**Solution:** Interdepartmental Interdisciplinary Debriefing as a Performance Improvement Tool

**Organization:** Johns Hopkins Hospital
**Type:** Acute Care

**Primary Contact:** Susan Will MS, RNC, OB Patient Safety Nurse
**E-mail:** swill1@jhmi.edu
**Phone:** 410.955.7578

**IDENTIFICATION:**
The problem to be solved was better communication and coordination of care among three surgical services providing care for high-risk obstetrical patients. The clinical event was a case of a patient with a suspected placenta accreta or percreta, potentially requiring a cesarean hysterectomy. Based on the acuity of the case, obstetrical and perioperative staff decided that the best location for the surgery was the main operating room and determined what staff and resources were needed. The outcome of the case was considered successful with the birth of a healthy newborn, weighing 7 pounds and 14 ounces and a stable mother, discharged with her newborn post a cesarean hysterectomy for placenta accreta. This could have been the end of the story except that a staff nurse recommended that the team debrief after the case to identify opportunities for improvement. She recognized that communication, coordination and team work could have been better and felt empowered to request the debriefing. The baseline data that existed were the observations of the surgical teams regarding the planning and coordination of the surgical case.

**PROCESS:**
Interdisciplinary clinical debriefing is a useful tool that engages bedside clinical experts in identifying opportunities for making patient care safer. Debriefing provides staff with a forum to review facts of a clinical situation, discuss team member perceptions and identify opportunities for system improvements. Lessons learned can be applied to future cases. Including all disciplines in the debriefing process reinforces the unique role of each team member and provides a mechanism for the team to talk together about a case. In this situation the team debriefed several days after the surgical case. Included in the debriefing process were nurses, residents, attending obstetricians and anesthesiologists representing obstetrics, the general operating room and gynecologic-oncology. It is sometimes appropriate to include neonatology in the debriefing process. During the debriefing process the team focused on system improvements. The team considered patient factors, task factors, provider factors, team factors, and both unit and institutional environmental factors, with an eye towards best practice.

Ideally the interdisciplinary team debriefs right after a case, but the opportunity to debrief remains valuable even if it does not occur immediately after a clinical event. When it is feasible to “debrief” right after a case, the team can use an abbreviated approach. Staff can review the facts of the case and discuss briefly, what went well, what they learned and what can be done better the next time. In either approach to debriefing, it is critical that lessons learned during the debriefing conversation are captured so they can be applied to future cases.

**SOLUTION:**
During the debriefing process team members recommended several areas for practice improvement. A key improvement was the development of two perioperative check lists that outline team
responsibilities in posting and preparing for complex obstetrical cases scheduled in the main operating as well as unique responsibilities of the involved team members from each surgical specialty. These check lists have been tested and are currently being refined by representatives from obstetrics, general surgery and gynecologic-oncology surgery. The team has identified the need to develop an audit process to evaluate the impact of the checklists on the surgical process. Of course a real time evaluation that the team will continue to use is debriefing.

This process has been educational and beneficial for all team members as interdepartmental relationships have been formed and trust has increased. There is a greater respect and understanding of all team members’ roles and contributions. The outcome of this is better collaboration with the focus on safe patient care.