED is always too busy—I can't ever see having the time to do these debriefings"?

Our experts emphasized that the key to value of PRD is that it can improve patient outcomes and team well-being. Dr. Mullan emphasized the importance of understanding the physician's perspective, especially the duration of the PRDs, less than 10 minutes, and ensuring that the physician believed that the delta issues brought up were addressed. If not, "I would ensure that the follow-up system is designed adequately to address issues in a timely fashion." As one of Dr. Rose's colleagues pointed out, "We always have time for 1 or 2 more rounds of advanced cardiovascular life support/epinephrine if someone requests it, even when we know these actions are futile. Doing a PRD takes about as long and can do a lot more to help both the team and the next patient." Keep in mind that PRDs do not need to occur immediately. Oftentimes, scheduling the PRD allows the team to catch up on other patients and organize their priorities. The short answer here is that the value of PRD greatly exceeds the time and effort it takes. A PRD template from Dr. Mullan's previous publications is available and is part of the electronic copy of our article (available online at http://www.annemergmed.com).[5]

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IMAGES IN EMERGENCY MEDICINE

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DIAGNOSIS:

Retrograde jejunogastric intussusception. The incidence of retrograde jejunogastric intussusception is reported to be 0.1% after gastric surgery, including Billroth's operation I and II reconstruction and total gastrectomy with Roux-en-Y anastomosis.[1-4] Sudden epigastric pain, vomiting with or without hematemesis, and a palpable abdominal mass are the classic triad of retrograde jejunogastric intussusception.[5] The mortality rate ranges from 10% when treated within the first 48 hours to more than 50% with a 96-hour delay.[6] The diagnosis can be determined with a range of imaging studies, including endoscopy, ultrasonography or endoscopic ultrasonography, barium series studies, and abdominal CT. Immediate surgical intervention is usually necessary but successful endoscopic reduction has been reported.[7] Although rare, retrograde jejunogastric intussusception is a potentially life-threatening disease if the diagnosis and treatment are delayed. It can sometimes be observed on abdominal radiographs.

The patient underwent emergency laparotomy for segmental resection of the jejunum with Roux-en-Y anastomosis without complications.

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APPENDIX

The panel

David Kessler, MD: Academic pediatric emergency medicine department

Lauren E. Zinns, MD: 2 academic pediatric emergency medicine departments; also helping to establish debriefing program in pediatric ICU

Stuart Rose, MD: Academic adult emergency medicine departments

Paul Mullan, MD, MPH: 3 academic pediatric emergency medicine departments

Fawn Brown, RN: Community pediatric emergency medicine department