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Briefs and debriefs: Improving communication, reducing error, and enhancing safety

By Kathleen Shostek, RN, ARM, BBA, FASHRM, CPHRM and John Webster, MD, MBA, MS

Briefs and debriefs are strategies being used to reduce the risk of errors from ineffective communication, incorrect assumptions about patient care, high workload pressures, and a culture that does not foster open discussions for proactive problem solving in healthcare. Increasingly, high-performing healthcare teams are using multidisciplinary "briefs" before a procedure to create a clear plan of action and to set expectations about how the procedure should go. Then, following the procedure, teams end with "debriefs" to identify areas that could be improved. When there are active team briefs and debriefs, patients get better care and teams experience greater effectiveness with less frustration.

Although briefs and debriefs are tools that can be applied across all procedural areas with some modification, this article presents key information about how to incorporate these communication and improvement tools into the daily work of providing procedural care, using the operating room as an example.

The problem: An era of change

Healthcare is changing at an ever-increasing rate due, in part, to advancing technology, overwhelming system complexity, productivity demands, cost constraints, quality-based reimbursements, patient expectations, evidence-based decision making, electronic health records, patient and provider demographics, regulatory directives, and public sharing of quality and safety metrics. No one refutes the potential for improvement with a shift to team-based care delivery, but most have not adapted to this model. Team-based care requires more collaboration, enhanced coordination, and effective communication on all levels across the continuum of care to obtain optimal patient outcomes. Yet, when Sedgwick risk management and patient safety

consultants observe teams in procedural areas, including the operating room, we see a need for consistent use of evidence-based tools and strategies such as briefs and debriefs, known to decrease error and improve patient outcomes.

Despite the vigilance and attention to detail by highly skilled professionals who care deeply about patients, there is still an unacceptable incidence of preventable harm. Cases of wrong site surgery, retained surgical items, and unexpected perioperative deaths continue to occur. Unfortunately, potentially preventable harm events have been accepted as a normal consequence in healthcare delivery: iatrogenic infections, venous thromboembolic events, post-procedural complications, failure to follow intended protocols, and ineffective communication among providers, patients, and caregivers.

The following represent worrisome gaps of healthcare quality and safety:

- ✓ Nearly 70% of sentinel events (SE) reported to the Joint Commission involve communication breakdowns
- ✓ Human factors, leadership, and communication are the top three roots causes of SEs
- ✓ "Never events," now known as "serious reportable events" (SRE) continue to occur in reputable hospitals across the country

Patient safety and risk reduction imperative

Patient-centric care, improved outcomes, and reduced risk are achievable goals if a team can facilitate better sharing of information, create a collaborative environment that leverages the strengths of all participants, use tools like checklists, and implement strategies such as briefs and debriefs. Encouraging a climate in which it is the norm for all members of the team to voice concerns and clarify procedures or plans supports the journey toward a culture of safety. Changing the culture requires team leaders to flatten the hierarchy, proactively share information with the team, and support active involvement in the plan so everyone on the team has a shared mental model.

Strategies, tools, and actions

Briefs

Briefs are held for planning purposes and to set the tone just before the procedure (or for the day or the shift). The surgeon or proceduralist should lead a brief discussion (usually a minute or two) with all team members sharing information essential to the patient and the procedure:

- Identify the names and roles of team members
  - This sets the tone, invites collegiality, and creates psychological safety
- Identify what the plan is, including any unique aspects for this case, this patient, this procedure
- Include shared goals, pitfalls, or barriers. Ask: what are the likely contingencies we should be prepared for?
  - Are there any issues affecting team performance, such as resource issues, experience level, equipment concerns, optimal timing of breaks, critical steps in the procedure, etc.?
- End with a statement by the surgeon to the team: "If you have any quality or safety concerns, please speak up!"

Debriefs

Debriefs are a pathway to improving team performance. Debriefs, in the form of (quick) structured feedback discussions, are most effective when conducted in an environment where honest mistakes are viewed as learning opportunities, not by assigning blame or failure to an individual. They should be short and ideally initiated and facilitated by the surgeon as leader. Debriefs are a key feature of high-performing teams. They should be done regularly and built into the workflow for every case/procedure, not just when things go poorly.

Debriefs should answer the following questions:

- What did we do well and what will we do differently next time?
- What are the lessons learned and to be shared?
- What "glitches" were identified that need to be fixed, including system, equipment, and process issues?

A formal method to track identified issues must be implemented along with strong commitment to fix them, including the "who, what, and when" responsibilities. This includes feedback to the involved team(s) on actions taken and changes made.

The debrief is meant to be a team performance improvement tool; think patient outcomes. However, there may be times when the issues are recurrent and require a complete process review and system redesign. This may require a thorough failure mode and effects analysis for process improvement.

In summary, implementing tools such as briefs and debriefs can help strategically improve communication and the effectiveness of teams with the goal of reducing the potential for error and harm. As aptly put by Mary Salisbury, RN, MSN, of Kingston, RI, briefs promote proactive sharing of information to plan for the safe care of this patient; debriefs allow teams to review and improve the safety of care for the next patient.

Recommended Actions

- ✓ Learn and use the non-technical skills of surgical team leadership
  - Pause for team member introductions
  - Make eye contact
  - Create a safe and open environment for team members to raise concerns
- ✓ Begin by leading briefs to clarify the plan and expectations for the procedure
- ✓ Invite input from all members of the team relating to patient safety and contingencies
- ✓ Implement debriefs. Ask:
  - What did we do well?
  - What will we do differently next time?
  - What were the system or equipment glitches that we will commit to fixing?
  - Who will own it?

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SUCCESS STORY: Leadership team at Sutter Health stepping up for patient safety

Sutter Health
We Plus You

In these challenging times in the healthcare industry, it is amazing to see a leadership team continue to set clear priorities around patient safety and quality. The leadership team at Sutter Health, a broad healthcare network providing care to patients and their families in more than 100 northern California communities, has demonstrated its commitment to OB services by launching a comprehensive initiative they refer to as the Perinatal Patient Safety Program.

This initiative started with a review of ten years of claims data to spot trends or systemic issues. Next, each hospital in the Sutter system submitted to a comprehensive on-site assessment. Clinical and patient safety experts from Sedgwick's risk management and patient safety team interviewed clinical staff and assessed the policies and procedures governing practice and the environments in which care was provided. Those assessments identified best practices and systemic weaknesses across perinatal services at all Sutter facilities. The goal of this phase of the project was to engage staff in discussion around the challenges they face which have the potential to compromise care and to assist them and the leadership team in creating an environment consistently able to support both providers and patients, with the goal of producing the safest care and the best possible outcomes.

Following unit-based assessments, all staff members were provided skills training using TeamSTEPPS, a program designed to enhance teamwork, reduce hierarchy and improve communication. A partnership with their affiliated university, Samuel Merritt University, was established to provide additional training in simulation, allowing for staff to practice the new skills they were learning. The enthusiasm of staff was palpable and changes have already begun.

Despite the challenges of scheduling such comprehensive assessments and training programs, the positive response from the perinatal staff's physicians and nurses has resulted in the Sutter leadership team stepping up once again, with plans to engage the OR and ED departments for the next wave of patient safety assessments and training. Creating this level of mindfulness and commitment to patient safety and empowering staff with the skills needed to create and sustain a culture of safety will certainly confirm Sutter Health's commitment to both the patients of northern California and to the caring professionals that serve them.

TechnologyBytes

BY ANN GAFFEY RN, MSN, CPHRM, DFASHRM

Electronic health record implementation in hospitals and physician office practices: Communication challenges and risk management strategies

The race continues for hospitals and physician office practices as they focus on attesting as "meaningful users" to obtain the valuable incentive money flowing from the HITECH Act. As of January 31, 2013, $11.59 billion has been paid in incentive money to hospitals and eligible professionals. Adoption rates of electronic health records (EHRs) continues to grow in leaps and bounds in both hospitals and physician office practices, and soon EHRs will be the rule rather than the exception in these care settings.

Poor communication between clinicians and patients has been known to drive litigation, in part because patients want answers when something bad happens. Even when all goes well with treatment, a breakdown in clinician-patient communication can create distrust on the part of the patient, making them feel their concerns are ignored or that their problems are inconsequential. With the implementation of EHRs, many clinicians feel the "elephant in the room" is making it difficult to establish rapport with a patient, and can be a distraction when trying to gather clinical information while maintaining eye contact and giving a patient their full attention. Communication with patients is impeded by the lack of skill in handling technology "real time" while simultaneously actively engaging the patient.

Documenting in an EHR can impact the clinician's flow when collecting a patient's history and completing a physical exam – recognizing this may not have been the order they would follow when documenting on paper. To avoid too much "clicking" around, one is prompted to follow the data entry fields in order. This in and of itself can be a distraction that draws the clinician's attention away from the patient and to the computer. The simple, yet critical, skill of making and maintaining ongoing eye contact with a patient is one of the challenges faced by new EHR users. In addition, assuring the patient that the encounter is about them, and not about typing, is another challenge often faced – and it's up to the clinician to convince the patient they haven't been reduced to a set of keystrokes on a computer. *(See inset.)*

Is there hope for the time-crunched, technology-challenged, "hunt-and-peck" on the keyboard clinician who is having difficulty navigating the EHR around the patient's narrative? Absolutely. An engaged patient is a satisfied patient, and communication strategies exist that will aid in involving the patient and clinician in a collaborative relationship with the EHR to decrease the risk of encounters with poor communication and dissatisfied patients. Introduce the following skill set to your clinicians as a risk reduction strategy when they take the helm at the computer:

- **Introduce** yourself and shake hands with the patient, placing the immediate focus on them – BEFORE turning to the computer.
- **Inform** the patient of the new record-keeping system, and that you will be accessing *their record* electronically – refrain from saying "let me put this in the computer."
- **Elicit** the patient's chief complaint and basic history without computer interface. Ask how they are and what brings them here today and, if possible, don't structure the interview around data-gathering demands from the EHR.
- **Explain** what they can expect during this visit: "First I am going to review your last visit and ask you some questions, then I am going to record our conversation in your chart

The patient's perspective of these encounters can be interesting.

For example, for those patients who can't see (or are never shown) the computer screen, some have reported they thought the clinician was "surfing the web." As reported by Baker and Keller, "In a study of 39 videotaped doctor-patient visits with exam room computing, in the 302 times the clinicians turned to use the computer, only 14% of the time did the doctors explain why they used it. After the visit, patients who received no explanation frequently reported thinking that their doctor had been doing work unrelated to their clinical visit." [1]

here so we can clarify the information at the end of the visit."

- **Invite** them to view the screen with you, and adjust to ensure they can see it. Think about "pushing" the computer into the interaction, rather than letting the computer "pull" you away.
- **Bridge** to the computer by using bridging statements to bring the patient along in the process. Take breaks to move back and forth between the computer and the patient. Use bridging statements such as, "Let me look up your most recent lab results and show you how they compare to the last set you had drawn, then we will talk about the pain you are having."
- **Engage** in eye contact as frequently as possible – don't let the patient sit idly while you type at the keyboard in silence. If you can type and talk while making eye contact, do so. In addition, be cognizant of positional changes related to the patient and computer/monitor that may minimize the ability to make eye contact.
- **Establish a routine** where you take "natural" breaks from using the computer to interact directly with the patient (only).
- **Close** the encounter by logging off and letting the patient know their record is secure.

The introduction of technology into the clinician-patient relationship, while challenging, does not need to be a barrier to good communication. By using risk reduction strategies to improve communication with patients while navigating the EHR, clinicians can establish and maintain open lines of communication, continuing a positive relationship with patients and their "new" records.

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Emerging risk management challenges associated with ACOs

By Barbara Youngberg, JD, BSN, MSW, FASHRM

Any risk manager working in healthcare knows one of the greatest challenges is managing the risks of today while planning for the risks of tomorrow. We often think that as new risks are identified we must learn new skills to manage them. All too often we fail to appreciate that our current skills or knowledge about the vulnerabilities of our organization can be very useful in future planning and can help us identify the tools and strategies that might be the most effective in managing the enterprise into the future. We can use what we already know about the root causes of error to help us design new tools to manage the emerging risks inherent in our enterprise. These tools will be particularly important as we migrate to Accountable Care Organizations (ACO) and other integrated delivery models.

Changes underway in our healthcare delivery system

Now that the Patient Protection and Affordable Care Act has survived constitutional challenge and the final rules about ACOs have been simplified, healthcare organizations and providers are planning organizational change in order to maximize reimbursement and achieve the goals of providing coordinated high-quality care to patients across the continuum. Dr. Donald Berwick, former administrator of the Centers for Medicare & Medicaid Services (CMS), stated that the triple aim of ACOs is to provide better care for individuals, better health for populations, and lower per capita costs of care without any harm whatsoever to patients. This seems well-aligned with the goals of enterprise risk management. Now quality and safety will be goals that, when achieved, will result in financial rewards.

With the changes in reimbursement now linking payment to quality, we can no longer characterize adverse events and medical liability as "the cost of doing business" or the results of a "failed legal system that we cannot change." Risk managers need to refocus their efforts on quality and safety, because the financial cost of risk for poor quality is now very much a part of the health care financing landscape. Transparency is no longer optional. We must provide information and share data so that patients and payers can select providers that deliver the highest quality service at a competitive price.

Systems providing this care will need an infrastructure designed by leaders who recognize the importance of optimizing and standardizing communication and procedures between all providers, assuring cultural and IT support for optimal care.

Risk management realities relative to ACOs

Coordination of care will be mandated and coordination requires good communication, a process for handoffs, and secure and timely information. Patients will have more choice as to where to seek care and some will use data to help them make these decisions, so data will need to be both complete and accurate. ACOs will not be organization-based, they will represent care provided outside the walls of the organization; a formal risk management presence may not be apparent in these sites of care.

Given this, the key competencies risk managers should foster to assure safe and effective care to patients in ACOs include:

- Leadership
- A culture of teamwork where every provider is mindful of their role in reducing risk and advancing safety and transparency
- A flattened hierarchy, which promotes a culture of mutual respect
- An IT infrastructure to support care and inform patients and providers

Recognizing how these system issues might be compromised in current care systems will assist in planning for the future.

What we know about leadership

Risk management and patient safety often is not a priority for the leadership team. Risk managers sometimes miss the opportunity to use their own leadership skills to make others aware of how their knowledge and abilities can be used to advance a safety-oriented strategy. New leaders will emerge under the ACO model. By aligning with them and providing them with the tools to manage their businesses, risk managers and risk management concepts can be at the center of this new business model.

A culture which encourages teamwork and mutual accountability

The healthcare environment has often rewarded individual accomplishments and examples of teamwork successes are sometimes hard to find. Root cause analyses (RCA) often identify failures in teamwork as contributing to error. The tight team dynamic associated with almost any healthcare encounter requires communication, handoffs, and mutual respect in order for any team to function optimally. Teamwork skills are seldom fully utilized; however, teamwork training is available. If communication breakdowns are identified as frequent root causes of errors in your organization, you should begin now to engage staff in effective teamwork and communication training such as TeamSTEPPS®.

In addition, healthcare has long had an accountability problem. Disruptive providers and persistent quality and safety problems have been well documented but often ignored. Now, with reimbursement tied to quality, there is a new level of attention to issues affecting quality of care and this attention will hopefully drive performance.

Risk management has long held data that could identify "at risk" providers, but this data often is not part of the process designed to assure provider accountability. Risk managers might also assist in the due diligence process that should occur prior to adding new providers to the ACO or delivery system.

Healthcare is still a hierarchical culture. Disrespectful behavior is common in the healthcare environment and can (and often does) have a negative effect on the quality of care. If hierarchy has been identified as a problem in your organization, risk managers can educate providers about the problem and work with them to implement strategies to flatten it out. In networks where all levels of caregivers are working together and where non-physician advanced practitioners may be running aspects of the practice, a culture of mutual respect must be maintained. Some tools to jump-start this process are identified in the list of resources below.

FUTURE-FOCUSED RESOURCES

Resource	Web link
Planning for safe handoffs	http://www.ncbi.nlm.nih.gov/books/NBK2649/
AHRQ / PSNet: Evidence-based practice on safe handoffs	http://www.psnet.ahrq.gov/primer.aspx?primerID=9
Transitions of Care (TOC) Portal: Resources to plan for transitions of care	http://www.jointcommission.org/toc.aspx
National Transitions of Care Coalition	http://www.ntocc.org
FAQs on ACOs	http://www.kaiserhealthnews.org/Stories/2011/January/13/ACO-accountable-care-organization-FAQ.aspx?gclid=CPXxtOqapbYCFRCmPAodqQcACg
"Developing a Culture-Based Workforce: Top Healthcare Workplaces Share Best Practices" (*Becker's Hospital Review*, March 22, 2013)	http://www.beckershospitalreview.com/hospital-management-administration/developing-a-culture-based-workforce-top-healthcare-workplaces-share-best-practices.html
Accountable Care Organizations: AHA Research Synthesis Report, speaking to the leadership and management structure for ACOs	http://www.aha.org/research/cor/content/ACO-Synthesis-Report.pdf
"Effective HIE Infrastructure Essential for ACO Success" (*Executive Insight*, August 16, 2012)	http://healthcare-executive-insight.advanceweb.com/Features/Articles/Effective-HIE-Infrastructure-Essential-for-ACO-Success.aspx

IT challenges will be formidable

Many organizations have already made significant investments in IT and other technology only to realize that what was purchased was not integrated into other systems, was easily circumvented, or caused new and even more vexing problems. Organizations that sought to cure problems through technology failed to address issues of culture which were the true root cause of the quality problems most often experienced. In this new environment, technology will be necessary to assure the flow of information, to measure and report quality, and to establish accountability. Risk managers should work with their IT departments now to confirm that systems are capable of integrating both inpatient and outpatient information and that privacy and security of information can be guaranteed.

Conclusion

In a new enterprise where care is decentralized and distributed, where quality is an imperative and transparency is part of every healthcare encounter, risk management skills will need to be part of everyone's job description. Risk management's goal should be to serve as coach and mentor so that the culture of the organization – and everyone working in it – is one of mindfulness and customer service. Sharing data and promoting best practices will help move organizations forward.

Giving up bad habits and outmoded and ineffective practices will allow risk managers to develop their roles as mentors. Using aggregate data to spot culture or systemic problems now will help focus on future issues likely to challenge systems into the future.

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Healthcare Risk Management

Think strategically, plan proactively

Tools and resources to create safer systems

It is a challenge for risk managers to successfully manage the risks of today and have time to think about the challenges posed by risks of the future. Yet with dramatic changes approaching in the healthcare delivery system, risk managers should review what these changes are likely to look like and what current strengths they possess that can reinforce systems that will be needed to support care. As the Accountable Care Organization emerges as a delivery system model, providers – including nurses, physicians, and ancillary providers – will be forced to work together in teams to care for patients across the continuum. They will be required to communicate effectively and coordinate care so patients don't fall through the cracks, objectives which have proven challenging in our current healthcare environment.

In the past, risk managers often used their best judgment to design strategies to deal with impending risk. Now, the rise in evidence-based "best practice" information can assist in the proactive design of systems and processes to standardize communication and handoffs. The Agency for Healthcare Research and Quality has funded many studies that prove the benefit of specific strategies and programs.

Sedgwick's risk and patient safety staff recommends the following resources as great tools to help you plan your risk reduction strategies. These will be important to consider now in order to make your organizations more accountable to patients and payers in the future.

- "Mistake-Proofing the Design of Health Care Processes" – found at http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/mistakeproof/index.html – is a synthesis of practical examples from the real world of healthcare, showing the use of process or design features to prevent medical errors or the negative impact of errors. It contains over 150 examples of mistake-proofing that can be applied in healthcare– in many cases, relatively inexpensively.

- The TeamSTEPPS® program, which focuses on enhancing teamwork through improved communication and reduction of hierarchy, is a great resource. The TeamSTEPPS program can be very helpful in optimizing care handoffs. Evidence-based reports detailing how organizations have effectively integrated the TeamSTEPPS approach into their culture can be found at http://www.ahrq.gov/research/findings/evidence-based-reports/makinghcsafer.html.
- "Making Health Care Safer II" also identifies 12 patient safety strategies "encouraged" for adoption based on the strength and quality of evidence, including:
  - #5 / Team training – TeamSTEPPS: teamstepps.ahrq.gov/about-2cl_3.htm
  - #9 / Rapid response systems – TeamSTEPPS, Rapid Response Module: www.ahrq.gov/teamsteppstools/rrs/rrsinstructmod.pdf

To learn more about Sedgwick's healthcare risk management and patient safety expertise and how we can help you implement these tools and resources, including the successful TeamSTEPPS program, call us at 866-225-9951.

Upcoming Events

Visit the Sedgwick professional liability and HCRM team at these upcoming events:

- RL Solutions Annual User Group Conference
  July 9-12 | Toronto, ON, Canada
  booth B
  panelist: Lynn Gmeiner, VP Client Services, Professional Liability
- Willis Healthcare Forum
  July 17 | Chicago, IL
  presentation: "Physician Integration: Claims Challenges & Best Practices" by Jayme Vaccaro, JD, Director, Professional Liability Claims
- American Congress of Obstetricians & Gynecologists District II Conference
  July 25-26 | Saratoga, NY
  presentation: "Critical Care Safety Essentials" by Kathleen Shostek, RN, ARM, BBA, FASHRM, CPHRM, Senior Healthcare Risk Management Consultant

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