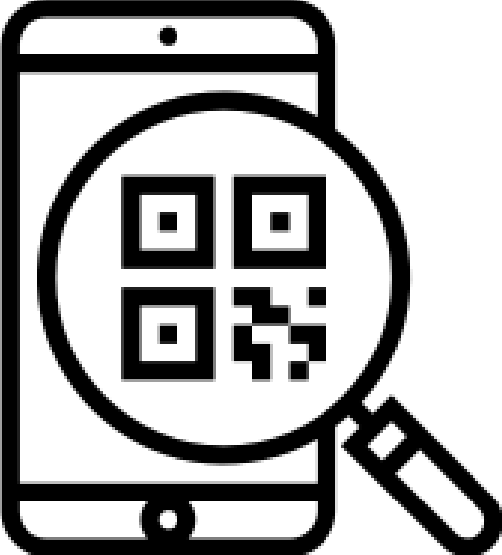


Practical strategies to integrate
healthcare simulation & debriefing
into a quality/safety agenda

@KomalBajajMD

3/7/2022



Healthcare Simulation

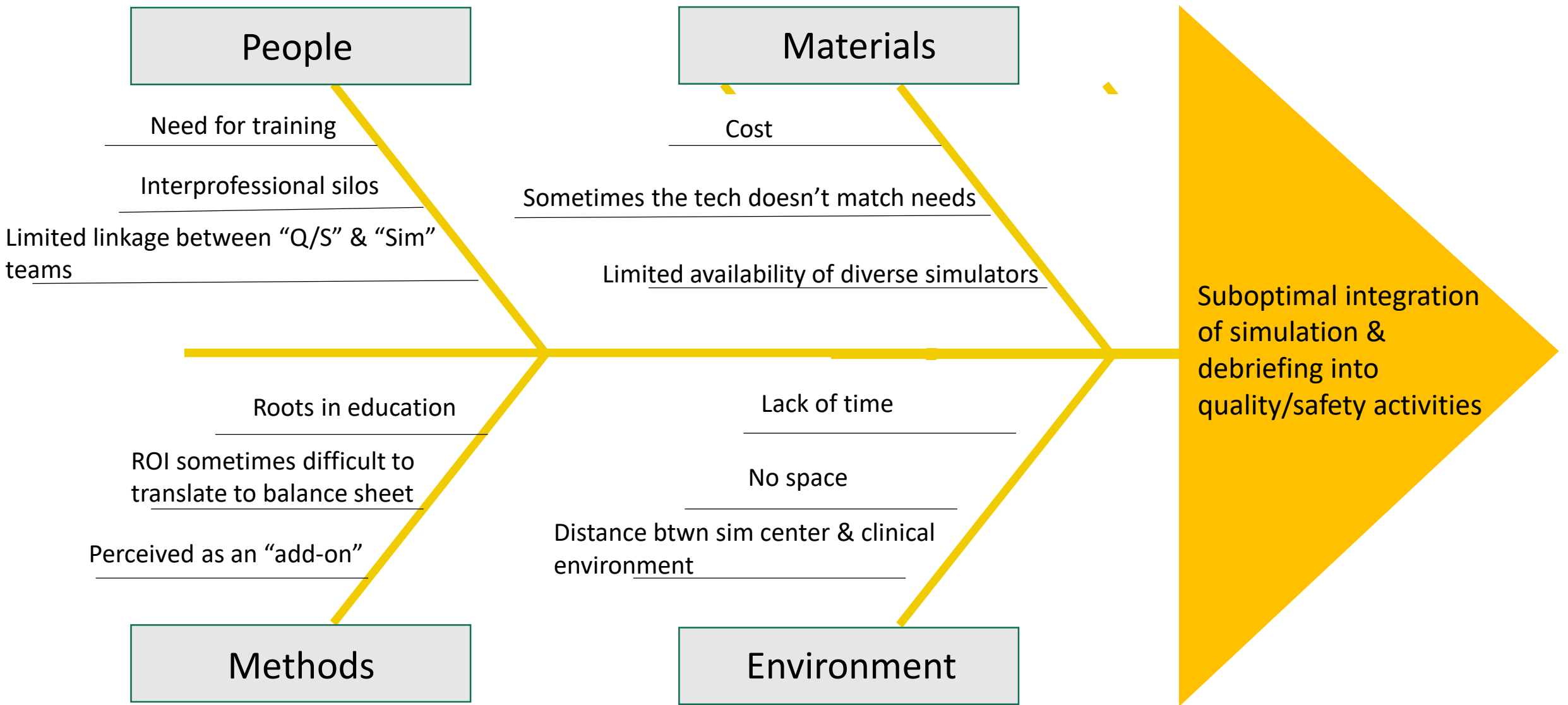
Dictionary

Second Edition



What are barriers to integration of simulation & debriefing into a quality/safety agenda?





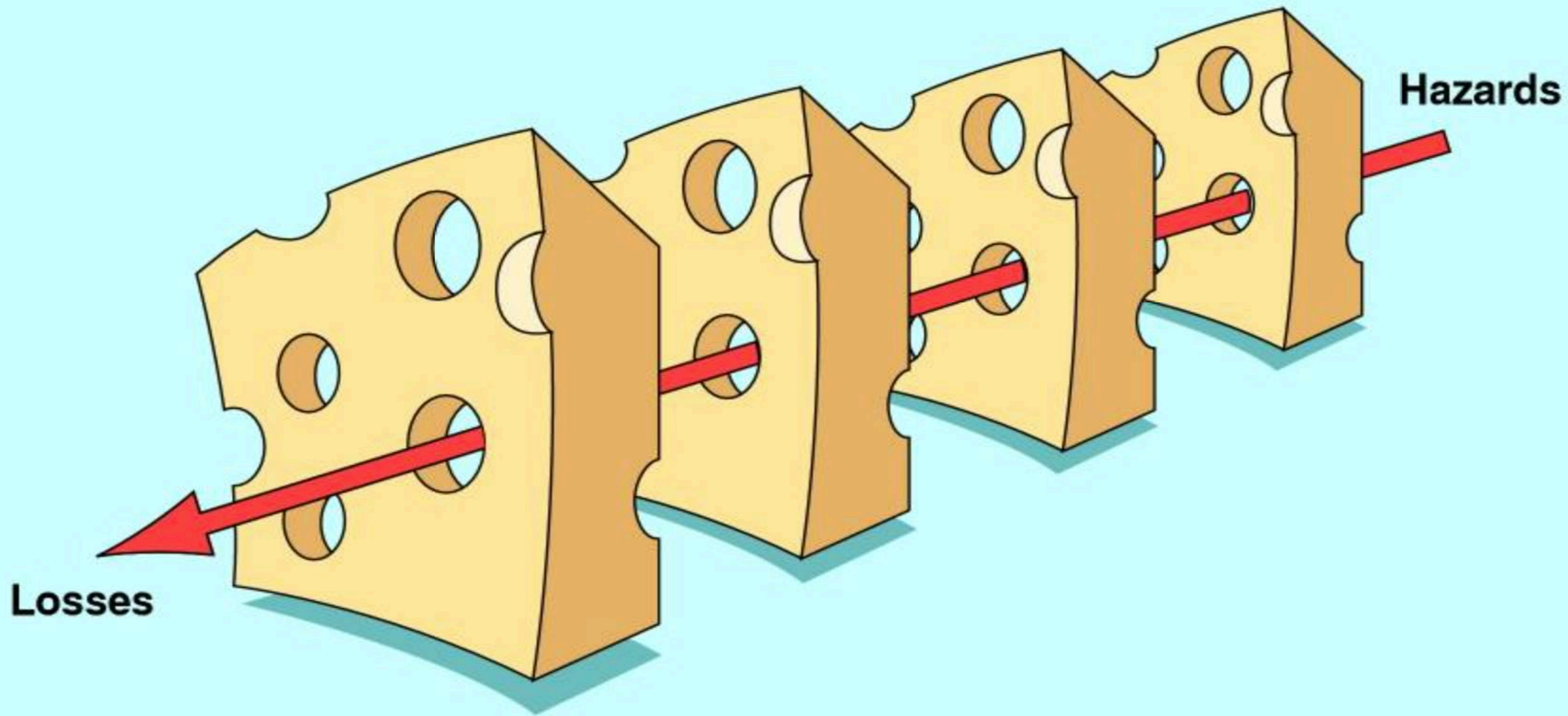
Strategies to integrate
healthcare simulation
& debriefing into a
quality/safety agenda



Consider simulation as a means of study or test
of change (or both!)



- Which cart to select?
- What items should go into the hemorrhage cart?
- How should each drawer be organized?
- What units/areas need a cart? Are multiple required?
- What's the best cart location?
- What are efficient ways to for multiple team members to access the cart at the same time?
- How to efficiently train teams to the new cart-related workflow?
- Are teams routinely using the cart effectively?



PEARLS for System Integration (PSI) Healthcare Debriefing Tool

	Objective	Task	Sample Phrases
1 Pre-Work <Scenario Here>	Develop sample pre-determined stakeholder objectives.	Work with stakeholders to identify and prioritize potential high-impact and high-risk changes and develop pre-determined objectives.	What do you perceive to be the highest risk changes associated with this new space/process? What are you most worried about with the implementation of X?
2 Description	Create a shared mental model by reiterating the focus of simulation and providing a summary of events / key medical issues.	Re-orient to shared understanding of simulation objectives and address any specific medical questions	"We are going to spend the next X minutes debriefing that simulation. This simulation is not about your individual knowledge or skills. The focus is to improve the systems and processes in which we work and identify system issues, including latent system threats. In this scenario [provide quick summary of scenario]."
3 Reactions (Optional)	Used to explore feelings about process/system being evaluated. Helpful for small groups and strong reactions (positive or negative).	Keep focus on system objectives, quickly follow up exploring reactions with exploring system objectives.	"How did you feel about working in this new unit / with this new process? " Quickly follow with "What about this new unit / process contributed to you feeling that way?"
4 Analysis	Explore variety of performance domains.	See backside of card for more details.	<p>Transition Statement (Use to introduce next pre-determined learning objective) "Let's talk about X, as that was an area of potential concern."</p> <p>Exploring Each Stakeholder Objective (Use to summarize discussion of one topic) "We identified some areas for improvement. Any other observations related to X before we move on?"</p>
Were all Stakeholder Pre-determined Objectives Covered?			
5 Summary	Identify system issues; potential solutions/ideas and next steps.	Provide summary to close the debrief and identify next steps.	"The biggest learnings / opportunities from today's simulation are X, Y, Z" (Summarize key learnings, action items, operational owners when time permits) "Are there any other potential changes we should capture?"



Using clinical simulation to study how to improve quality and safety in healthcare





OPEN ACCESS

SQUIRE 2.0 (*Standards for QQuality Improvement Reporting Excellence*): revised publication guidelines from a detailed consensus process

Greg Ogrinc,^{1,2,3} Louise Davies,^{1,2,3} Daisy Goodman,^{1,2} Paul Batalden,^{2,3}
Frank Davidoff,³ David Stevens^{3,4}

SQUIRE-SIM coming soon!



Strategies to integrate healthcare simulation & debriefing into a quality/safety agenda



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Keep an eye on the literature - robust examples of the impact of simulation exist (and are coming in faster than ever)



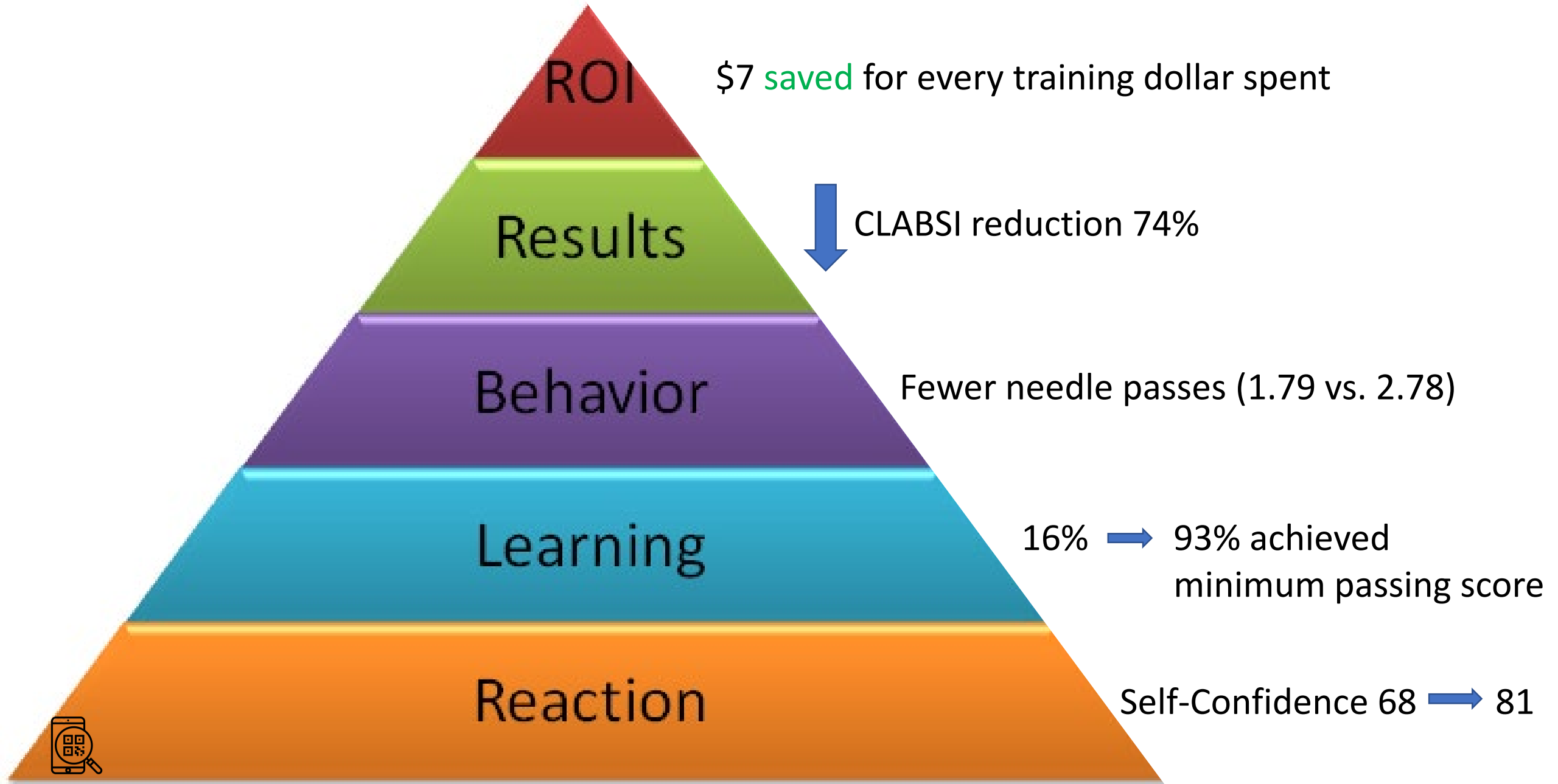
Quality

Simulation

Professional/
Society







ROI

\$7 saved for every training dollar spent

Results



CLABSI reduction 74%

Behavior

Fewer needle passes (1.79 vs. 2.78)

Learning

16% → 93% achieved minimum passing score



Reaction

Self-Confidence 68 → 81



RESEARCH ARTICLE

A model-based cost-utility analysis of multi-professional simulation training in obstetric emergencies

Christopher Wai Hung Yau ^{1,2}, **Erik Lenguerrand**¹, **Steve Morris**³, **Tim Draycott**²,
Elena Pizzo ^{4*}

1 Translational Health Sciences, University of Bristol, Bristol, United Kingdom, **2** Southmead Hospital, Bristol, United Kingdom, **3** Department of Public Health and Primary Care, University of Cambridge, Cambridge, United Kingdom, **4** Department of Applied Health Research, University College London, London, United Kingdom



Key findings:

National implementation of an established, multi-professional simulation training program for obstetric emergencies (PROMPT) or shoulder dystocia training is cost-saving when considering their impact on brachial plexus injuries

- over £1 billion saved (\$1.5 billion) over 30 years
- strong evidence to suggest repeat/sustained training



Use of a Surgical Debriefing Checklist to Achieve Higher Value Health Care

American Journal of Medical Quality
2018, Vol. 33(5) 514–522

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DOI: 10.1177/1062860618763534

ajmq.sagepub.com



Michael R. Rose, MD¹, and Katherine M. Rose, MD^{2,3}

54,003 cases → 4523 events/defect (92 causing harm/critical)



Lessons Learned & Opportunities

What Happened? What are the details of the event? Who, What, When, Where, How? Why did it happen?

DEBRIEFING CHECKLIST

- WHAT WENT WELL?
- RECOGNITION(S)
- ISSUE(S) THAT DID, OR COULD HAVE CAUSED HARM FOR THE PATIENT (INCLUDING NEAR MISSES)
- WERE/WAS THERE CRITICAL ELEMENTS OF INFORMATION THAT WE COULD HAVE HAD, SHOULD HAVE HAD (OR ACTUALLY DID HAVE) THAT WOULD HAVE PREVENTED THE ISSUE HAD WE EFFECTIVELY MADE THE INFORMATION AVAILABLE TO THE TEAM AT THE RIGHT TIME IN THE RIGHT WAY?
- ISSUE(S) THAT WASTED TIME, OR RESOURCES (PEOPLE, SUPPLIES, EQUIPMENT)
- ISSUES THAT INCREASED COSTS TO THE CARE AND WERE AVOIDABLE
- ISSUE(S) THAT DID, OR COULD HAVE NEGATIVELY AFFECTED HOW THE PATIENT AND FAMILY MEMBER EXPERIENCED THEIR CARE
- ISSUE(S) THAT DID, OR COULD HAVE NEGATIVELY AFFECTED THE COLLABORATION OF THE TEAM, THE TEAM'S EFFECTIVENESS, OR THAT DISTRACTED FROM OUR ABILITY TO FOCUS ON THE PATIENT (E.G. DISRESPECTFUL BEHAVIORS, OR UNCIVIL DISCOURSE)

Patient Label Here

Rose MR, Rose KM. Use of a Surgical Debriefing Checklist to Achieve Higher Value Health Care. *American Journal of Medical Quality.* 2018;33(5):514-522.



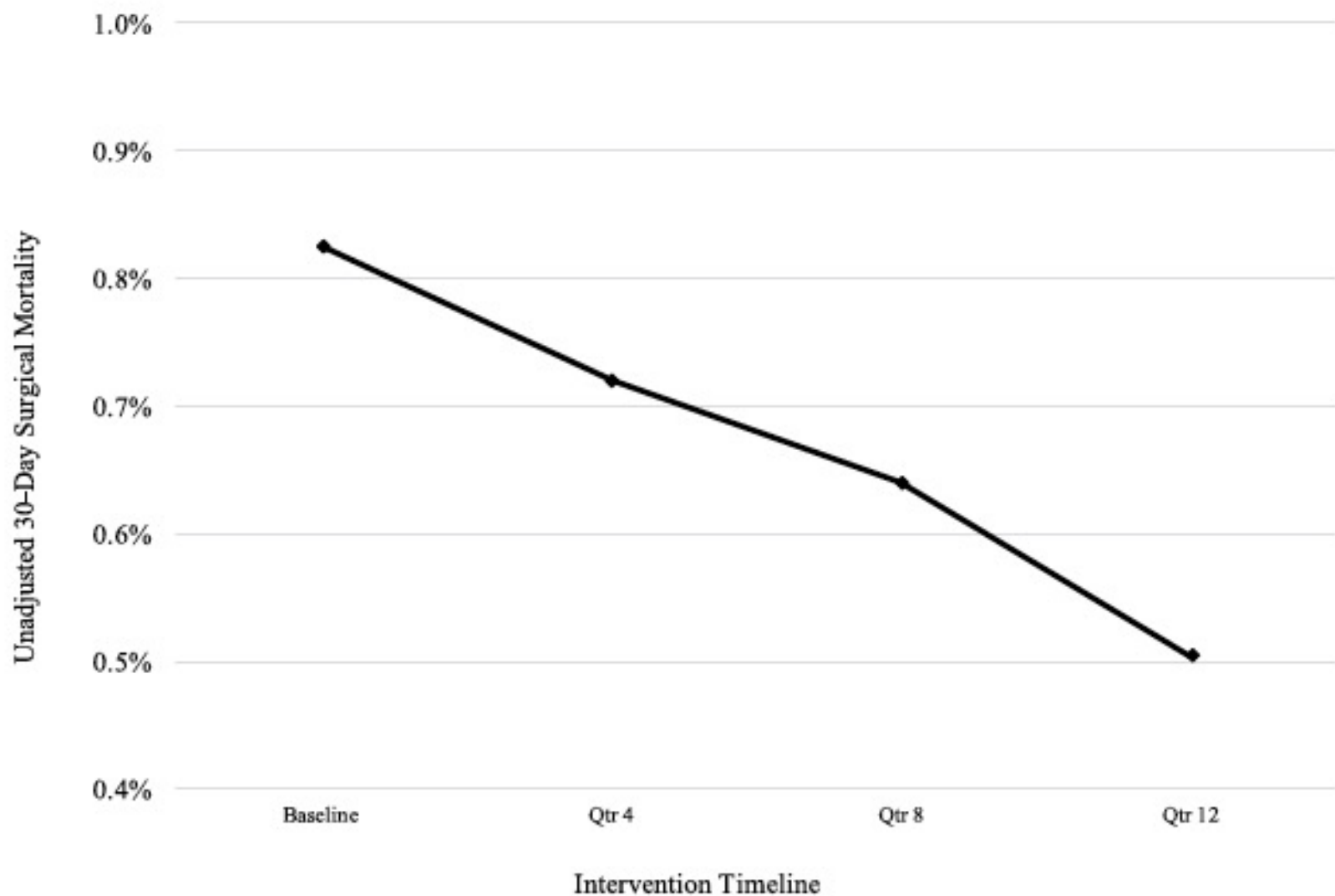


Figure 2. Unadjusted 30-day surgical mortality: baseline through quarter 12 of the intervention (2009-2010).

Unadjusted 30-day surgical mortality, which measures death during hospitalization for the index surgery, plus readmission with death within 30 days of surgery was used.



Table 1. Safety Climate in Surgery: Survey Responses From MacLeod Regional Medical Center Staff (2009-2012).

	% Respondents That Agree		
	Baseline (n = 156)	Post-Implementation (n = 132)	Top Peer ^a (n = 69)
“I am encouraged to speak up about patient safety concerns that I have”	72%	93%	100%
“McLeod has a good safety climate”	46%	90%	98%
“I would feel safe being treated here as a patient”	82%	89%	92%

^aA Top Peer of the 69 hospital surgical departments surveyed.



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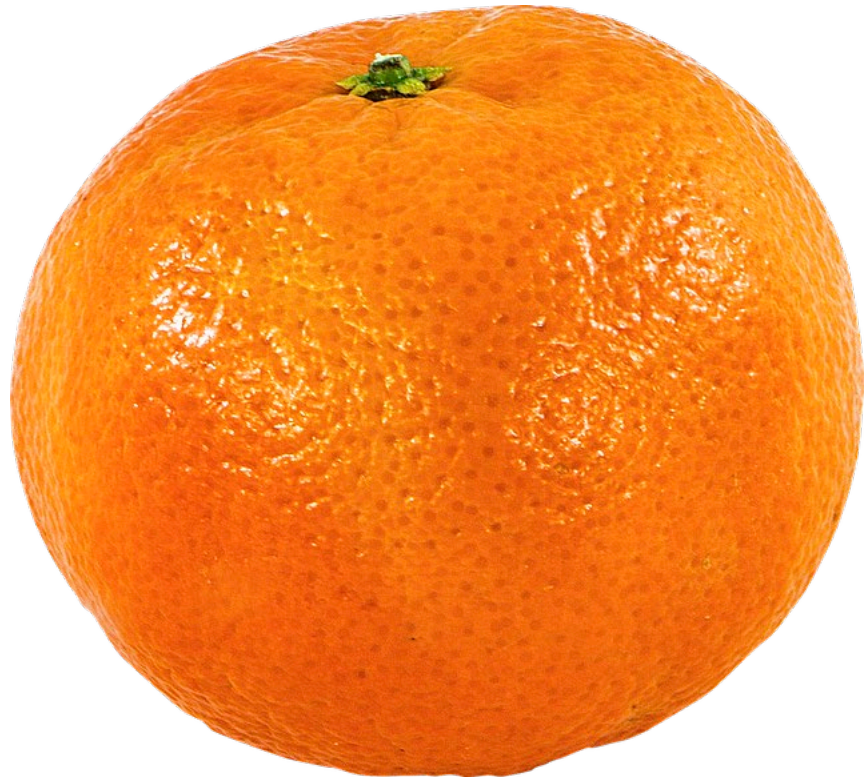
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Match tech to needs (Komal's soapbox: high-technology is not always better)



NYC HEALTH+ HOSPITALS

Staffed beds	6,681
ER visits	1,112,939



Healthcare Simulation Standards of Best Practice™

Simulation Design

**INACSL Standards Committee, Penni I. Watts, PhD, RN, CHSE-A,
Donna S. McDermott, PhD, RN, CHSE, Guillaume Alinier, PhD, MPhys,
PgCert, SFHEA, NTF, Matthew Charnetski, MS, NRP, CHSOS, CHSE,
Jocelyn Ludlow, PhD, RN, CHSE, CNE, CMSRN, Elizabeth Horsley, RN,
MSMS, CHSE, Colleen Meakim, MSN, RN, CHSE-A, ANEF,
Pooja A. Nawathe, MD, FAAP, FCCM, CHSE-A, CHSOS**



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Harness emerging accreditation requirements



Examine existing quality/safety structures for simulation representation

R³ Report | Requirement, Rationale, Reference

A complimentary publication of The Joint Commission

Issue 24, August 21, 2019

Published for Joint Commission-accredited organizations and interested health care professionals, *R3 Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, *R3 Report* goes into more depth, providing a rationale statement for each element of performance (EP). The references provide the evidence that supports the requirement. *R3 Report* may be reproduced if credited to The Joint Commission. Sign up for [email delivery](#).

Provision of Care, Treatment, and Services standards for maternal safety



Requirement	EP 4: Provide role-specific education to all staff and providers who treat pregnant and postpartum patients about the organization's hemorrhage procedure. At a minimum, education occurs at orientation, whenever changes to the processes or procedures occur, or every two years.
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Requirement	EP 5: Conduct drills at least annually to determine system issues as part of on-going quality improvement efforts. Drills include representation from each discipline identified in the organization's hemorrhage response procedure and include a team debrief after the drill.
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Getting Ready for 2021 Joint Commission Perinatal Standards

Lessons From the Field

Veronica Lerner, MD, FACOG;

Komal Bajaj, MD, MS-HPEd

Summary Statement: The new Joint Commission requirements on perinatal safety present a unique opportunity for the simulation community to actively engage with labor and delivery units nationwide. Considerations for implementation using “real-life” experience with the programmatic development of an in situ team-based simulation training program in obstetric emergencies are discussed. We urge simulationists to explore opportunities to promote culture change on a large scale to move the needle of maternal morbidity and mortality.

(Sim Healthcare 00:00–00, 2021)

Key Words: In situ simulation, obstetrics, The Joint Commission, accreditation, patient safety, perinatal outcomes, team training.



Examine your existing quality/safety structures for potential simulation involvement:

How close to the current quality/safety table of organization does simulation exist?

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Harness emerging accreditation requirements



Examine existing quality/safety structures for simulation representation



Consider clinical event-debriefing as a foothold for simulation

AHRQ Definition:

Debriefing is defined as **a dialogue between two or more people**; its goals are to discuss the actions and thought processes involved in a particular patient care situation, encourage reflection on those actions and thought processes, and incorporate improvement into future performance.





HEALTHCARE DEBRIEFING: LINKING QUALITY, SAFETY, & WELLNESS



When you consider a clinical event debriefing program, ask yourself.....

- Who are the stakeholders that need to be engaged?
- What debriefing framework works best for your local environment?
- Who will serve as debriefing champions and what is the training they will need?
- How can you foster psychological safety related to this new program?
- What clinical events should be debriefed?
- How will you collect the learnings from debriefings and where do they go?
- How will you close the loop with staff regarding the program?

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Consider clinical event-debriefing as a foothold for simulation

What's one concrete action you can take in the next three months to integrate simulation/debriefing into your quality/safety activities?



Resources
discussed
today:

