Structured debriefing in RAH ICU: a strategy for improving patient centred care

Svatka Micik RN PhD
Aim

- Discuss the significance of establishing a debriefing program
- Present different debriefing models and discuss their application within intensive care
- Identify key elements of a debriefing program
- Describe the process of tracking opportunities for improving patient centred care after debriefing
- Illustrate how debriefing sits at the heart of patient centred care
Why debrief?

- Discussion promotes shared views, increases the scope of information
- Learning is relevant, timely, driven by actual patient care events
- Value of listening to all voices and sharing experience equates to tangible effects for patients (complex therapies become about the patient, not just the therapy)
- Creates sense of team and increases team confidence
- Drives cohesive direction for improvement
Debriefing models

- Originally designed for commercial aviation, later modified for healthcare
- Underpinned by Kolb’s experiential learning theory (1984)
- Common phases include description of and reactions to the experience, analysis of behaviours and application or synthesis of new knowledge into clinical practice.

- **Plus-delta** Quick and dirty debriefing model for discussing problem flights. (Klair MB, 2000)

- **3D** Defusing, Discovering, and Deepening Debriefing. Enhances learning after real or simulated events. (Zigmont, Kappus, Sudikoff, 2011)

- **Crew Resource Management** Debriefing of team behaviours not so much of technical knowledge and skills (Cockpit Resource Management) (Diehl A, 2013)
Debriefing from the patient’s point of view

- Frame debriefing questions to what matters most to;
  - patient’s survival
  - improved clinical outcome (linked to evidence base)
  - Improved therapy experience
- Questions may include ‘How well did we use the CALS algorithm?’
- ‘How did we enact Code CALS roles?’
- ‘How could a health care system allow such an important process to go unrehearsed?’
- Were the care goals for the patient met?
Building a debriefing program

- Leadership buy-in
- Establish ground rules, make it safe, acknowledge importance of everyone's contribution
- Introduce debriefing concept as part of team based training (CALS course)
- Debrief following in-situ simulations, in clinical setting where event likely to occur (test systems and processes)
- Debrief following real situations
- Mandate interdisciplinary team participation
- Build debriefs into care (first Monday following ECMO de cannulation)
- Track action, improve systems, communicate changes
Applying debriefing in ICU: the case of ECMO & CALS

- Build evidence into practice guidelines (CALS-ERC and EACS, ECMO-ELSO ECMO)
- Nuances and critical elements in each guideline (speed – 5 min chest reopening and 60 min eCPR cannulation windows)
- Debrief to help team appreciate the nuanced elements that have incredibly high impact on outcomes
- Use time frames to help team appreciate the impact (positive or negative) on outcome of the team coordination effort (good or bad)
- Debrief to help improve understanding of the essential connection between inter professional behaviour and patient outcome
- Structured debrief can elicit other potential risks in the system
**CALS plus-delta debrief structure**

<table>
<thead>
<tr>
<th>plus</th>
<th>delta</th>
</tr>
</thead>
<tbody>
<tr>
<td>things that went well</td>
<td>things that need to be changed and potential solutions</td>
</tr>
<tr>
<td>Code CALS activation</td>
<td>Code CALS activation</td>
</tr>
<tr>
<td>Code CALS algorithm</td>
<td>Code CALS algorithm</td>
</tr>
<tr>
<td>Code CALS roles</td>
<td>Code CALS roles</td>
</tr>
<tr>
<td>identification of cause &amp; correct response &lt; 5 min</td>
<td>identification of cause &amp; correct response &lt; 5 min</td>
</tr>
<tr>
<td>team work</td>
<td>team work</td>
</tr>
<tr>
<td>communication</td>
<td>communication</td>
</tr>
<tr>
<td>other issues including patient/family consideration</td>
<td>other issues including patient/family consideration</td>
</tr>
</tbody>
</table>
Identify CALS opportunities

- CALS role allocation huddles on high risk shifts (limited specialist skill mix)
- Page & phone CALS team (intermittent paging delays and black spots)
- CALS mock re-openings (focus on response activation as well as response training)
- RAH CALS training course (emphasis on modified cardiac surgery ALS)
# Tracking CALS opportunities

<table>
<thead>
<tr>
<th>Identified opportunity</th>
<th>Responsible person</th>
<th>Plan of action</th>
<th>Date started</th>
<th>Tracking</th>
</tr>
</thead>
</table>
| **ICU cardiac wing team**  
Revamp Code CALS for the new RAH | ICU cardiac intensive care service medical and nursing lead | Rename Code Grey to Code CALS educate switch re name change  
Revamp CALS algorithm and seven key roles for the new site  
Posters for each room  
Educate cardiac wing team | 04.09.2017 | Use by staff  
Feedback from staff about Code CALS activation  
Code CALS debriefs |
| **ICU cardiac wing team**  
Identify how to establish RAH CALS training course | ICU cardiac intensive care service medical and nursing lead | Establish RAH CALS faculty  
Secure UKCALS faculty certification  
Establish RAH CALS training course  
Establish course frequency and participant numbers  
Inform staff | 07.02.2016 | Feedback from staff who undertake the course  
Debrief post in-situ and real Code CALS events |
| **ICU cardiac wing team**  
CALS simulations  
Identify frequency of simulations, who should attend | ECMO nursing/medical team | In situ simulations (2/52, testing response training and response activation) | 20.03.2016 | Code CALS CN portfolio  
In situ simulation debriefs |
CALS improvements

- CALS embedded practice in ICU
  - Right practice - CALS response in cardiac surgical emergencies
  - MER team CALS education
  - Expanded practice to cardiac surgical stepdown with assistance of MER team (ward staff occupy 3/7 roles, MER team the rest)

- Better outcomes for patients - reduction in time to chest reopening (<5 min)

- CALS course evaluation – participants feedback (confidence with protocol)
**ECMO plus-delta debrief structure**

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</thead>
<tbody>
<tr>
<td>things that went well</td>
<td>things that need to be changed and potential solutions</td>
</tr>
<tr>
<td>decision</td>
<td>decision</td>
</tr>
<tr>
<td>cannulation</td>
<td>cannulation</td>
</tr>
<tr>
<td>initiation</td>
<td>initiation</td>
</tr>
<tr>
<td>management</td>
<td>management</td>
</tr>
<tr>
<td>troubleshooting</td>
<td>troubleshooting</td>
</tr>
<tr>
<td>de cannulation</td>
<td>de cannulation</td>
</tr>
<tr>
<td>other issues including patient/family consideration</td>
<td>other issues including patient/family consideration (mixed messages, how can we do things better for patient/family)</td>
</tr>
</tbody>
</table>
Identify opportunities ECMO

- ECMO cannulation team TIME OUT (role confusion)
- ECMO cannulation team designation stickers (identify essential personnel, enable crowd/ noise control)
- ECMO cannulas stickers for case file/request to Gettinge (ensure meeting invasive device insertion standard)
- ECMO circuit prime occurs by ECMO team nurses and in ICU (space limitations, distractions, delay)
- Reduction of ECMO consumable costs
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<tr>
<td>ECMO team</td>
<td>ECMO lead (consumables)</td>
<td>Investigate possibility of consignment Investigate possibility for sharing stock with CTT Establish priming principles (consultant led decision to prime, ECMO nurse prime model, not priming back up circuit) Keep minimum Par levels</td>
<td>12.01.2018</td>
<td>Monitor usage Track cost</td>
</tr>
<tr>
<td>ECMO team</td>
<td>ECMO nursing, medical leads</td>
<td>Institute pre cannulation Time out Inform ECMO team Revise ECMO guideline</td>
<td>05.08.2018</td>
<td>Feedback from ECMO team ECMO debriefs</td>
</tr>
<tr>
<td>ECMO team</td>
<td>ECMO nursing lead</td>
<td>Prime circuit in ICU for RAH (as too difficult in ED, TS…) Nurse prime model Seek perfusion commitment to assist/back up when required</td>
<td>20.03.2018</td>
<td>ECMO priming nurses ECMO debriefs</td>
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ECMO improvements

- Adopted a nurse priming model with perfusion commitment to assist/back up when required
- ECMO team nurses accredited to prime (12 month program)
- ECMO priming phone APP & video, adding CVVHDF to ECMO circuit video
- Priming time 16-20 min (from 30 min)
Summary

▪ Two examples of embedded improved practices resulting in better patient management in complex, low frequency high consequence events
▪ Patient centred care demands real time evaluation of actual performance (debrief) to determine effectiveness of care provided
▪ Debrief results in analysis, reflection and targeted changes that are based on actual team performance and thus more likely to impact future behaviour and performance
Want to introduce a Debriefing program in your ICU?

- Debriefing is at the heart and soul of patient centred care
- Start small
- Celebrate your wins