Implementing clinical debriefing programmes

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Critical event debriefing (CED) or 'hot debriefings' (HoDs) can be described as a trigger-based, immediate postevent, interprofessional, expertly facilitated conversation where clinicians recount, reflect on, and improve personally and as a team.[1] The process and experience of clinicians who cared for the patient is more complex and involves thoughts and emotions that go beyond the 'case' or 'resuscitation' and the debriefing itself.[2] The *American Heart Association* guidelines for neonatal resuscitation highlight 'team debriefing' as a key step in their cognitive aid.[3] There is evidence that implementing a 'Cold Debrief' programme for teams that care for patients in cardiac arrest improves outcomes[4] yet in practice 33% of events are routinely debriefed.[5] Critical events in anaesthesia are debriefed infrequently and those associated with communication breakdowns were even less likely to be debriefed[6]. How do we fuel local implementation of CED programmes to harvest the opportunity for personal and systems learning required for continuous improvement?

In their *EMJ* study, Sugarman *et al* present a potent description of the local adaptation, implementation and dissemination of a CED programme in an emergency department (ED). They report on the findings of a quality improvement programme at a single institutions' ED where a retrospective audit was conducted to examine the occurrence of HoDs in the North-West of England. Stakeholder interviews and a needs assessment process yielded a novel format for conducting locally relevant HoDs: the 'TAKE STOCK' model.[7]

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Figure 1 Brigham Resilience in COVID-19-pandemic Emergency Forum (BRIEF) programme brochure.[9]

The authors defined criteria for an HoD as: unexpected death, paediatric standby, distressing event, staff request and unexpected outcome. The programme was developed at one institution, it has been shared freely under creative commons license across 42 ED and Ambulance trusts in the UK. The authors prepared an implementation guide that includes a process for the conversation, guidance for those leading the conversation in the form of do's and don'ts and other useful materials: a poster of the mnemonic TAKE STOCK, and the Data Collection Sheet. Over the course of 9 months, an embedded internal team developed the practice and process for CED based on local interviews, an evolving iterative design process.

The development and implementation approach as described shares strategies and features that have been fruitful when implementing debriefing programmes to improve communication and decrease burnout in intensive care units[8] and EDs[9 10] during the COVID-19 pandemic. There are four features of the TAKE STOCK programme that we would like to highlight as they have been critical to successfully implementing locally tailored debriefing programmes in our experience.

1. Engage professionals from all levels of leadership: Involve active clinicians, CED programme leaders and ED leadership.
2. Prototype, pilot, iterate and adapt: Start with a prototype knowing that it will evolve and welcome iteration and innovation as part of the process.
3. Create clear processes and feedback loops: Define triggers for CED and set times and places for debriefing.
4. Create emotional connection with creative naming and branding: Use naming and branding to forge an emotional connection to the participants helping establish the practice of debriefing as part of their own routines and identities (figure 1 for example).

We suspect that CED programmes will continue to grow and serve as a critical mechanism to support people and processes in complex health systems. When, where, for what purposes and in what way these programmes are implemented are on the research agenda. CED programmes have the potential to impact expected and unexpected areas of practices in emergency medicine including mitigating social and racial biases, combating the epidemics of burnout and suicide, and responding to the ongoing COVID-19 pandemic.

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doi:10.1136/emermed-2021-211133

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