NH AIM/ERASE Monthly Webinar

May 8, 2025
Welcome!

- We will begin shortly
- Reminder, we will be recording this session
- Your line will be muted upon entering. Please enter comments or questions in the chat
- Maggie Coleman & Emily Brayton will monitor the chat box and call on you to unmute yourself
- If you have trouble connecting, please email **Margaret.A.Coleman@hitchcock.org**

To Receive CME/CNE Credit for Today's Session
Text: 833-884-3375
Enter Activity Code: 148180
Need help? **clpd.support@hitchcock.org**
The above CE information is ONLY for live attendance. CE will be available for later viewing via a link shared after the webinar.

REMINDERS:
Please feel free to share the recording with colleagues and those you feel would benefit if they are unable to attend @ **www.NNEPQIN.org:** Educational Offerings | NNEPQIN

We HIGHLY value your input. Please be sure to **complete the evaluation** that Maggie Coleman will send to you immediately following the webinar. It takes less than 5 minutes to complete.

Team debrief after an unexpected event: Supporting team and patient well-being

Today's Agenda

- AIM Bundle Updates:
  - Maddie Bridge and Maggie Coleman
- Team debrief after an unexpected event: Supporting team and patient well-being
  - Ella Damiano MD, Assistant Professor of Obstetrics and Gynecology, Geisel School of Medicine, Dartmouth Health
  - Joel Bradley MD, Clinical Assistant Professor of Pediatrics, Geisel School of Medicine, Dartmouth Health
- Q&A
- Announcements
- Please note: Today's speakers have nothing to disclose.

NH PQC

This presentation is applicable to all pregnant and parenting patients.

A quality improvement initiative to support best practices that make birth safer, improve maternal health outcomes and save lives.

CDC works with MMRCs to improve review processes that inform recommendations for preventing future deaths.

https://saferbirth.org/

https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/index.html

Critical Collaborations: NNEPQIN/NHPQC, ERASE and AIM

Alliance for Innovation on Maternal Health moves established guidelines into practice with a standard approach to improve safety in care

Perinatal Quality Collaboratives mobilize state or multi-state networks to implement clinical quality improvement efforts and improve care for mothers and babies

Maternal Mortality Review Committees conduct detailed reviews for complete and comprehensive data on maternal deaths to prioritize statewide prevention efforts

Created from a Centers for Disease Control, Division of Reproductive Health source

AIM Bundle Updates

Perinatal Mental Health Conditions

Rebecca Casey, APRN – Case Consultation and Education Opportunities for all AIM Participants

- **Weekly open office hours on Mondays from 12:45-1:45pm virtually**.
  - Bring specific case management questions (no PHI), typical challenges, or come hear what other sites are encountering.
  - Changing to Tuesdays from Noon-1PM starting June 10
- **Becca is also able to hold tailored lunch and learn, education, and discussion sessions for your team**.
  - Postpartum depression, psychosis, and medication management, "What do I do when Zoloft fails?"

Rebecca Casey, APRN – Case Consultation and Education Opportunities for all AIM Participants

- **May 19, 2025** special session on PTSD Trauma Informed Care with Q&A opportunity. Please join through weekly open office hour Webex link.

Please contact Maddie Bridge at Madalynne.M.Bridge@hitchcock.org if you would be interested in scheduling a tailored learning session or want the office hours Webex calendar invite!

"TOXIC" Film Screening for Respectful and Equitable Care Education Measure

- "TOXIC" is a short film (~25 minutes) about a day-in-the-life of a pregnant Black woman, and the racism and injustices that she faces.
- We can provide film screenings for your team with a facilitated group discussion (CE is available)
- Click HERE for the film website and trailer
- "The facilitated discussion after the film was enlightening and respectful." – Recent participant

Please contact Maddie Bridge at Madalynne.M.Bridge@hitchcock.org if you are interested in scheduling a session for your group.

June QA – PMHC Outcome Measure

- **Timeframe**: June 1, 2025 – June 14, 2025
- **Instructions**: Keep track of how many PMHC patients deliver on your unit, and how many of those patients were referred to/received treatment
- **Resources**: review the June or December 2024 QA webinars for information on improving the accuracy of this data

Please contact Maddie Bridge at Madalynne.M.Bridge@hitchcock.org or Maggie Coleman at Margaret.A.Coleman@hitchcock.org with any questions.

June Webinar – Call for Content!

- Thursday June 19, 2025 from Noon-1PM
- **Strategy showcase: QI implementation successes at New Hampshire birthing hospitals**
- Create 1-2 slides and speak for ~5 minutes about a successful project or strategy from your hospital related to the AIM Patient Safety Bundles

Please contact Maddie Bridge at Madalynne.M.Bridge@hitchcock.org and Maggie Coleman at Margaret.A.Coleman@hitchcock.org if you would like to present!

PMHC Bundle Measure: Debriefs

Metric	Name	Description	Notes
ALL S1*	Patient Event Debriefs	**Rate progress (1, not yet started – 5, fully in place) towards putting and keeping the structure measure fully in place.** Has your department established a **standardized process to conduct debriefs with patients** after a severe event?	• Include patient support networks during patient event debriefs, as requested. • Severe events may include **the The Joint Commission sentinel event definition**, severe maternal morbidity, or fetal death. • This measure is not intended to represent a disclosure conversation but rather reflects a standard part of care that is a discussion between the patient and their care team

Ella Damiano MD, Assistant Professor of Obstetrics and Gynecology, Geisel School of Medicine, Dartmouth Health

Joel Bradley MD, Clinical Assistant Professor of Pediatrics, Geisel School of Medicine, Dartmouth Health

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DEBRIEFING AFTER AN UNEXPECTED EVENT: SUPPORTING TEAM AND PATIENT WELL-BEING

AIM/ERASE MM Webinar
May 8th 2025

Ella Damiano, MD
Joel Bradley, MD

Dartmouth Health

Objectives

1) Discuss when multidisciplinary team debriefs should occur.
2) Apply the “hot debrief” model to an obstetric unit.
3) Demonstrate best practices for event disclosure and debriefing with the patient.

INFORMAL POLL OF EXPERIENCES TO DATE

- Have you been part of a great debriefing?
- Have you discussed an unexpected event with a patient as a team? Do you have a method?
- Have you personally sought support after a difficult event from a peer or team member?

HIGH LEVEL GOALS FOR HEALTH CARE DELIVERY

Quintuple Aim

National Academy of Medicine

- ✓ Safe
- ✓ Effective
- ✓ Patient-centered
- ✓ Timely
- ✓ Efficient
- ✓ Equitable

Co-production

IS EMOTIONAL SAFETY ALSO PATIENT SAFETY?

EDITORIAL

Emotional safety *is* patient safety

Audrey Lyndon [1], Dána-Ain Davis,[2] Anjana E Sharma [3], Karen A Scott [4]

A growing body of research on patients' and families' understanding and conceptualisation of patient safety[1 2] begs the question of how and why we, in healthcare and the field of patient safety and quality, conceptualise patient safety as a domain separate from patient-centredness and patient experience.[3] In this issue, as patients, as loved ones and as caregivers of people receiving medical treatment who have experienced disrespect, dismissal, medical racism,[8] near-misses and patient harm. However, we argue that limiting the conceptualisation of the patient's perspective on safety as 'feeling safe' while maintaining a distinction between 'feeling

Lyndon et al BMJ QS 2023

HOW CAN WE RESPOND EQUITABLY TO SAFETY EVENTS, LEARN, AND CONTRIBUTE TO BETTER CARE?

WHAT IS THE PROCESS?

A SIMPLE MAP TO FOLLOW WHEN THINGS GO WRONG

Bringing the clinical team together after events: Our Journey to the "Hot Debrief"

- Immediate debrief (versus "cold debrief")
- Communication challenges
- Mixed message to the patient and family
  - Provider vs. RN
  - OB vs. Pediatrics
- Hospital-wide focus by multidisciplinary physician quality group

Benefits of Hot Debriefing

Four essential elements

- Active self-learning
- Improvement intent
- Specific events
- Multiple information sources

Human Factors
Volume 55, Issue 1, February 2013, Pages 231-245
© 2012, Human Factors and Ergonomics Society, Article Reuse Guidelines
https://doi.org/10.1177/0018720812448394

SAGE journals

Training, Education, Instructional Systems

Do Team and Individual Debriefs Enhance Performance? A Meta-Analysis

Scott I. Tannenbaum and Christopher P. Cerasoli

Improved team performance by 20-25%

- Measured by a variety of methods (i.e. simulation outcomes, hospital records, self-ratings, subject matter expert ratings)

What type of events to include?

Advances in Simulation
BMC

Adv Simul (Lond). 2021 Mar 29;6:9. doi: 10.1186/s41077-021-00163-3

Debrief it all: a tool for inclusion of Safety-II

Suzanne K Bentley [1,2,3], Shannon McNamara [4], Michael Meguerdichian [3,5], Katie Walker [3], Mary Patterson [6,7], Komal Bajaj [3,8]

- Past emphasis on “bad” outcomes
- Shift focus to examples of positive team collaboration, near misses
- “capture valuable discussion…such as capacities, adjustments, variation, and adaptation for successful operations in a complex system”
- Allow our team to decide on which cases to debrief

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Obstetric Team Debriefing Form

Remember: Debriefing is meant to be a learning experience and a way to address both human factors and systems issues to improve the response for next time. There is to be no blaming/finger-pointing.

Type of event: _____ **Date of event:** _____

Location of event: _____

Members of team present: (check all that apply)

- ☐ Primary RN
- ☐ Primary MD
- ☐ Charge RN
- ☐ Resident(s)
- ☐ Anesthesia personnel
- ☐ Neonatology personnel
- ☐ MFM leader
- ☐ Patient Safety Officer
- ☐ Nurse Manager
- ☐ OB/Surgical tech
- ☐ Unit Clerk
- ☐ Other RNs

Thinking about how the obstetric emergency was managed,

Identify what went well: (Check if yes)

- ☐ Communication
- ☐ Role clarity (leader/supporting roles identified and assigned)
- ☐ Teamwork
- ☐ Situational awareness
- ☐ Decision-making
- ☐ Other: _____

Identify opportunities for improvement: "human factors" (Check if yes)

- ☐ Communication
- ☐ Role clarity (leader/supporting roles identified and assigned)
- ☐ Teamwork
- ☐ Situational awareness
- ☐ Decision-making
- ☐ Other: _____

Identify opportunities for improvement: "systems issue" (Check if yes)

- ☐ Equipment
- ☐ Medication
- ☐ Blood product availability
- ☐ Inadequate support (in unit or other areas of the hospital)
- ☐ Delays in transporting the patient (within hospital or to another facility)
- ☐ Other: _____

Safe Motherhood Initiative

ACOG

Revised March 2019

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Obstetric Team Debriefing Form

For identified issues, fill in table below

ISSUE	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE
	1	
	2	
	3	
	4	

Safe Motherhood Initiative

ACOG

Revised March 2019

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Our selected tool

- Consistence across the organization
- Primary outcome: staff satisfaction
- Secondary measures: outcomes and system improvements as a direct result of debriefs
- All STOP5 debriefs were rated “good” to “excellent” by staff who had participated in them (32% rated “excellent,” 38% “very good,” and 30% “good”)
- Ninety-eight percent of respondents believed that they should do more debriefs

STOP5: a hot debrief model for resuscitation cases in the emergency department

Craig Andrew Walker[1,2], Laura McGregor[3], Cameron Taylor[1], Sara Robinson[1]

[1]Emergency Department, Royal Infirmary of Edinburgh, Edinburgh, United Kingdom
[2]Critical Care Department, St John’s Hospital, Livingston, United Kingdom
[3]Scottish Centre for Simulation and Clinical Human Factors, Forth Valley Royal Hospital, Forth Valley, United Kingdom

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Obstetric Hot Debriefing Tool

Hot Debrief Tool: STOP

Facilitator: Thank the full team and ask “Is everyone okay?”

If yes, then continue as below and state first:

- We are going to have a short team debrief.
- Purpose is to improve quality of patient care; it is not to assign blame.
- Your participation is welcomed but not mandatory.
- All information discussed during this debrief is quality protected and confidential.

Track our debriefs here!

S Summarize the case

T Things that went well

O Opportunities to improve

P Points for further action and follow-up

Walker CA, McGregor L, Taylor C, Robinson S. STOP5: a hot debrief model for resuscitation cases in the emergency department. Clin Exp Emerg Med. 2020 Dec;7(4):259-266.

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Outcomes / Opportunities

- Optional paper record keeping
- Email to quality lead or medical director

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Obstetric Hot Debriefing Tool

Date: _____ **MRN:** _____

Attendees:

_____

_____

Hot Debrief Tooling: STOP

Facilitator: Thank the full team and ask "Is everyone okay?"

If yes, then continue as below and state first:

- We are going to have a short team debrief.
- Purpose is to improve quality of patient care; it is not to assign blame.
- Your participation is welcomed but not mandatory.
- All information discussed during this debrief is quality protected and confidential.

S Summarize the case

T Things that went well

O Opportunities to improve

P Points for further action and follow-up

Notes

Is follow-up debrief required?

☐ Yes ☐ No

Adapted from Edinburgh Emergency Medicine STOP5.

Walker CA, McGregor L, Taylor C, Robinson S. STOP5: a hot debrief model for resuscitation cases in the emergency department. Clin Exp Emerg Med. 2020 Dec;7(4):259-266. doi: 10.15441/ceem.19.086. Epub 2020 Dec 31. PMID: 33440103; PMCID: PMC7808839.

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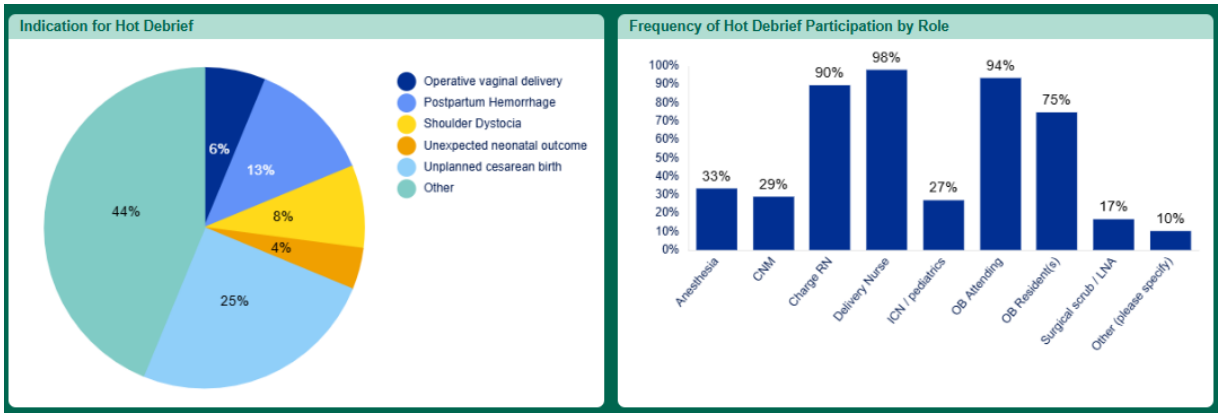
Education

- Grand Rounds
- Charge Nurse meeting
- Provider meetings
- Launched the pilot!

Pilot Data from 29 Hot Debriefs



Feedback from Staff - Strengths

- Reconciliation
  - "Hopefully allows people to **leave concerns at work** instead of going home and thinking about them"
  - "great for team cohesiveness and closure"
  - "allows team members to give each other praise for a **job well done**"
- Perspective sharing
  - "You understand what happens on the BP side of things prior to getting the infant"
  - "Great time for teams to understand each other's needs and concerns
- Timeliness
  - "timely review, often **won't be able to get the same team back together** on a different shift"

Feedback from Staff - Opportunities

- Shared leadership
  - "Seems like provider is typically always leading debrief. Think we should figure out a way to diversify this"
- Competing demands on time
  - "so hard to assemble the whole team - like herding cats"
  - "Hard to step away from stabilizing baby if baby is very sick to go do the debrief"
  - "It is often difficult for the ICN team to do a hot debrief soon after the event has happened because the team involved is usually pretty involved in patient care. Coordinating with the ICN team about timing is helpful."
- Follow-up Management
  - Lack of clarity on follow-up of opportunities (email vs. paper)

YOU'VE DEBRIEFED AS A TEAM. WHAT HAPPENS NEXT?

A SIMPLE MAP TO FOLLOW WHEN THINGS GO WRONG

Identify and name → Debrief, Analyze and Report → Communicate with the patient and family → Improve → Reflect → Heal

BUT WHO IS RESPONSIBLE FOR DOING THE TALKING?

Disclosing Errors to Patients: Perspectives of Registered Nurses

Sarah E. Shannon, Ph.D., R.N · Mary Beth Foglia, Ph.D., M.N., M.A., R.N. · Mary Hardy, M.A., R.N. · Thomas H. Gallagher, M.D.

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Article-at-a-Glance

Background

Disclosure of medical errors has been conceptualized as occurring primarily in the physician-patient dyad. Yet, health care is delivered by interprofessional teams, in which nurses share in the culpability for errors, and hence, in responsibility for disclosure. This study explored nurses' perspectives on disclosure of errors to patients and the organizational factors that influence disclosure.

"Nurses conceived of the disclosure process as a team event occurring in the context of a complex health care system rather than as a physician-patient conversation. Nurses felt excluded from these discussions, resulting in their use of ethically questionable communication strategies. The findings underscore the need for organizations to adopt a team disclosure process. Health care organizations that integrate the entire health care team into the disclosure process will likely improve the quality of error disclosure."

Shannon et al *Jt Comm J Qual Saf* 2009

OB-SPECIFIC STATEMENT ON THE ETHICS OF DISCLOSURE

- ANA Code of Ethics (2025)
- ACOG (2019)

Provision 3

PROVISION 3:

The nurse establishes a trusting relationship and advocates for the rights, health, and safety of recipient(s) of nursing care.

3.3 Responsibility in Promoting a Culture of Safety

Nurses participate in the development of, implementation of, review of, and adherence to policies that promote patient health and safety, reduce errors, and establish and sustain a culture of safety. When errors or near misses occur, nurses immediately assess the patient and report events to the appropriate authority, according to professional and/or institutional guidelines. Communication should start at the level closest to the event and should proceed to a responsive level as the situation warrants. Respect for persons requires responsible disclosure of errors to patients.

- **Who**—The attending physician should lead the discussion. If the physician cannot be present, it is preferable to have a senior member of the health care team lead the discussion. The circumstances of the adverse event often will dictate what other members of the health care team also must be present. Whenever possible, at least two members of the health care team should be involved in any discussion of an adverse event with the patient and her family.
- **What**—Only factual information must be communicated to the patient. Patients must be reassured that as additional, reliable information is obtained, they will be notified promptly.
- **When**—Even if all details of the incident are not known, disclosure must be timely. Disclosure should occur as soon as reasonably possible, while emphasizing to patients that it is an ongoing process of communication.
- **Where**—Disclosure should occur in a quiet and confidential setting that will be most comfortable to the patient.
- **How**—Patient dignity must always be respected. A disclosure conversation should include empathy for what patients and their families have experienced.

DESCRIBE AN APPROACH TO GATHERING INTERPROFESSIONAL PERSPECTIVES ON THE EVENT

Who understands the process of care?

What is the story that is SHARED across the team?

"One view is no views"

"Apology is about meeting the needs of the person who has been hurt."
(Lazare A On Apology 2005)

Two types of apology: empathetic and accountable (both are needed in clinical practice)

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An example of apology after an unexpected outcome

- **Acknowledgement**
  - I know that you were hoping for a vaginal delivery. Unfortunately, we needed to do a cesarean because the cervix stopped dilating despite our best efforts to progress your labor.
  - How has this experience been for you?
- **Explanation**
  - As you know, your cervix stopped dilating at 7cm. We gave extra medication through the IV called oxytocin to increase the contraction strength. Despite this medication, the labor did not progress.
- **Remorse / Empathy**
  - I am so sorry this happened to you. When you are ready, I'd like to know what questions you have.
- **Reconciliation**
  - First, I want to assure you that you will continue to receive the best possible care going forward.
  - We do analyze every case in which we did an unplanned cesarean to help decrease their use in the future.
  - What are your questions? Is there anything else that we can help you with during your recovery?

Fischer and Frankel *J Gen Int Med* 2020
Lazare A. Apology in Medical Practice. *JAMA*. 2006

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Communication to the patient: How should it be done?

Alberta Health resources

- Early Disclosure: When Care is Reasonable.

Four part model

Acknowledgment

Explanation

Remorse / Empathy

Reconciliation

Harm is rarely limited to the patient

A second victim is defined as: "Any health care worker, directly or indirectly involved in an unanticipated adverse patient event, unintentional healthcare error, or patient injury, and who becomes victimized in the sense that they are also negatively impacted."

VanHaecht K et al *Int J Env Res Public Health* 2022

*Clinicians may experience a wide variety of psychological and physical symptoms for days, weeks, or months.

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Discussion

Next Month:

- The next NH AIM/ERASE Monthly Webinar will be Thursday June 19, 2025 at noon.
- **Strategy showcase: QI implementation successes at New Hampshire birthing hospitals**

Announcements

- Evidence to Practice: Eat, Sleep, Console webinar presented by the Vermont Oxford Network on Wednesday May 14 from 12-1pm. Register HERE
- NH Breastfeeding Taskforce – Annual Breastfeeding Conference on June 9, 2025 from 7:30am-4:30pm. Virtual and in-person options available. Registration is open on EventBrite, click HERE
- Spring NNEPQIN Virtual Conference – Thursday June 12, 2025, registration details click HERE.

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Important Links

- Becca Casey Monday Open Office Hours (12:45-1:45pm) Webex Link HERE

Acknowledgements

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