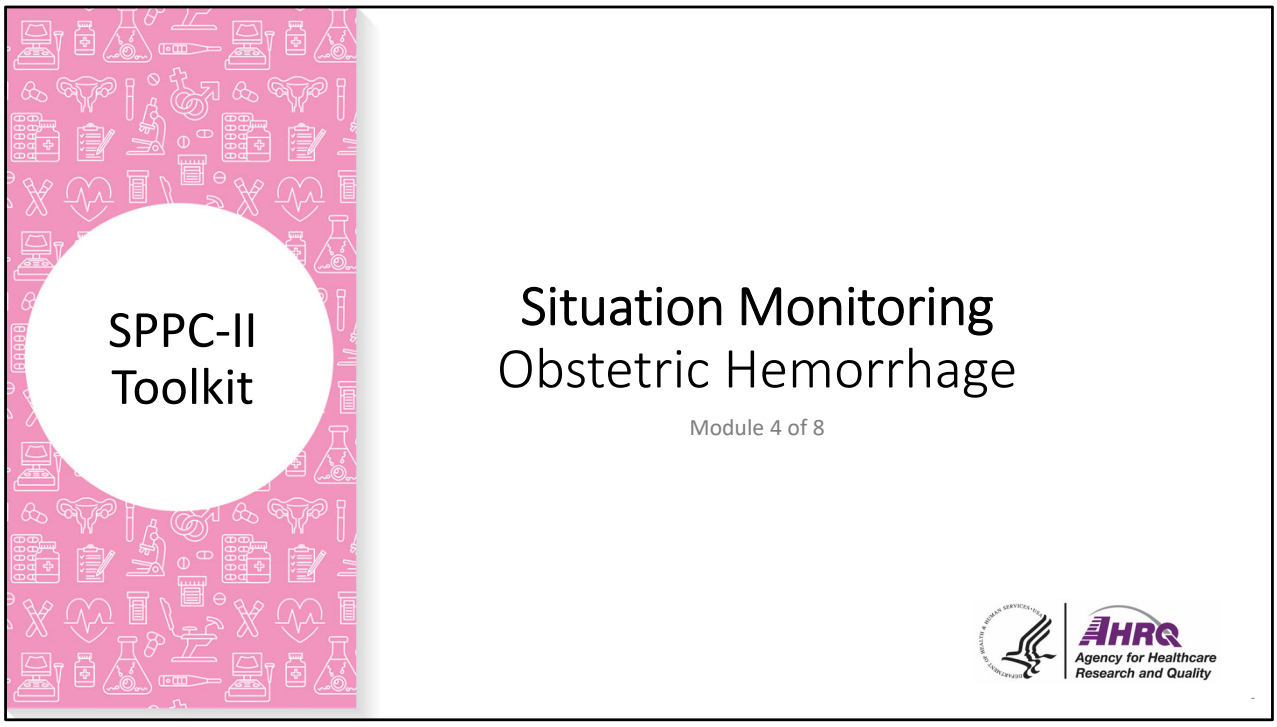
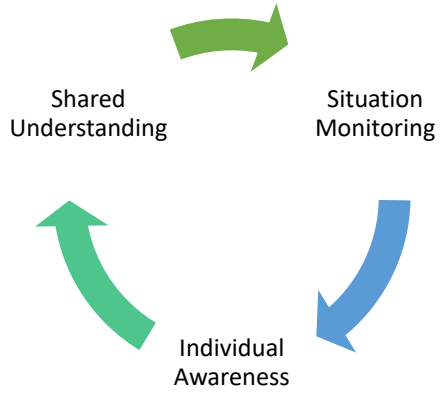


SCRIPT

Welcome to Module 4 of the Safety Program for Perinatal Care-II (SPPC-II) Teamwork Toolkit. In this module, we will talk about situation monitoring: what it is, how to do it, and what tools and strategies we can use to establish our shared understanding of the situation with our teammates.

Monitor To Establish Awareness

- Monitor to identify new or changing information
- Create individual awareness of what's going on and what is likely to happen next
- Discuss observations with appropriate team members to establish shared understanding
  - Better decision making
  - Support the patient, self, and other team members



SCRIPT

Situation monitoring is a way for team members to be aware of what is going on around them. Present awareness enables individuals to respond to changes more nimbly and creates opportunities to assist other team members as needed, facilitating mutual support. Situation monitoring is moderated by communication, which allows for the sharing of new and emerging information with other team members in order to develop and maintain shared understanding.

Situation monitoring is a continuous process because of the dynamic situations in which teams function. This process consists of three components:

1. **Situation monitoring** (an individual skill) is the process of actively scanning and assessing elements of the performance environment, including persons, objects, goal progress, climate, and resources, to gain information or maintain an accurate understanding of the context in which the team functions. Situation monitoring is a skill, which implies that it can be taught, developed, and improved. It enables team members to identify potential issues or minor deviations early enough to correct and handle them before they become a

problem or pose harm to the patient, family members, or others.

2. **Situation awareness** (an individual outcome) is the state of knowing the conditions that affect one's work. It is a detailed picture of the situation. Note that situation awareness is not a static "thing" or concept. Because the situation and context in which the situation exists are dynamic and ever changing, team members must continually assess relevant components of the situation and update their individual situational awareness.

3. **Shared cognitive maps** (a team outcome) are the result of each team member maintaining his or her situation awareness and sharing relevant facts with the entire team. Doing so helps ensure that everyone on the team is "on the same page.“

Ask:

- When have you used situation monitoring in your work?
- How did the information that you obtained from the environment affect how you approached or responded to the situation?

SCRIPT
Don't ruin this exercise for others if you're already familiar with it!

Take a look at each image. What do you see?

Instructor Tip: *Allow the audience time to peruse the images.*

Based on your perception, you could be seeing different things in each of the three images..... and all of you could be right.

Image 1 – Who sees the Native American chief? Who sees the person in a heavy winter coat looking into the darkness?

- Would someone who sees the Native American chief like to explain how they're seeing it?
- Would someone seeing the person in the winter coat like to share how they are seeing it?

Image 2 – Duck or rabbit?

- Who sees the rabbit? Where is your attention that lets you see the rabbit?
- Who sees the duck? What are you looking at to see the duck?

Image 3 – Old woman or young woman?

- Who sees the old woman? What features do you see?
- Who sees the young woman? What features are you looking at?

The purpose of this exercise is to showcase how each of us can look at the same thing and sometimes see something different, depending on whatever it is we are paying attention to at the moment. It's possible for us to come back another time and see something different, if we are more attuned to new details.

However, did you notice how by sharing information you were (hopefully) able to see both subjects in each image? Did you notice how open you were to listening to the new information from someone else that would help you see something different? This is the attitude we want to bring to patient care. Each of us can look at a situation and, based on our personal histories, backgrounds, training, and experience, as well as our current state of mind, see something different. By sharing our different perspectives and information, we can get a fuller picture of what's going on. It also enables all to have a shared mental model while delivering care.

Strategies

Individual Awareness can become Shared Understanding through:

- ***Briefs*** to establish and communicate a care plan
- ***Huddles*** to provide ongoing updates or modify the care plan
  - Supplement with ***call-outs***
- ***Debriefs*** to learn and improve from an experience.

Tip! Always check-back to verify information (Module 3).

SCRIPT

Now that you have the concepts and principles you should follow when situation monitoring, you will learn about the tools and strategies you can use to be effective. In this module we teach you about briefs, huddles, and debriefs.

Remember: as we discussed in Module 3, always use check-backs to verify information.

What are Briefs and Huddles?

Semi-structured conversations among team members designed to improve patient care by formulating a plan and getting all parties on the same page.

Briefs are hosted at the start of a case.

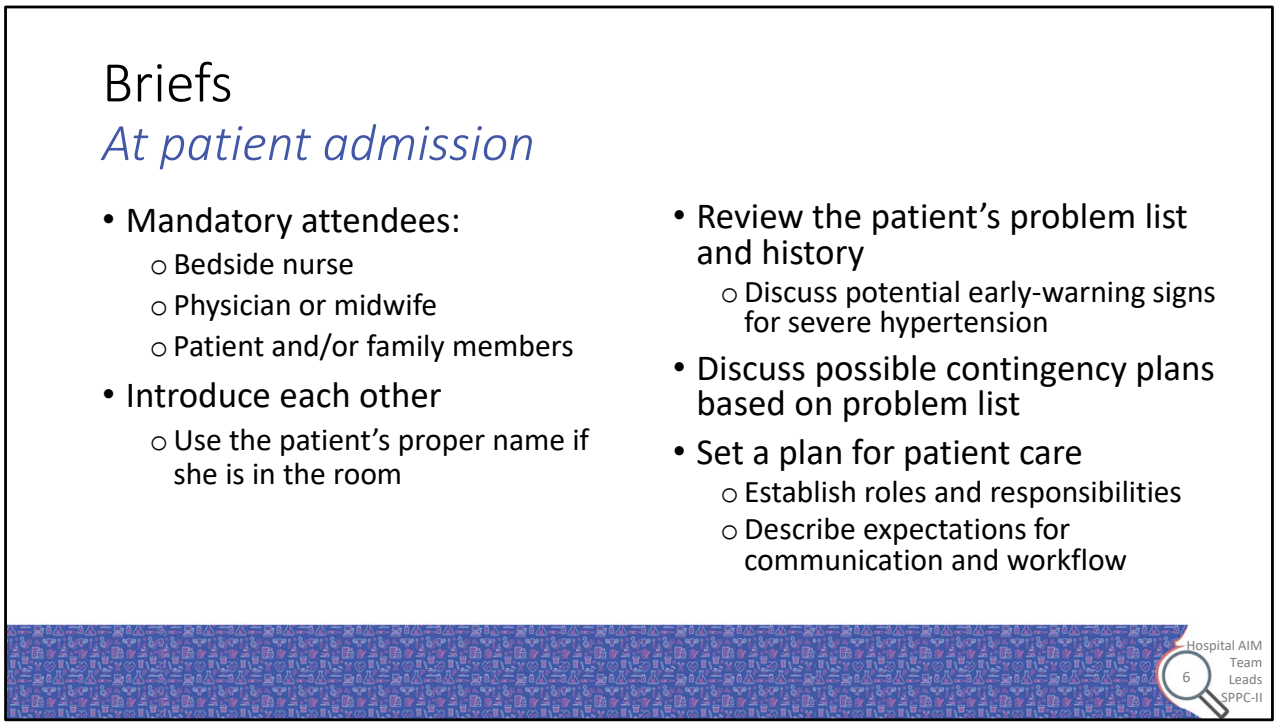
Huddles are held ad hoc at any time during care.

SCRIPT

You have probably participated in a brief or a huddle before even if that isn't what they have been called. Briefs are sometimes referred to in some settings as huddles, and huddles are sometimes called time-outs. Semantics aside, they serve very similar purposes. Formally defined, briefs and huddles are semi-structured interdisciplinary conversations with all team members designed to improve patient care by formulating a plan and getting all parties on the same page. The central takeaway here is that they are *planning meetings* during which the full team or at the very least key team members meet to discuss the patient care plan, devise a strategy for meeting the patient's unique needs, ensure that all team members have the same understanding about the care plan, and strategize contingency plans for managing unforeseeable events should they occur.

The main distinction between what makes one of these meetings a brief or a huddle is *when* they take place. Briefs, ideally, take place at the start of each case, whereas huddles can be called at any time, often in response to an emergent event, to get the team back on the same page and reassess the care plan should a change become necessary.

Let’s consider the more subtle differences between these two meetings before we get into the logistics of hosting one.

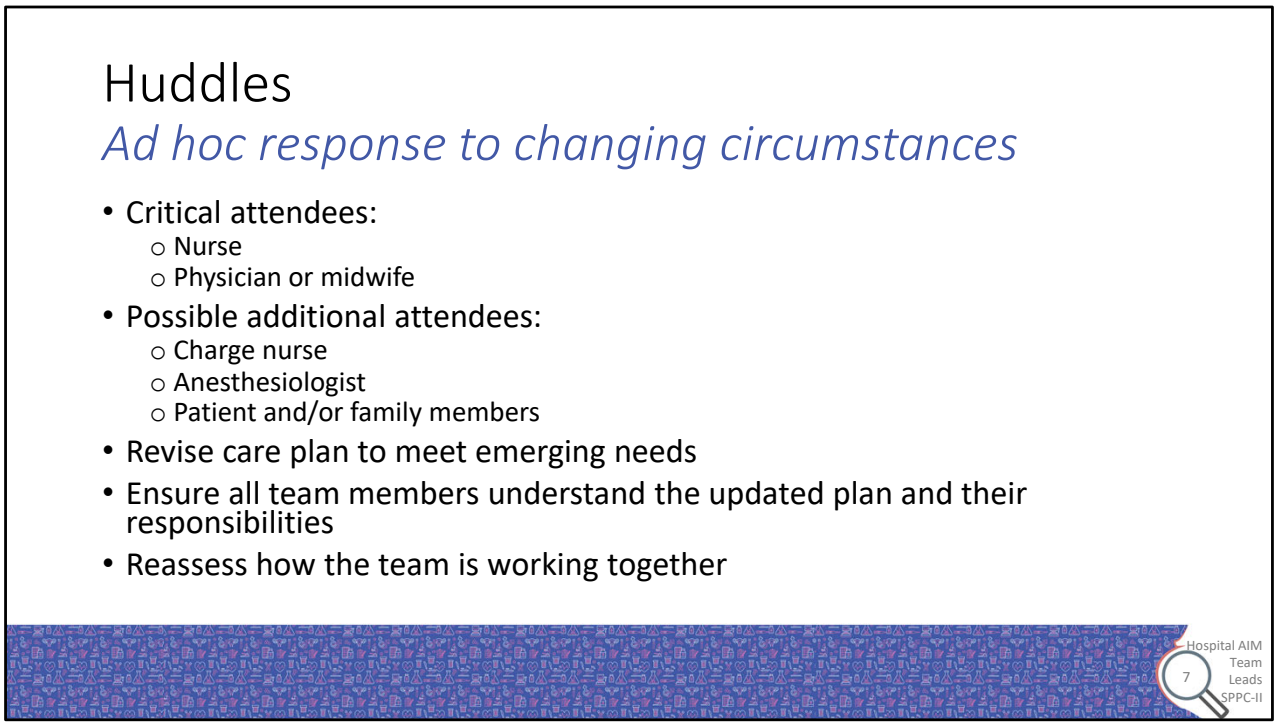


SCRIPT

Briefs are your opportunity to start each case with a solid plan of care and ensure that the primary care team agrees with and is prepared to adhere to the care plan. At a minimum, these meetings should take place between the bedside nurse and attending physician, although other team members such as the charge nurse, midwife, and patient should also be welcome to attend. Although it's often impossible to get everyone in the room at the same time, engaging as many team members as possible, including the patient and family, helps ensure that everyone is on the same page and has the opportunity to contribute to care decisions.

During a case briefing, the team should review the patient's problem list and history, devise a care plan, consider potential problems that might emerge throughout her care, and talk through contingency plans in case of those events. From the teamwork perspective, briefs provide all providers a chance to introduce themselves to each other in case they aren't already familiar with each other, describe roles and responsibilities, and set expectations for how they will work together such as when and how often they will be in contact and preferred mechanisms for communicating.

Everyone at the meeting should be in agreement with the plan and have had a chance to voice any concerns, either about the patient history or the ability for the team to care for the patient.



SCRIPT

As we've already learned, the purpose of the huddle is only subtly different from a brief. Not all cases will require team members to huddle. A huddle may be more of a hindrance than a help during routine textbook cases with no surprises or abnormal challenges that unfold predictably.

Unfortunately, the reality of patient care is such that sometimes surprises happen or a case is complex and requires significantly more team involvement than is typical. In these instances, huddles might be a good strategy for you to keep the team informed of changing circumstances.

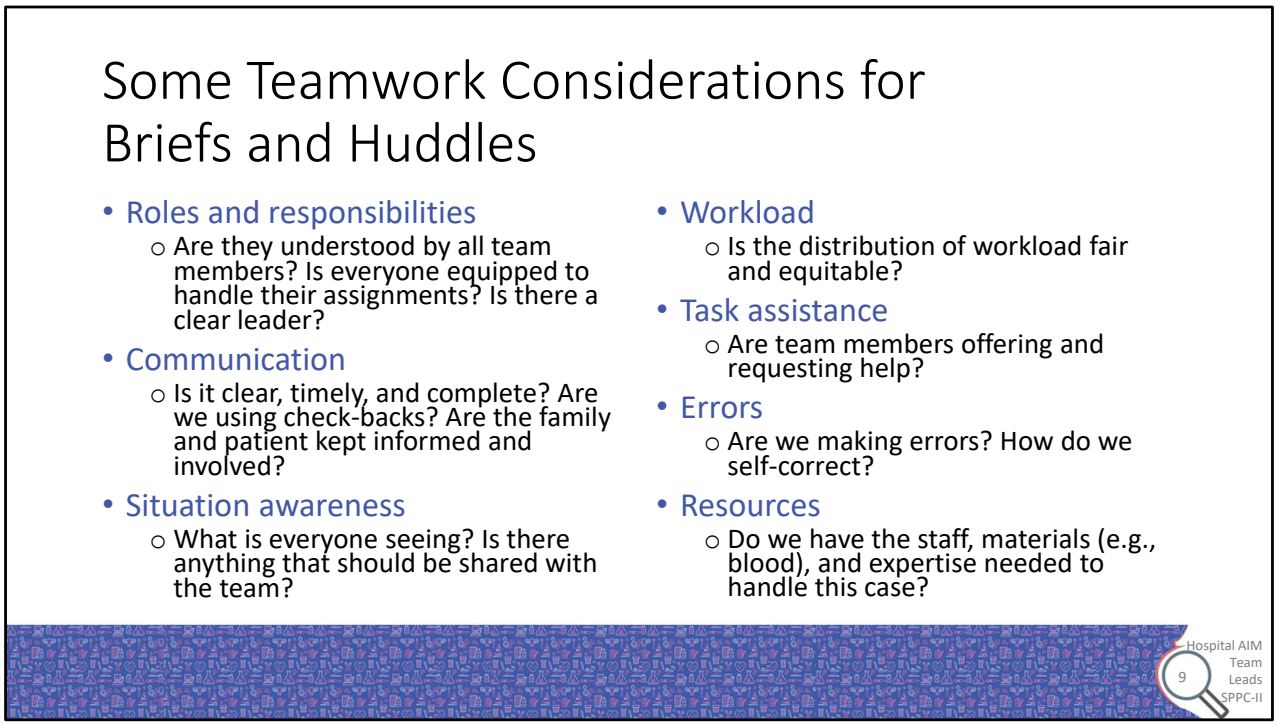
Huddles may require attendance from more than just the bedside nurse and attending. Any residents, anesthesiologists, midwives, or charge nurses also assisting with the case may need to be present for a huddle. However, like a brief, the objective is to leave the meeting with a care plan that all team members understand and agree with. Huddles are also a great time to reassess how well the team is working together and make minor adjustments to their approach to teamwork.

Points of Discussion in Briefs & Huddles

- Patient problem list and history
- Teamwork considerations
- Hemorrhage-specific planning

SCRIPT

In order to plan and pivot well, you and your team will want to review both the patient's problem list and personal history as a way to prepare for the clinical work involved with caring for this patient. You would also do well to think about teamwork considerations that go beyond the pure clinical aspects of patient care. We'll go over a few of these in a moment. Finally, if your facility is addressing the AIM Hemorrhage Clinical Bundle as part of your commitment to improving patient safety, there are a few hemorrhage-specific planning questions you can address in your briefs and huddles.



SCRIPT

During your briefs and huddles you can think about team performance from various angles. A few items you might discuss include:

- Roles and responsibilities – Does everyone know who is on the team? Does everyone know what each of their team members are responsible for? Are roles and assignments appropriate for the team members' level of experience and expertise? Is there a clear leader?
- Communication – How is it? Is it clear, timely, and complete? Is everyone getting the information they need when they need it? Are we confirming the receipt of information and clarifying uncertainties with a check-back? Are the verbal and nonverbal communication strategies the team used effective? Are we keeping the patient and her family involved and informed?
- Situation awareness – What is everyone seeing? Is there anything that needs to be shared with the team? Is each member maintaining up-to-date awareness? Are team members communicating relevant insights and changes in the status of the patient to the rest of the team? Does the team have a similar understanding of what's going on with this patient?
- Workload – Is workload fair and equitable? Are there enough staff to handle the workload?
- Task assistance – Are team members offering and requesting help from each

other? Are offers of help genuine? Are requests for help honored?
- Errors – Are we making any errors? How do we self-correct?
- Resources – Do we have the staff, materials, and expertise needed to handle this case? For instance, was there enough medication to manage a severe hypertension event?

You may find you don't need to cross-walk through each of these points at every huddle or brief, especially if you're familiar with your teammates and already have an established system and expectations in place for working together. However, it doesn't hurt to touch base with each other on these points from time to time or use this list as a gentle reminder about how and what team dynamics may be affecting care beyond the clinical context. Even textbook clinical cases can sometimes go awry when teamwork is weak, so it's important to consider these elements, too.

Hemorrhage-Specific Planning

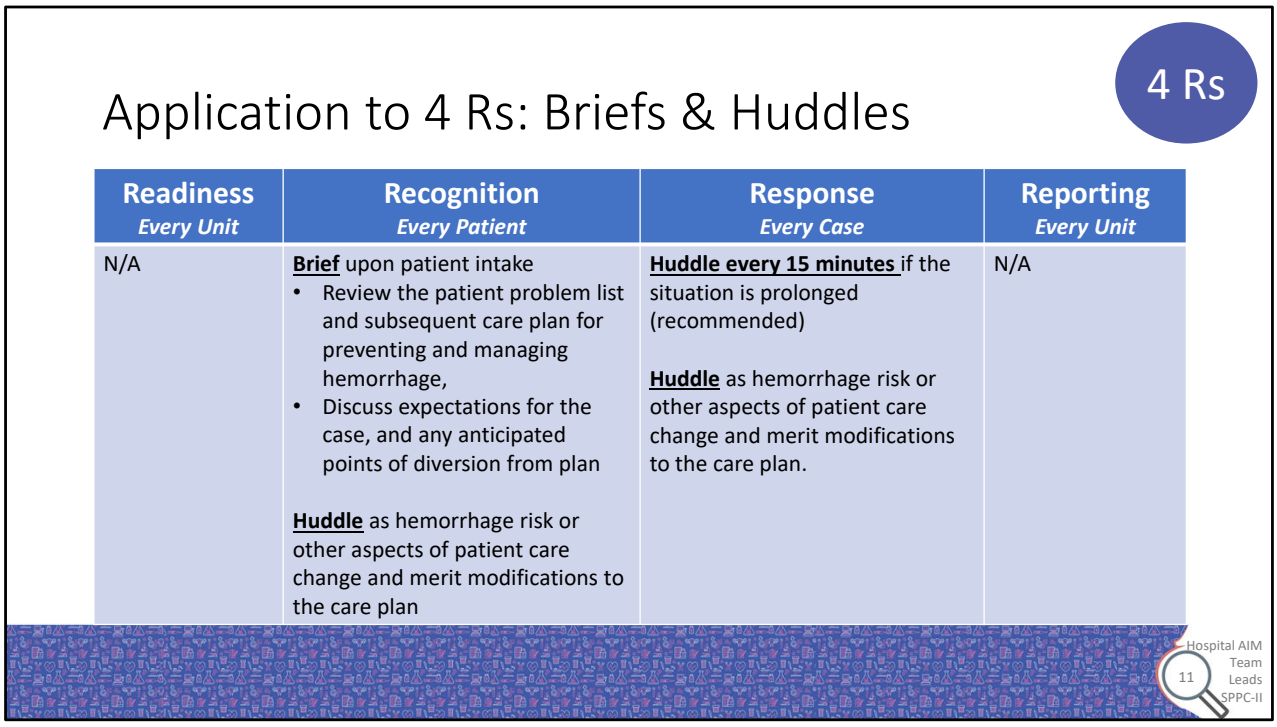
Tip! Convene a huddle at the first signs of a hemorrhage and every 30 minutes that the event is prolonged.

- ✓Is the patient at risk for hemorrhage? What are her early-warning signs?
- ✓How much blood has she lost?
- ✓What is our best plan of care for responding to hemorrhage?
  - ✓ What does the facility protocol suggest we do?
- ✓Do we have a contingency plan?
- ✓How is the patient doing?
  - ✓ Is she distressed? What fears or anxiety has she communicated?
- ✓Are the family and patient aware of the plan?

SCRIPT

Whether you are briefing or huddling, you might find the following questions to be useful discussion points if you are concerned about hemorrhage.

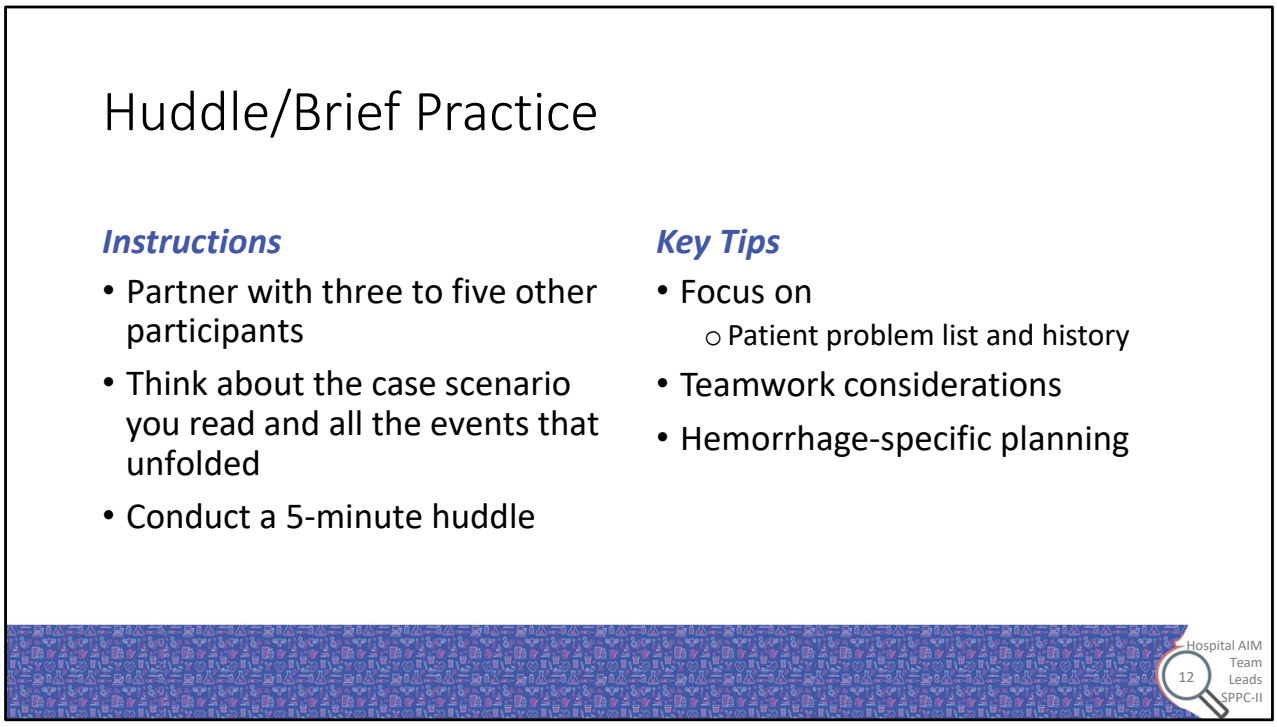
- Begin by asking if the patient is at risk for hemorrhage. What are her early warning signs, if any? How do we make sure she doesn't worsen?
- If she's already started to bleed, how much blood has she lost so far?
- What is our best plan of care for responding to hemorrhage? Consider what the facility's standard protocol for hemorrhage suggests you do.
- Do you have a contingency plan? What will you do if medication does not reduce hemorrhage?
- Have you asked the patient how she is doing? Is she distressed? What fears or anxiety has she communicated?
- Finally, are the family and patient aware of what is unfolding and the plan for managing her condition?



SCRIPT

Briefs and huddles are primarily applicable to the Recognition and Prevention and Response stages in the AIM 4 Rs framework.

With regards to cases involving maternal hemorrhage, use briefs at admission and consider the patient's risk of hemorrhage in addition to her other risks. In the event a mother does begin to hemorrhage, respond by huddling immediately and at least every 15 minutes if the situation is prolonged.

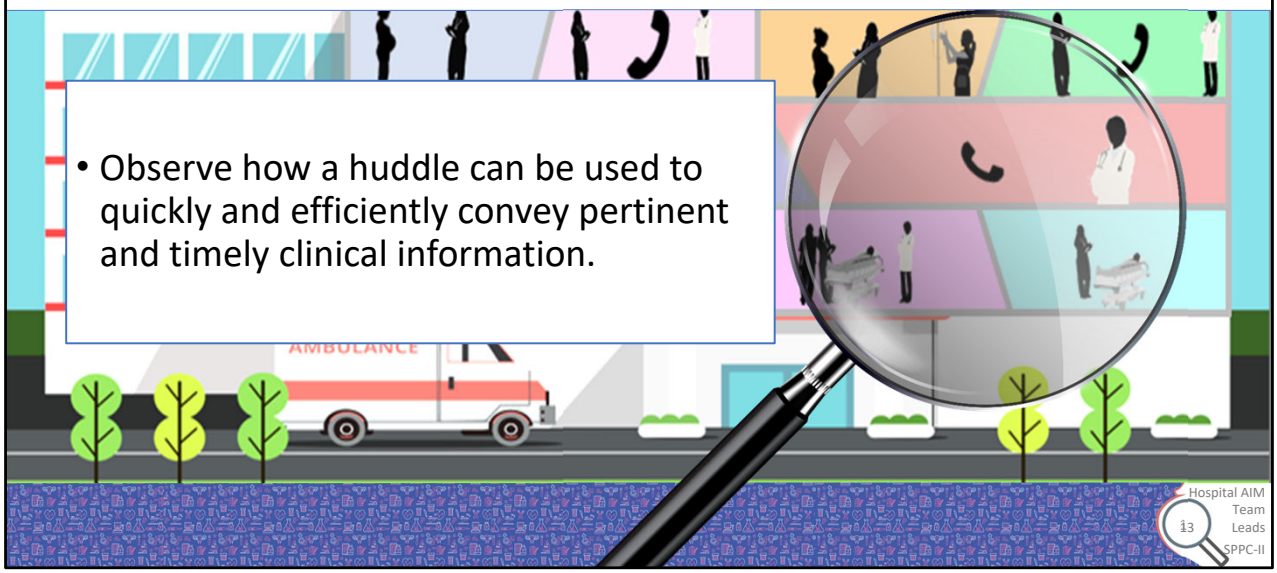


SCRIPTS

Get into groups of three to five people. Recall the case scenario from the introduction module and all the events that unfolded. Conduct a 5-minute huddle about this case or any particular aspect of it.

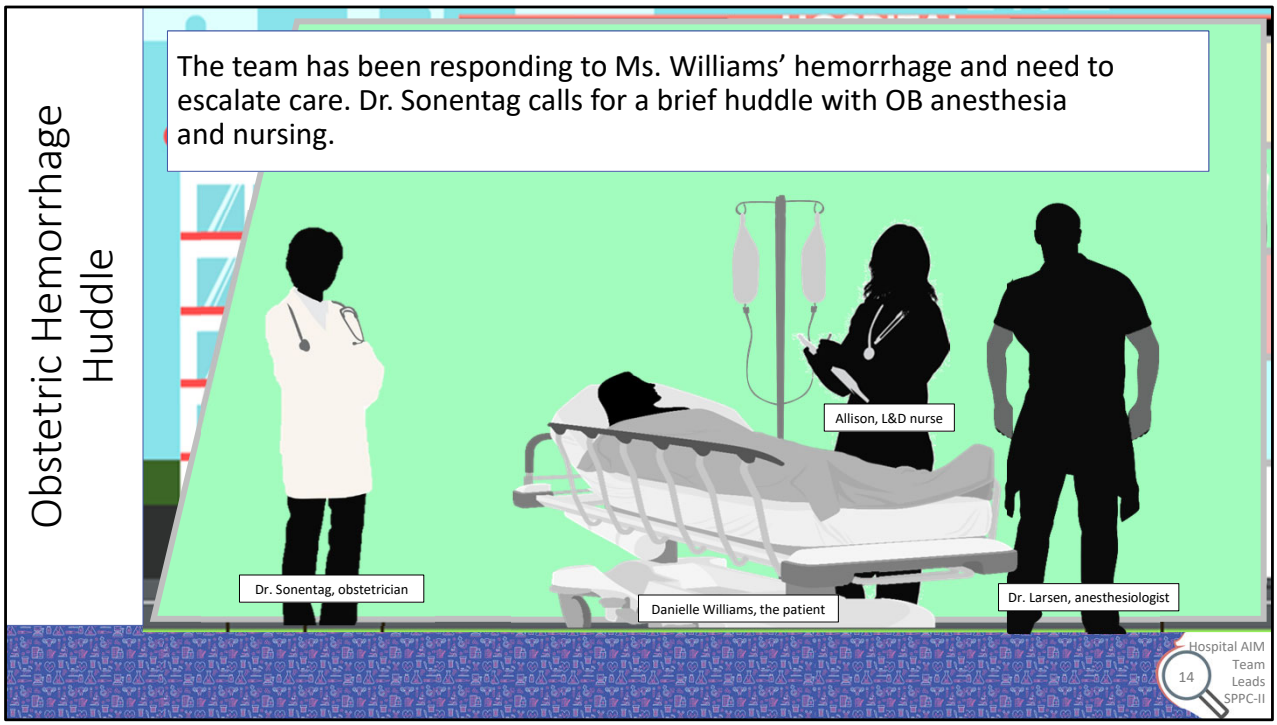
As you go through this exercise, think about the patient's problem list and history, any teamwork considerations that arose, and what specifics you might want to address about the hemorrhage event.

Obstetric Hemorrhage Huddle



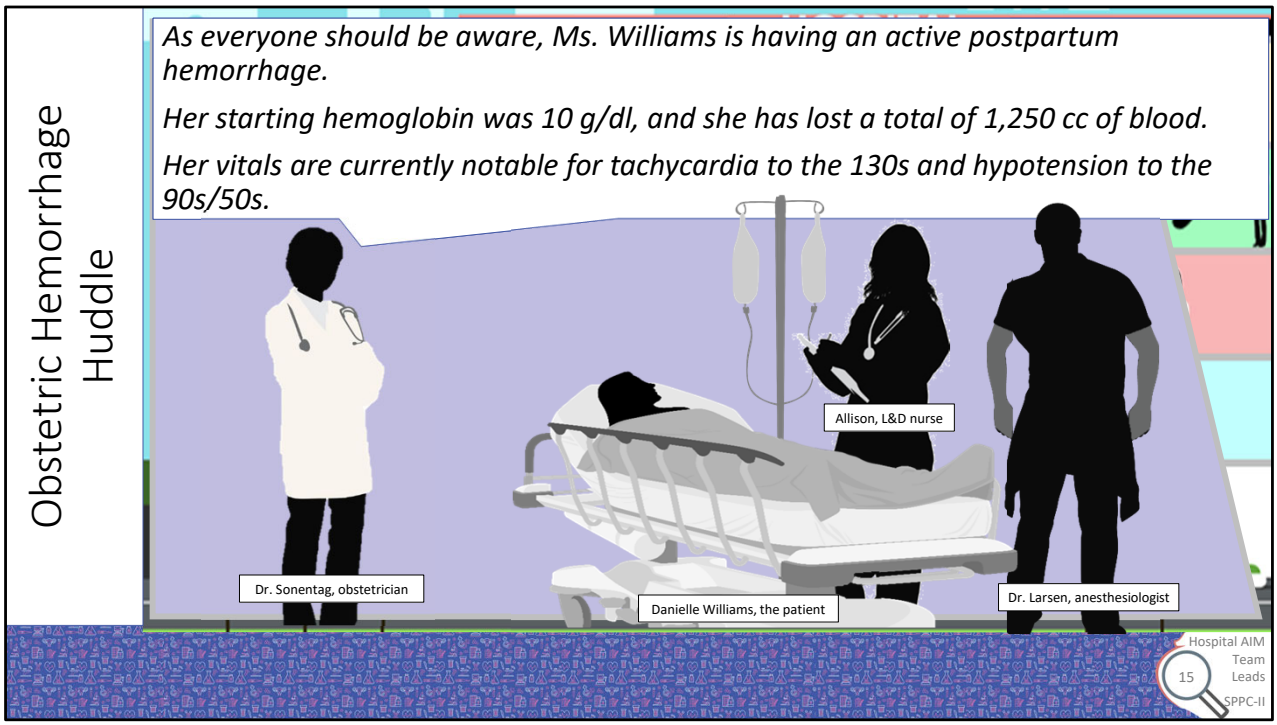
SCRIPT

We will now revisit a scene from the postpartum hemorrhage master scenario presented in Module 1. In this scene, we will demonstrate how a huddle can be used to quickly and efficiently convey pertinent and timely clinical information to appropriately inform the team and advance patient care.



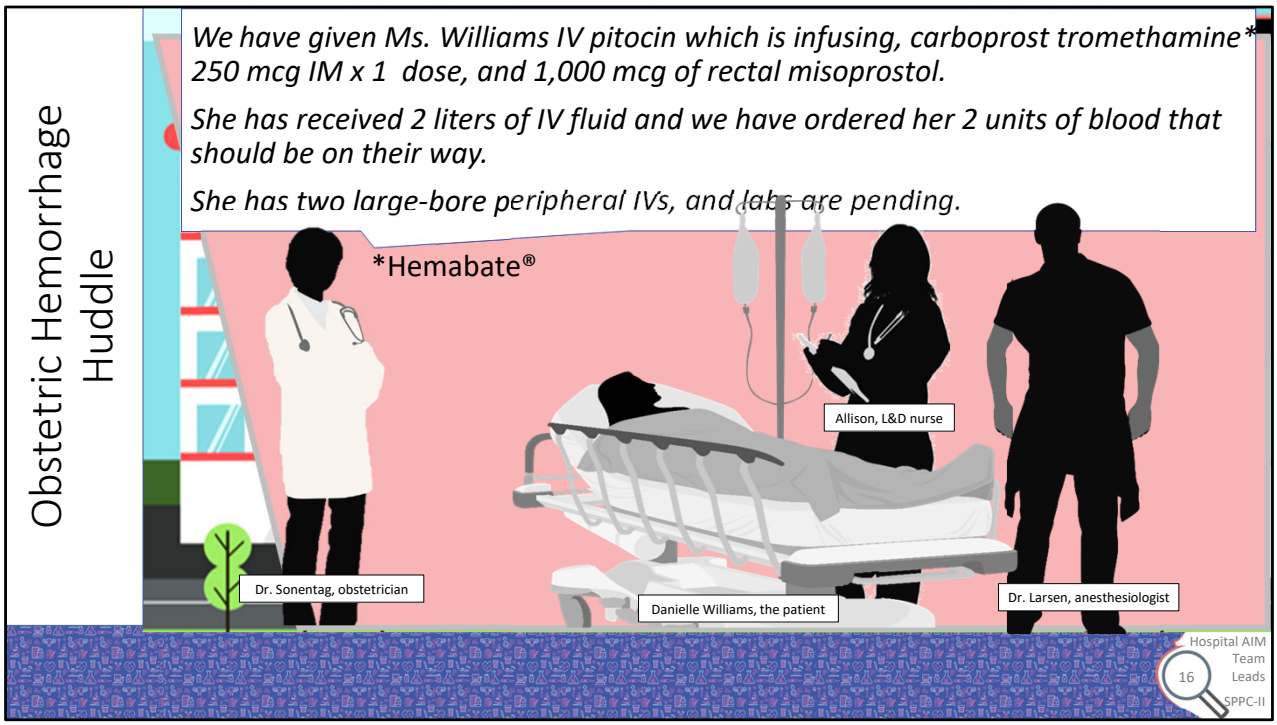
SCRIPT

As you likely recall from the master scenario presented in Module 1, Ms. Williams is an actively bleeding patient with many known risk factors for postpartum hemorrhage. She did indeed have a hemorrhage, and the team has been responding to it; however, they need to escalate care. Although the case remains an emergency, a huddle can be conducted quickly to efficiently mobilize the necessary components to provide the optimal, safest care for the patient. At this point, Dr. Sonentag, the obstetrician, calls for a brief huddle with OB anesthesia and nursing.



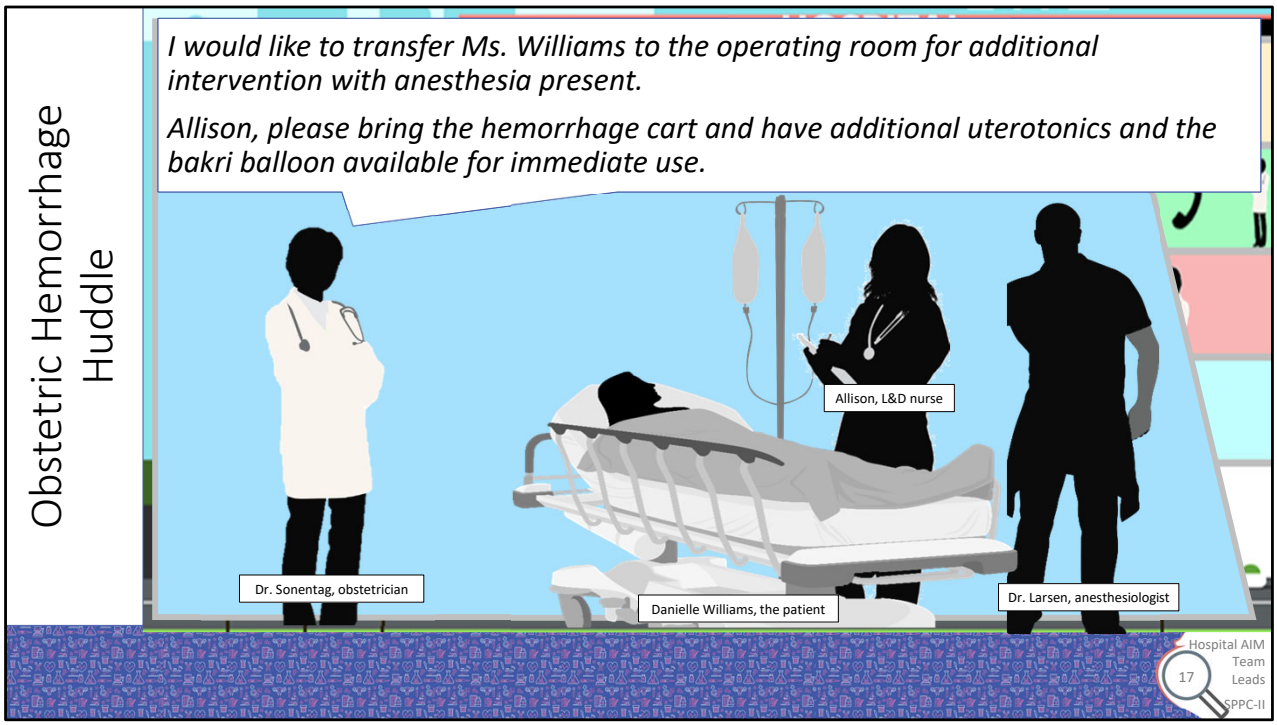
SCRIPT

To start the huddle, Dr. Sonentag provides a limited clinical background with pertinent information only, given the emergent nature of the ongoing hemorrhage. He tells the team, “As everyone should be aware, Ms. Williams is having an active postpartum hemorrhage. Her starting hemoglobin was 10 g/dl, and she has lost a total of 1,250 cc of blood. Her vitals are currently notable for tachycardia to the 130s and hypotension to the 90s/50s.”



SCRIPT

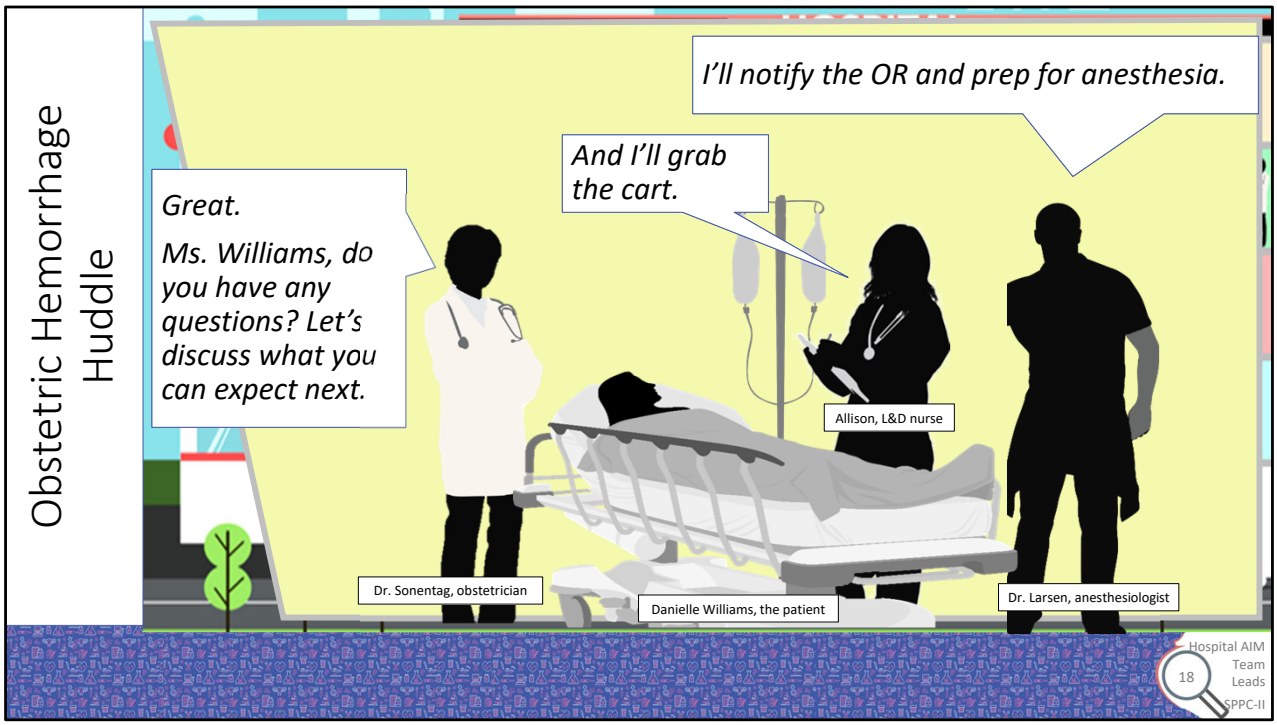
Dr. Sontentag continues the clinical background summary and provides the team with information regarding what interventions have been thus far been done in addition to what has been ordered and is pending. He says, “We have given her IV pitocin which is infusing, carboprost tromethamine (Hemabate) 250 mcg IM x 1 dose, and 1,000 mcg of rectal misoprostol. She has received 2 liters of IV fluid and we have ordered her 2 units of blood that should be on their way. She has two large-bore peripheral IVs, and labs are pending.”



SCRIPT

Dr. Sonentag continues, “I would like to transfer Ms. Williams to the operating room for additional intervention with anesthesia present. Please bring the hemorrhage cart and have additional uterotonics and the bakri balloon available for immediate use.”

Dr. Sonentag has identified that he would like to change the clinical location to the operating room, which will require a large degree of coordination between nurses, techs, anesthesia, etc.

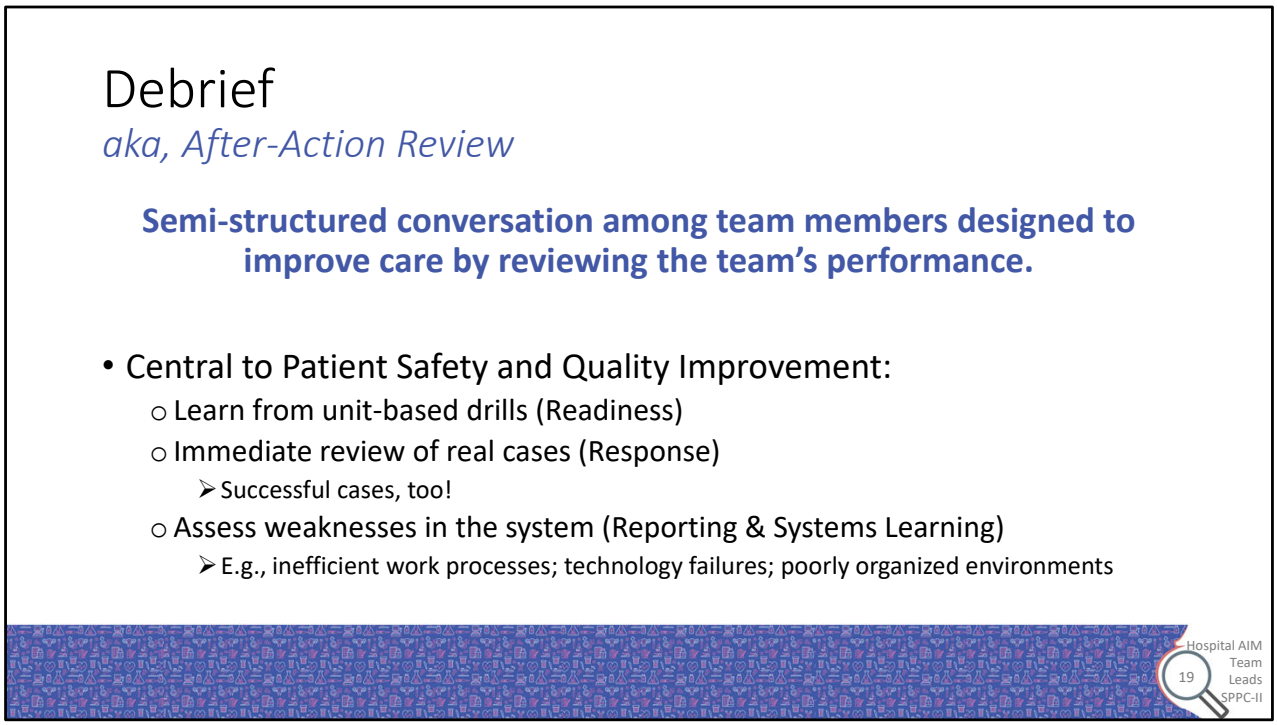


SCRIPT

In response, the team members identify what responsibilities they will assume for next steps. Dr. Larsen, the anesthesiologist indicates that he will notify the OR and prep for anesthesia while Allison, Ms. Williams' bedside nurse, aims to grab the cart.

Knowing what her clinical teammates will be doing next, Dr. Sonentag returns his attention to his patient, asking if she has any questions and sharing what Ms. Williams can expect next.

By convening a huddle, the team was able to quickly and efficiently update the entire team about the patient's clinical status, what interventions have been performed thus far, and what needs to happen moving forward. They disbanded with a plan of action and shared understanding of each others' responsibilities.



SCRIPT

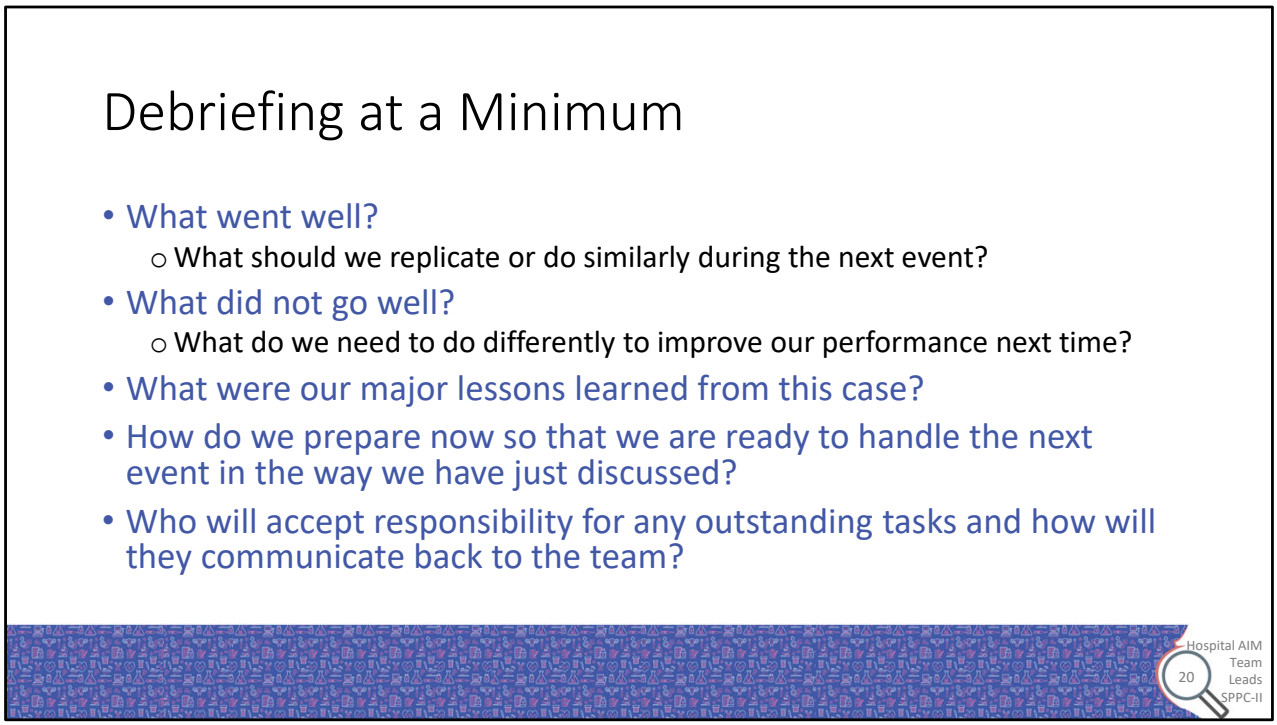
Also known in some facilities as "after-action reviews," debriefs are semi-structured, interdisciplinary conversations with all team members to review the team's performance during a recent case or clinical event. The purpose is to learn from the event with the intention of applying those lessons to future team performance under similar circumstances. As such, debriefs are a critical tool for improving patient safety and quality improvement within your facility.

They may be used in training practice scenarios, like unit-based drills, as opportunities for personal and team performance feedback. In these situations, the focus will be on practicing teamwork and clinical skills so that the team is prepared to respond to a real event. Debriefs may also be used in regular clinical practice in two ways. First, as an after-action review of a patient case, especially one involving an adverse event like severe hypertension. These after-action reviews provide an opportunity for the team to reflect on their performance and discuss ways to either perform better or sustain good performance in the future. Debriefing each case, whether the case went smoothly or there were adverse events associated with the patient's care, is good practice. You can learn much from reflecting on what helped

a case succeed as much as you can learn from figuring out what the team could have done to prevent unwanted events, particularly when the causes of some events were beyond the control of the team and had nothing to do with the team's ability to perform well.

Finally, debriefs can be used on a larger scale to assess system weaknesses. Generally, these types of debriefs will be held in the Reporting and Systems Learning stage in response to an adverse event and involve unit representatives who were not initially involved with a particular case. The purpose of these types of debriefs will be to conduct a root-cause analysis of an event to look for ways that the system (and not the team) itself can be improved. Examples of system issues include technology failures, such as alarms that are easily turned off; environmental concerns, such as poorly organized environments that contribute to human errors or work inefficiencies; and processes that create delays in patient care.

The remainder of this module focuses on that second type of debrief: after-actions reviews, because these are the ones that you can leverage most consistently in your everyday practice. Learning how to debrief cases and making it a habit to do so regularly will help you to provide consistent high-quality care as you begin to recognize patterns of good teamwork and can correct behaviors that deviate from these patterns.



SCRIPT

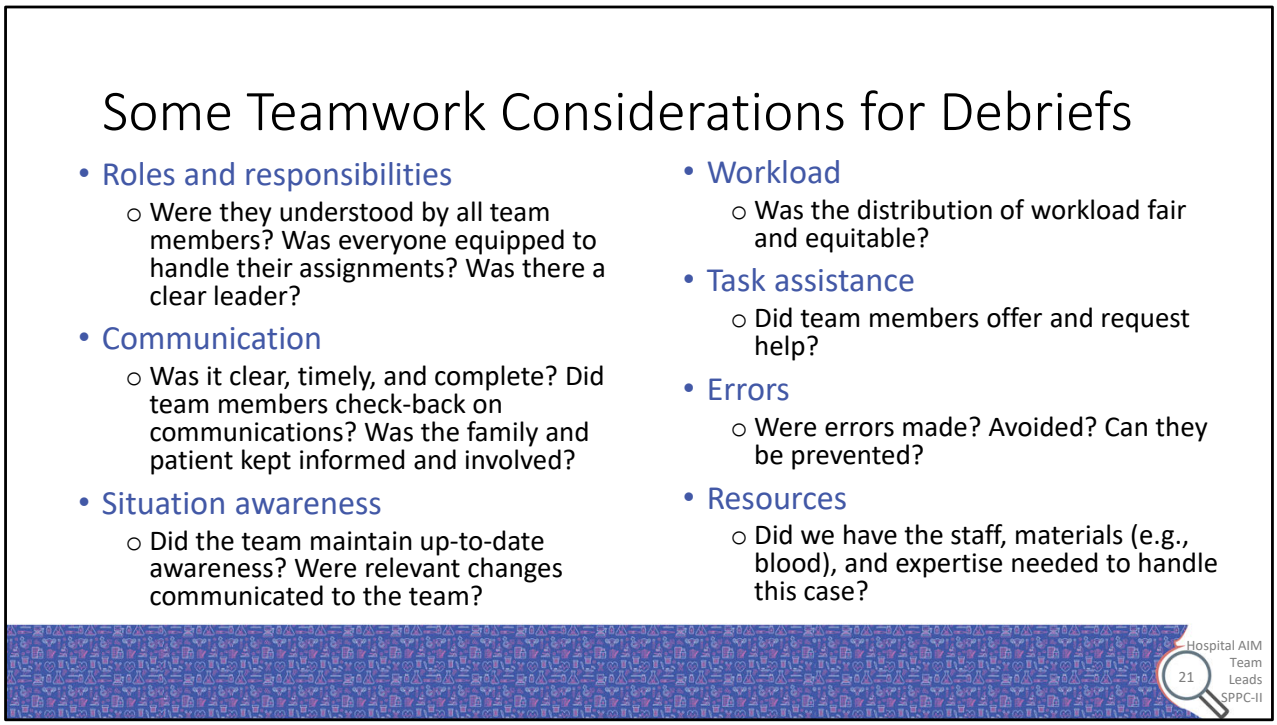
Because debriefs are real-life learning opportunities, it's important to conduct the debrief in a way that maximizes learning and leaves team members feeling like they know exactly what to do differently (or the same!) next time.

There are many questions you can ask during a debrief to help you understand.

At a minimum, the high-level questions your team should discuss during a debrief include:

- What went well? Sometimes, things that went well might not have been a direct result of anything the team did; however, it's useful to explore what the team *can* do to repeat good performance and outcomes during the next event.
- What did not go well? Similarly, you will want to explore aspects of the case that might have hit some snags along the way and, importantly, discuss what it is your team can do differently to avoid or better manage those difficulties in the future.
- Summarize your major takeaways by asking what the team's lessons learned were from this case.

- Finally, your team will want to thoughtfully think about what you can do now so that you are ready in the future to implement the strategies you've discussed. Sometimes follow-through might be needed. In these cases, be clear about who is responsible for the task.



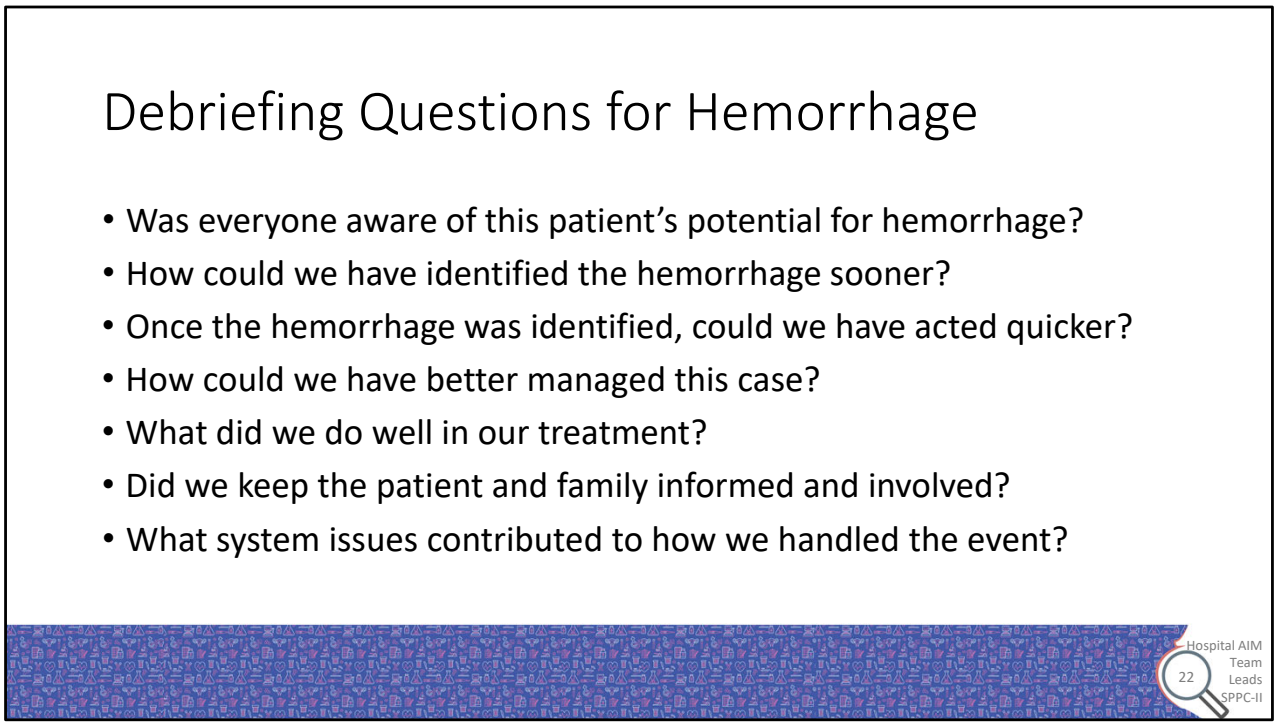
SCRIPT

During your debriefs, you can think about team performance from various angles. A few items you might discuss include:

- Roles and responsibilities – Did everyone know who was on the team? Did everyone know what each of their team members were responsible for? Were roles and assignments appropriate for the team members' level of experience and expertise? Was there a clear leader?
- Communication – How was it? Was it clear, timely, and complete? Did everyone get the information they needed when they needed it? Did everyone check-back or close-the-loop to confirm messages were correctly understood? Were the verbal and nonverbal communication strategies the team used effective? Was the family and patient kept informed and involved?
- Situation awareness – Did each member maintain up-to-date awareness? Did they communicate relevant insights and changes in the status of the patient to the rest of the team? Did everyone maintain a similar understanding about the patient's situation?
- Workload – Was workload fair and equitable? Were there enough staff to handle the workload?
- Task assistance – Did team members offer and request help from each other? Were offers of help genuine? Were requests for help honored?

- Errors – Were mistakes made? Were there any near misses? How could mistakes and near misses be prevented?
- Resources – Did the team have the staff, materials, and expertise needed to handle this case? For instance, was there enough medication to manage a severe hypertension event?

Please note the topics presented here are not exhaustive. There are lots of questions you can ask and explore regarding your team's performance.



SCRIPT

As you debrief cases of patients who suffered obstetric hemorrhage, you might consider exploring additional hemorrhage-specific questions with your team. These could include, but certainly aren't limited to:

- Was everyone aware of this patient's potential for hemorrhage?
- How could we have identified the hemorrhage sooner?
- Once the hemorrhage was identified, could we have acted quicker?
- How could we have better managed this case?
- What did we do well in our treatment?
- Did we keep the patient and family informed and involved?
- What system issues contributed to how we handled the event?

A few points to highlight in these questions are the thoughtful ruminations about how to better involve patients and family members and to focus on both those desirable behaviors you'd like to replicate in the future in addition to changing any behaviors that did not serve you well in the present case.

Debrief Ground Rules

- Host the debrief **as soon as possible** following a case or event
  - Anyone can request and lead a debrief
- Keep it **short** (5–10 minutes) but pertinent
- **All-inclusive**
  - Acknowledge good contributions
  - Solicit thoughts from silent team members
- Communication is **open, transparent,** and **interactive**
- Maintain **respect**
- **No finger-pointing**

SCRIPT

Debriefs do not have to be long conversations. It's amazing what you can accomplish in 5–10 minutes if you follow a format. It's better to have a short meeting that doesn't address every checklist item than to not have one at all.

Time will be an important factor in the success of a debrief. It's better to hold debriefs immediately following a case or event, while the details are still fresh in everyone's memory. Don't wait for a perfectly scheduled time for a lengthy debrief because by then team members won't recall as well what improvements the team could make.

That said, debriefs are best when they are all-inclusive and each team member has an opportunity to listen as well as share their own insights. A good debrief facilitator will both acknowledge contributions and solicit input from team members who aren't speaking up. Importantly, any team member and request and lead a debrief. It is not only the responsibility of the physician to ensure a debrief is completed.

The only time some of these rules may not apply is when you are conducting a debrief of a serious event with the larger staff. In these cases, individuals who weren't involved in the original case might be convened to learn from the event and/or help solve larger systems-based problems that limited team effectiveness. Even if that is the case, during all debriefs,

communication should be open, honest, transparent, and interactive.

Importantly, respect should be maintained at all times, and all finger-pointing should be avoided. Debriefs are not opportunities for venting personal grievances or blaming individual team members for failures. A good debrief session is focused on looking for ways the team can perform well in the future.

Debrief Discussion Tips

- Focus on **positives** as well as negatives
- **Share feelings** about recent events
  - Find ways to extend support to struggling team members
- Discuss **how to apply lessons** in practice
- **Take de-identified notes** about the outcomes of your discussion
  - Store these separate from any identifying patient information
- **Assign responsibility** to team members for follow-through

SCRIPT

During the team debrief, you should focus on positives (that is, what went well) just as much as negatives (or what didn't go so well). Sometimes it might be helpful to start the discussion with positives, especially if you have reticent teammates who are hesitant to speak up. Of course, use your judgment. In cases with poor patient outcomes it might feel unpalatable to discuss positives. It's critical in such cases especially to let the debrief be a forum for staff to share their feelings about recent events and find way to extend support to struggling team members.

Given that debriefs are learning opportunities, your team will want to give some consideration to how the lessons they've discussed can be applied. It's not always enough to simply agree to do better next time. Sometimes the team needs to have followup conversations with each other or outsiders to actualize their plan. In these cases, the team should consider being clear about who will shoulder the responsibility for managing the follow-through. Having a designated note taker will help you to manage and log any decisions made during your debrief. Any notes should be de-identified and kept separate from patient information.

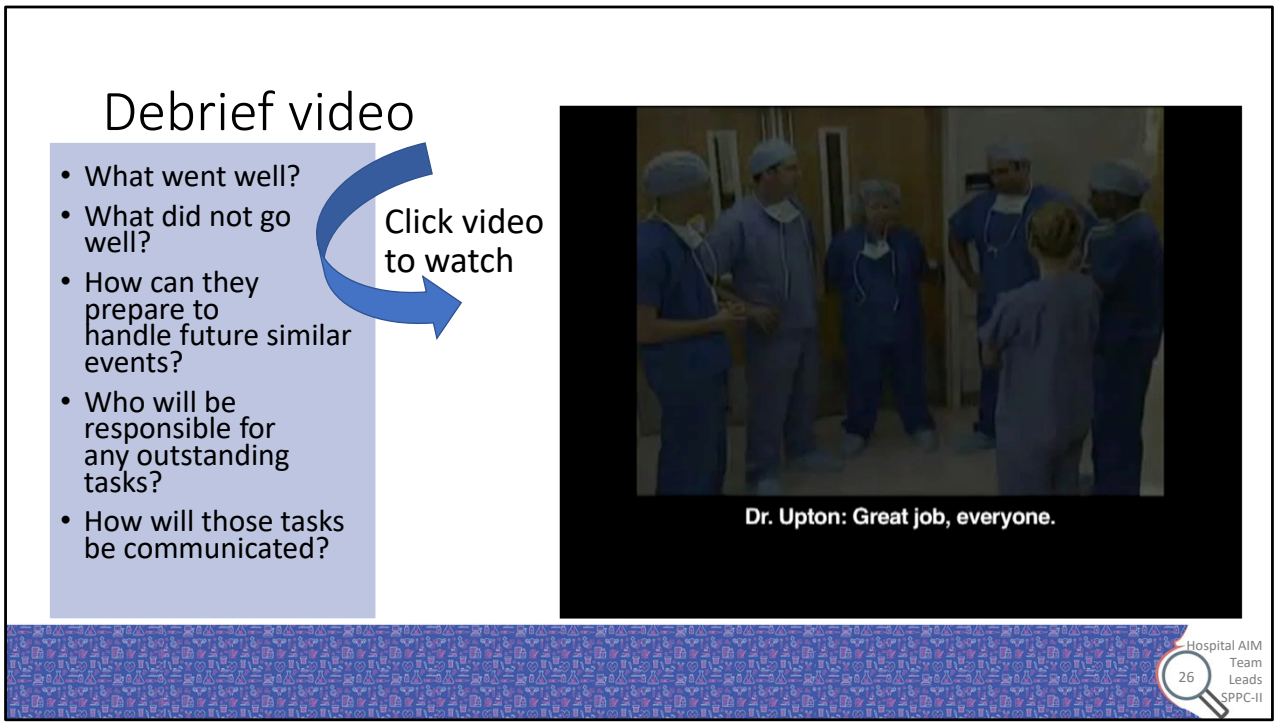
Application to 4 Rs: Debriefs

Readiness *Every Unit*	Recognition *Every Patient*	Response *Every Case*	Reporting *Every Unit*
Debrief after unit education on protocols and unit-based drills to improve and/or sustain performance	N/A	**Debrief** after events to support patients, families, and staff **Debrief** regularly to establish a culture of continuous learning from successes and failures When **debriefing,** specifically discuss how well the team adhered to the clinical protocol	Host unit-wide **debriefs** to facilitate multidisciplinary review of serious events to address systems issues and enable others to learn

SCRIPT

Debriefs may be applicable at the Readiness, Response, and Reporting stages described by AIM's 4 Rs framework. In the Readiness stage, you might debrief with your team members after unit education on protocols and unit-based drills. During these sessions, you can talk about what went well, what didn't go so well, and what you would change during a live event or the next drill.

During the Response stage, you might debrief after a patient hemorrhage event. Regular debrief sessions after such events help to establish and sustain a culture of continuous learning. Relatedly, unitwide "debriefs" might be used at the Reporting stage to facilitate multidisciplinary review of serious events, address systems issues, and enable staff uninvolved with the actual event to learn from the case.



SCRIPT

Click the video to see an example of a debrief. Please note that the scenario does not relate to an obstetric hemorrhage. We encourage you to focus on the technique, rather than the context. While you are watching, think about what they are discussing in regard to what went well, what did not go well, how they can prepare to handle future similar events, who will be responsible for any outstanding tasks, and how those tasks will be communicated back to the team.

Discussing the Debrief Video: *Pros*

- Convened the debrief before everyone could leave
- Facilitator set a positive tone
- Solicited opinions from multiple team members
  - Did not input his opinion
- Pointed out examples of good teamwork (i.e., task assistance)
- Specifically asked to discuss communication (i.e., teamwork)
  - Was not solely focused on the clinical scenario

SCRIPT

What did you think about the video you just saw? What did you think the team did well?

This team demonstrated a number of good debrief habits. First, the facilitator got everyone together before they could go off to their various responsibilities. This enabled the team to keep the debrief shorter and speak with more saliency. He also set a positive tone for the debrief. It seemed clear that this was an opportunity and not a punishment. He solicited opinions from multiple team members about what went well and pointed out examples of good teamwork when they were brought up. He also began to address teamwork elements about how the team performed when he asked how their communication went, not simply focusing on the clinical aspects of the case. It's also important to note that he himself withheld his opinion, instead asking the team members to share their perspective. This is notable because had the facilitator, who seemed to have some formal power in the group, led with his opinions, the team members may have been less likely to share theirs. Instead, it was made clear that their input was wanted and valued.

What other things did you like about this debrief?

Discussing the Debrief Video: *Limitations*

- Uncertain how long they debriefed
  - Probably no more than 5–10 minutes
- Not everyone spoke up
- Could have had more discussion
- Did not explicitly talk about how to replicate good performance
- Did not discuss weaknesses or how to improve
  - "What would you like to do differently next time?"

SCRIPT

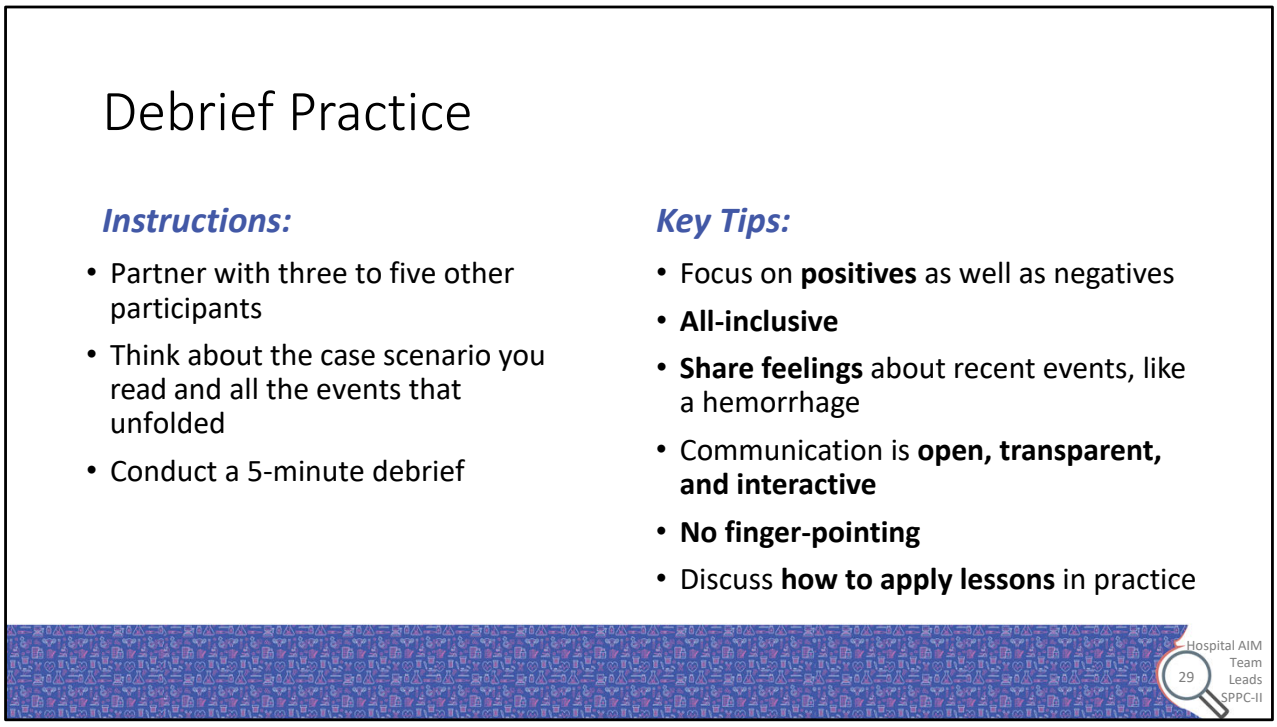
The biggest limitation from this debrief example is that we weren't able to see the entire session, so we don't know how long the debrief carried on. However, the pacing of the video seems to indicate that they probably did not spend more than 5–10 minutes together, which hopefully reinforces to you that debriefs do not have to be arduous meetings. They can be very effective even when kept short.

A few other aspects that seemed missing from the debrief included the fact that not everyone spoke up. There definitely could also have been more discussion at times and opportunity given to members to respond to points made by other team members. Even simple "I agrees" to demonstrate that the team are all on the same page about what the others mentioned could have been helpful in ensuring that everyone was, indeed, on the same page.

They also did not explicitly talk about how to replicate good performance. For example, when the anesthesiologist said it was good for him to be brought in early, there wasn't discussion about how they can make sure he's brought in early again on the next case or what contributed to him being able to come in early. That is the sort of discussion that helps team members know exactly what to do in the next case.

While it's really good that the team discussed what they did well, it is actually important to also be honest about places where they could improve. It actually makes an interesting point—while we often tend to focus a lot on deficiencies, sometimes it's easier to gloss over our weaknesses and focus explicitly on strengths in a team setting. Trust, vulnerability, and moral courage are key players in being able to admit to weaknesses, so sometimes it may take the facilitator asking the question, "What would you like for us to do differently next time?" to encourage this sort of honest discussion.

Of course, since the debrief video was cut short, it's entirely possible this team did eventually address all of these points. I simply bring them up to encourage you to remember them when you debrief!

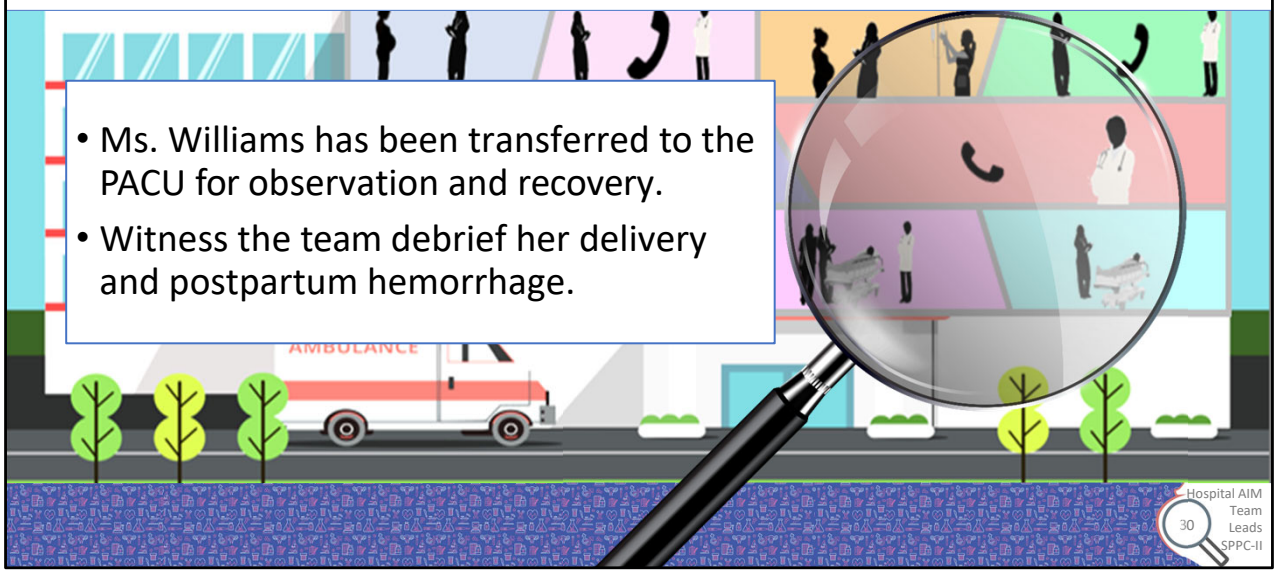


SCRIPT
Get into groups of three to five people. Recall the case scenario from the introduction module and all the events that unfolded. Conduct a 5-minute debrief.

As you go through this exercise, remember to consider positive behaviors or events in addition to the negatives. Try to be all-inclusive—get everyone talking. Remember, it's OK to share feelings about the events. Don't finger-point; instead, make sure that communication is open, transparent, and interactive.

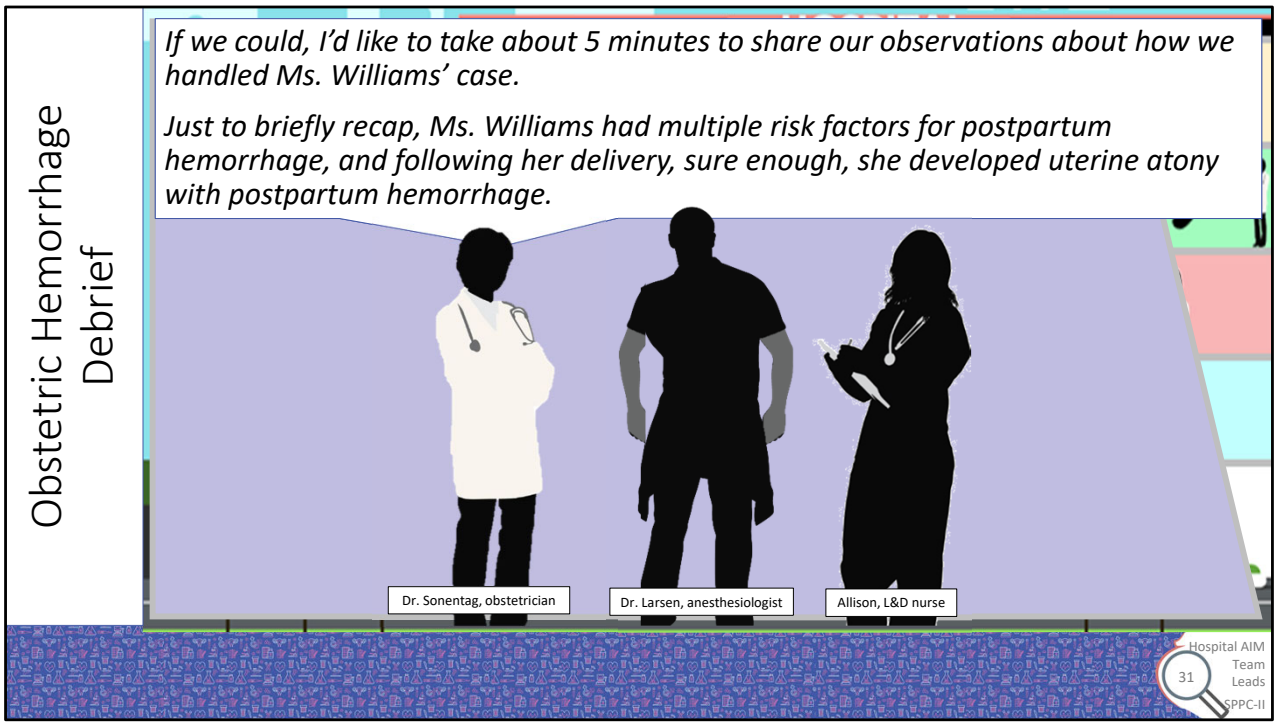
Make sure to spend some time talking about how to apply any lessons learned into practice for future patient care.

Obstetric Hemorrhage Debrief



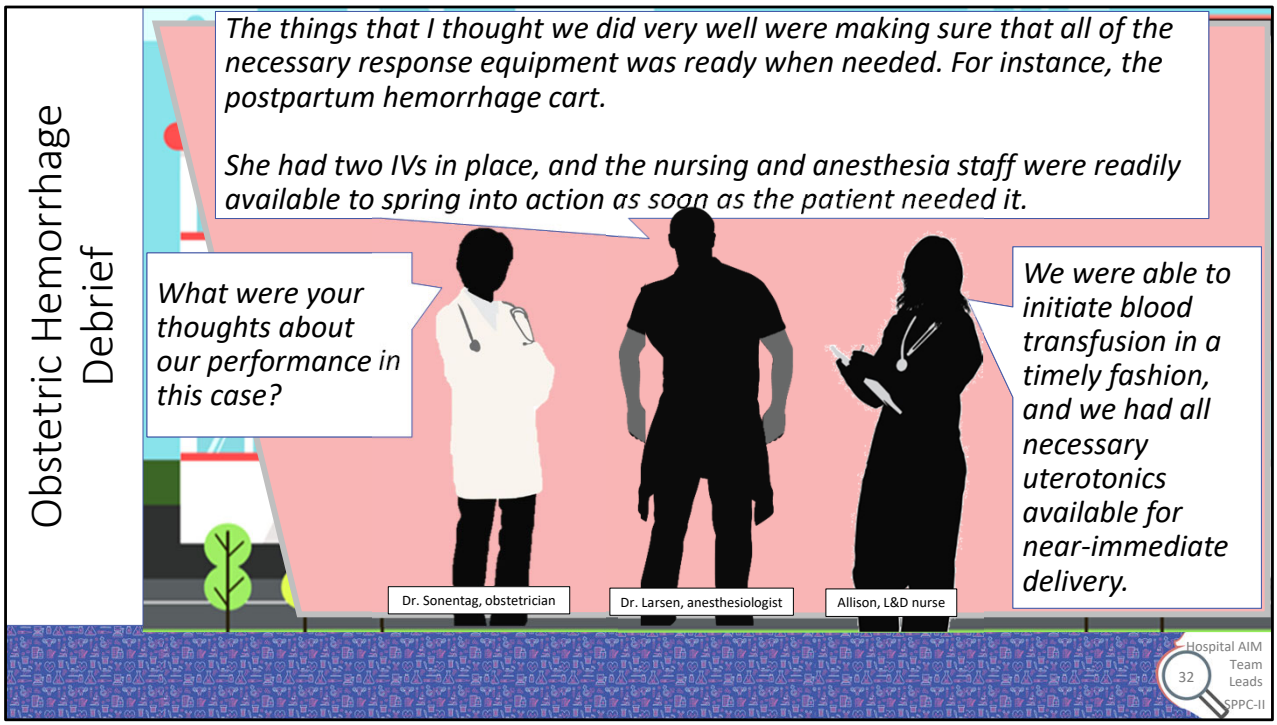
SCRIPT

Recall that the postpartum hemorrhage master scenario presented in Module 1 ended with Ms. Williams being cleaned, returned to the supine position, transferred to the stretcher, and transferred to the PACU for additional observation and recovery. The events that transpired during Ms. Williams' delivery and postpartum care definitely warrant a debrief. Following patient transfer, the delivery team including anesthesia, assembles for a debrief of the delivery…



SCRIPT

The team lead, Dr. Sonentag, begins on a positive note, "If we could, I'd like to take about 5 minutes to share our observations about how we handled Ms. Williams' case. Just to briefly recap, Ms. Williams had multiple risk factors for postpartum hemorrhage, and following her delivery, sure enough, she developed uterine atony with postpartum hemorrhage."



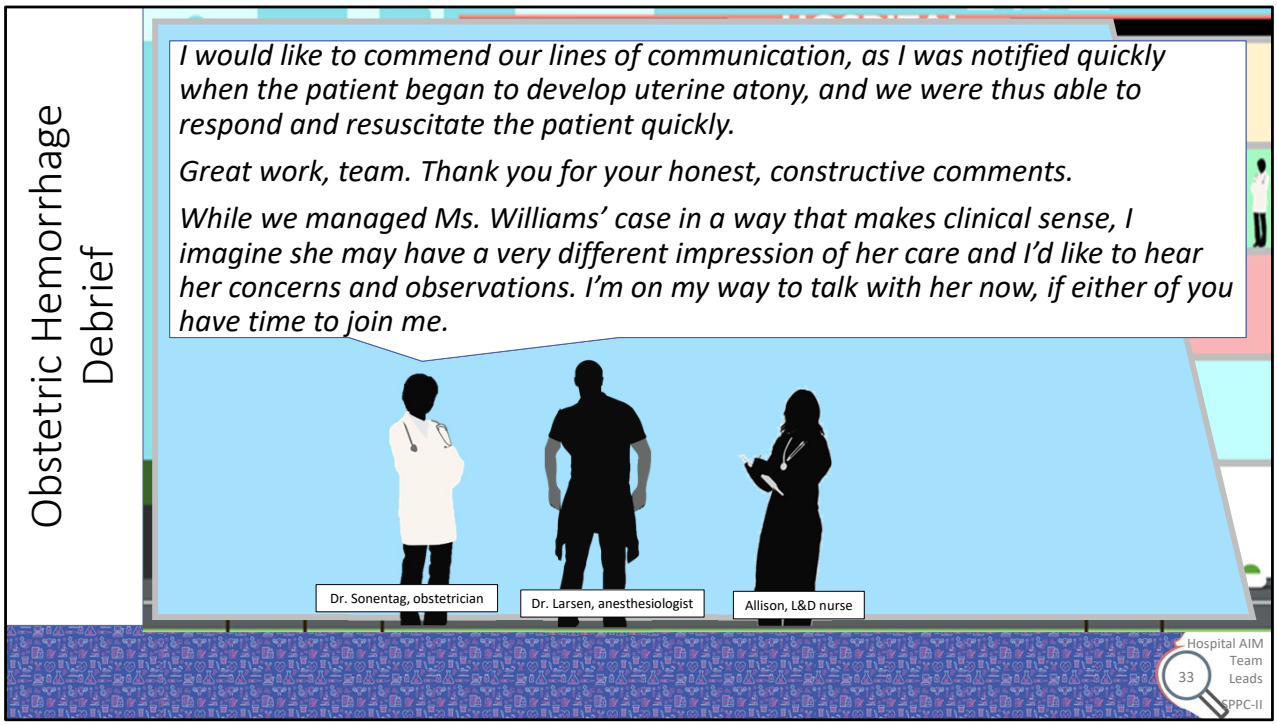
SCRIPT

Different team members should be encouraged to participate and contribute their thoughts and feelings about their experiences. Each team member has a unique perspective, and everyone can learn from one another.

Dr. Sonentag prompts discussion by asking, “What were your thoughts about our performance in this case?”

Dr. Larsen, the anesthesiologist, shares that the things he thought they did very well “were making sure that all of the necessary response equipment was ready when needed.”

Allison, the bedside nurse involved with the case, was pleased the team was “able to initiate blood transfusion in a timely fashion and had all necessary uterotonic available for near-immediate delivery.”



SCRIPT

Debriefs should occur following all clinical events. It enables a full-circle communication and provides an opportunity for feedback from the team for future improvement.

To wrap up the debrief, Dr. Sonentag thanks his teammates for their good work and honest, constructive comments. He offers his own insights last, suggesting that he wants to check in with Ms. Williams and gain her perspective on the delivery, reinforcing the idea of the patient as a team member. He acknowledges that Ms. Williams may have a different impression of her care. Although it may not be entirely appropriate to include the patient in formal team debriefs so that staff can feel that they can speak freely, it is wise to talk with your patients about how they perceived their care. They may provide novel insights or at least a different but important perspective.

Related, though beyond the scope of this module and toolkit, is the important issue of providing support and resources to patients and clinicians after a traumatic event. Additional information about partnering with patients and families can be found on the resources page at the end of this module.

Summary

- Situation Monitoring is critical to establishing individual and shared awareness of the patient, clinical environment, and other teammates
- Three tools for sharing independent situational awareness:
  - Briefs
  - Huddles
  - Debriefs

SCRIPT
Situation monitoring is critical to establishing individual and shared awareness about the patient, other teammates and colleagues, and the clinical environment at large.

Three tools for helping teams share independently held information in service to establishing a shared awareness of the situation and creating a common understanding of expectations include briefs, huddles, and debriefs. Each of these team meetings are respectively held before, during, and after events. They allow teams to prepare for care, pivot as the situation changes, and learn from the experience to improve performance for the next case.

Resources

Institute of Medicine. Partnering with patients to drive shared decisions, better value, and care improvement. 2013. https://nap.nationalacademies.org/read/18397/chapter/1. Accessed July 8, 2019.

Agency for Healthcare Research and Quality. Engaging Patients and Families in Their Health Care. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/patient-safety/patients-families/index.html. Accessed July 8, 2019.

Agency for Healthcare Research and Quality. Patient and Family Engagement in Primary Care. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/patient-safety/reports/engage/casestudies.html. Accessed July 8, 2019.

SCRIPT

For additional information about partnering with patients and families, you might reference the resources listed on the slide.

Acknowledgments

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