

An Innovative Method to Debrief Critical Events

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Introduction: Debriefing provides an opportunity to share and analyze information following a critical event and identifies system gaps that affect patient safety and quality of care. Barriers to debriefing include time available due to conflicting patient care issues, fear of judgement from colleagues, and lack of administrative support. This QI project examined cold debriefings, in the form of case reviews, as a method to address identified barriers and evaluate current processes in the perianesthesia department.

Identification of the Problem: Debriefing following critical events in the perianesthesia department was not being performed. Staff surveys indicated barriers to debriefing included time to debrief and not feeling comfortable leading a debriefing session or providing feedback. Lack of debriefing also resulted in missed opportunities to evaluate current processes and identify gaps in practice.

Purpose of the Study: Determine if cold debriefing, using a case review format, addresses the identified barrier of time and provides a safe environment for staff to debrief and provide feedback.

Methods: The primary nurse caring for a patient who experienced a critical event was asked to complete a case review outline based on Gibbs Reflective Cycle. The case review was provided to staff, during two sessions scheduled for the following month, allowing staff to adjust care and schedules to attend. Immediately following a debriefing session, all attendees completed a survey evaluating the debriefing process and patient care related to the critical event that needed further evaluation.

Outcomes/Results: To date, six debriefing sessions have been completed. An average of 10-15 staff have attended each session and surveys have indicated the current format provides a safe environment for debriefing and providing feedback.

Discussion: A wide spectrum of critical incidents occur in the perianesthesia environment, many of which are related to the cardiovascular and respiratory systems. Debriefing these events provides staff the opportunity to discuss current processes related to patient care and identify opportunities for improvement.

Conclusion: Cold debriefing, using a case review format, may address the barrier of time and fear of judgement which have been preventing debriefing sessions from occurring.

Implications for Perianesthesia Nurses and Future Research: Debriefing critical events in the perianesthesia environment will allow nurses to evaluate current processes and make suggestions for improving care provided to patients.