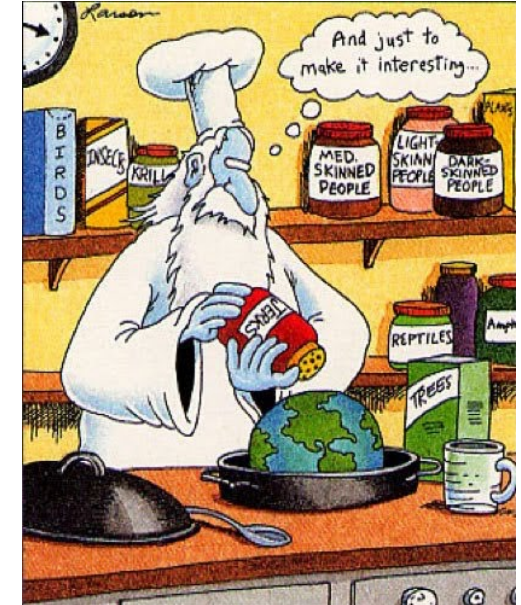
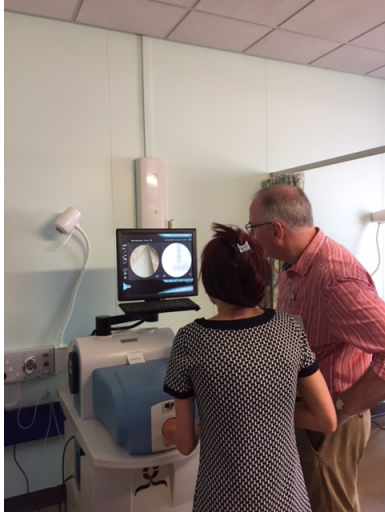


Using Debriefing to Influence QI



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Aim of the Session



Group Discussion



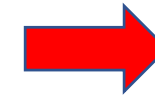
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Quality improvement made simple

What everyone should know about health care quality improvement

The conception of improvement finally reached as a result of the review was to define improvement as better patient experience and outcomes achieved through changing provider behaviour and organisation through using a systematic change method and strategies.¹

Dr John Øvretveit



The dimensions of quality

Safe

Avoiding harm to patients from care that is intended to help them.

Timely

Reducing waits and sometimes harmful delays.

Effective

Providing services based on evidence and which produce a clear benefit.

Efficient

Avoiding waste.

Person-centred

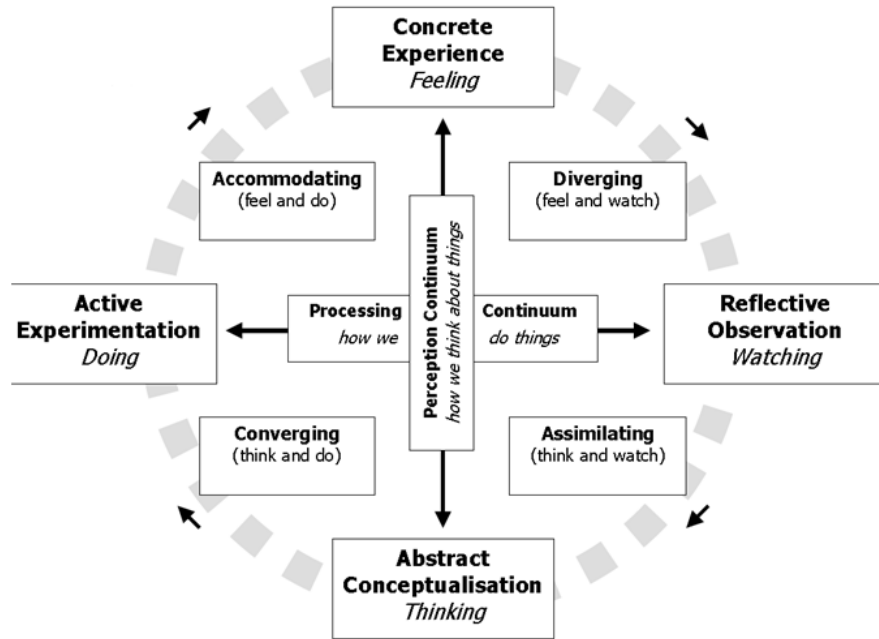
Establishing a partnership between practitioners and patients to ensure care respects patients' needs and preferences.

Equitable

Providing care that does not vary in quality because of a person's characteristics.

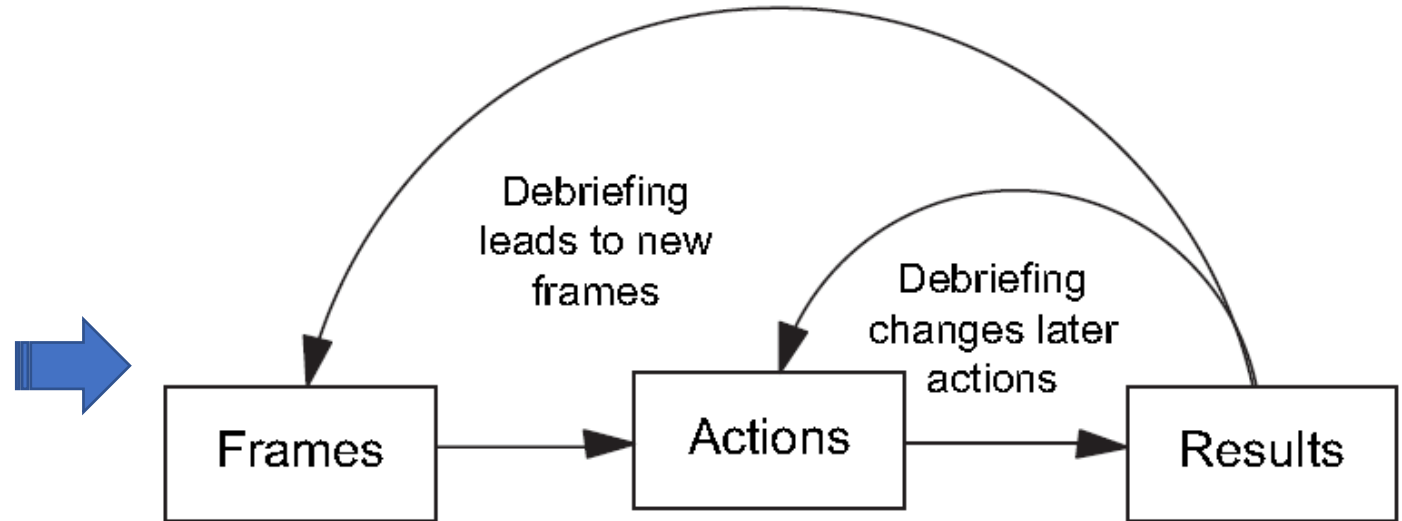
Educational Philosophy - Adult Learning

'Debriefing with good judgement'



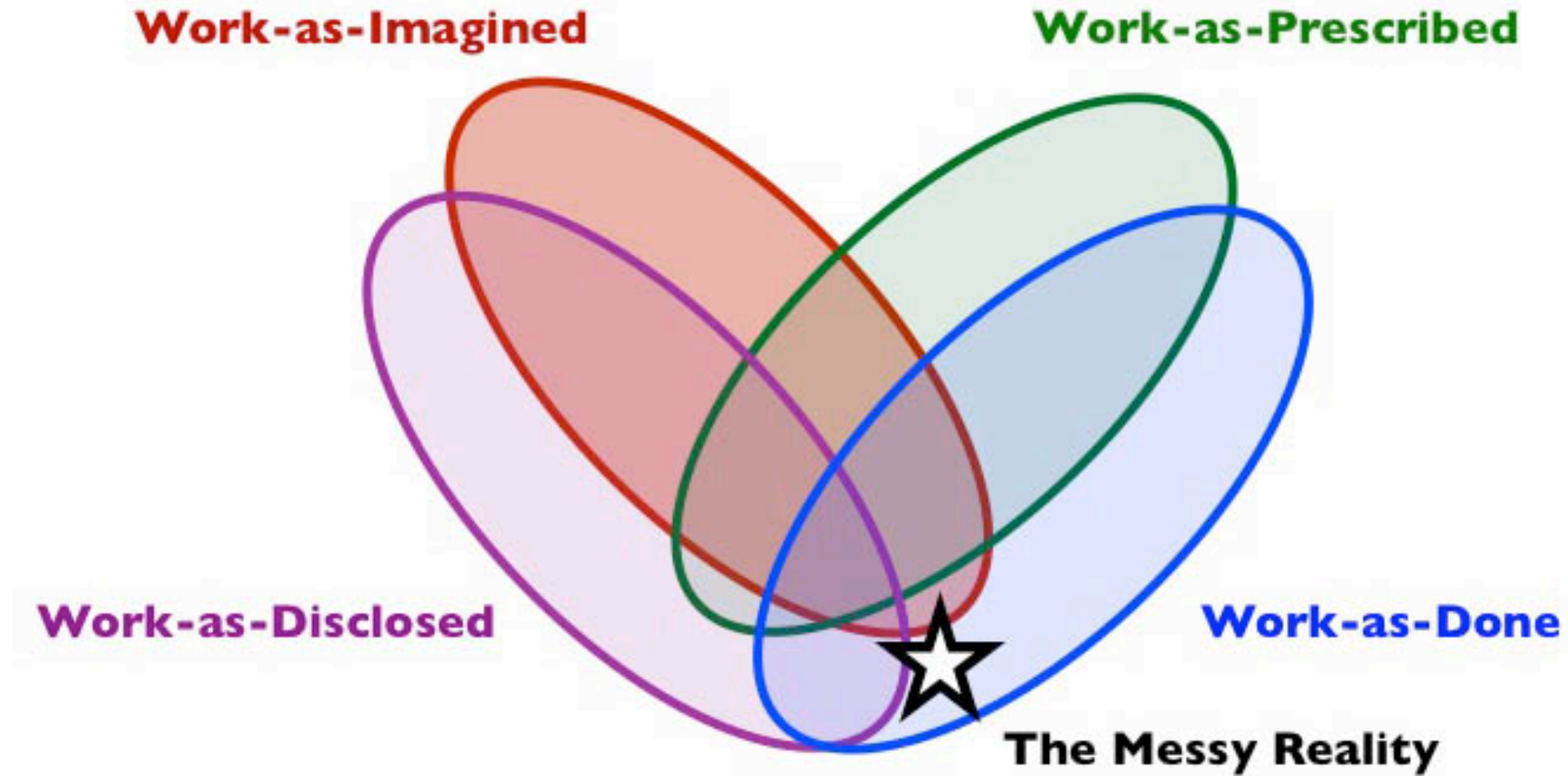
© concept david kolb, adaptation and design alan chapman 2005-06, based on [kolb's learning styles](#), 1984

Kolb, 1984



Rudolph et al, 2007

Human performance within care 'systems'





Psychological
Safe space

The image shows a medical simulation environment. In the center, a medical mannequin with a realistic face and closed eyes lies in a hospital bed. The mannequin is wearing a white hospital gown with a small pattern and has several thin wires attached to its chest. The bed has a yellow pillow and a blue blanket. To the left, a woman with dark hair, wearing a dark patterned top and a red stethoscope, is looking towards the mannequin. To the right, another woman with dark hair, wearing a blue medical scrub top, is also looking towards the mannequin. The background includes a window with horizontal blinds and some medical equipment.

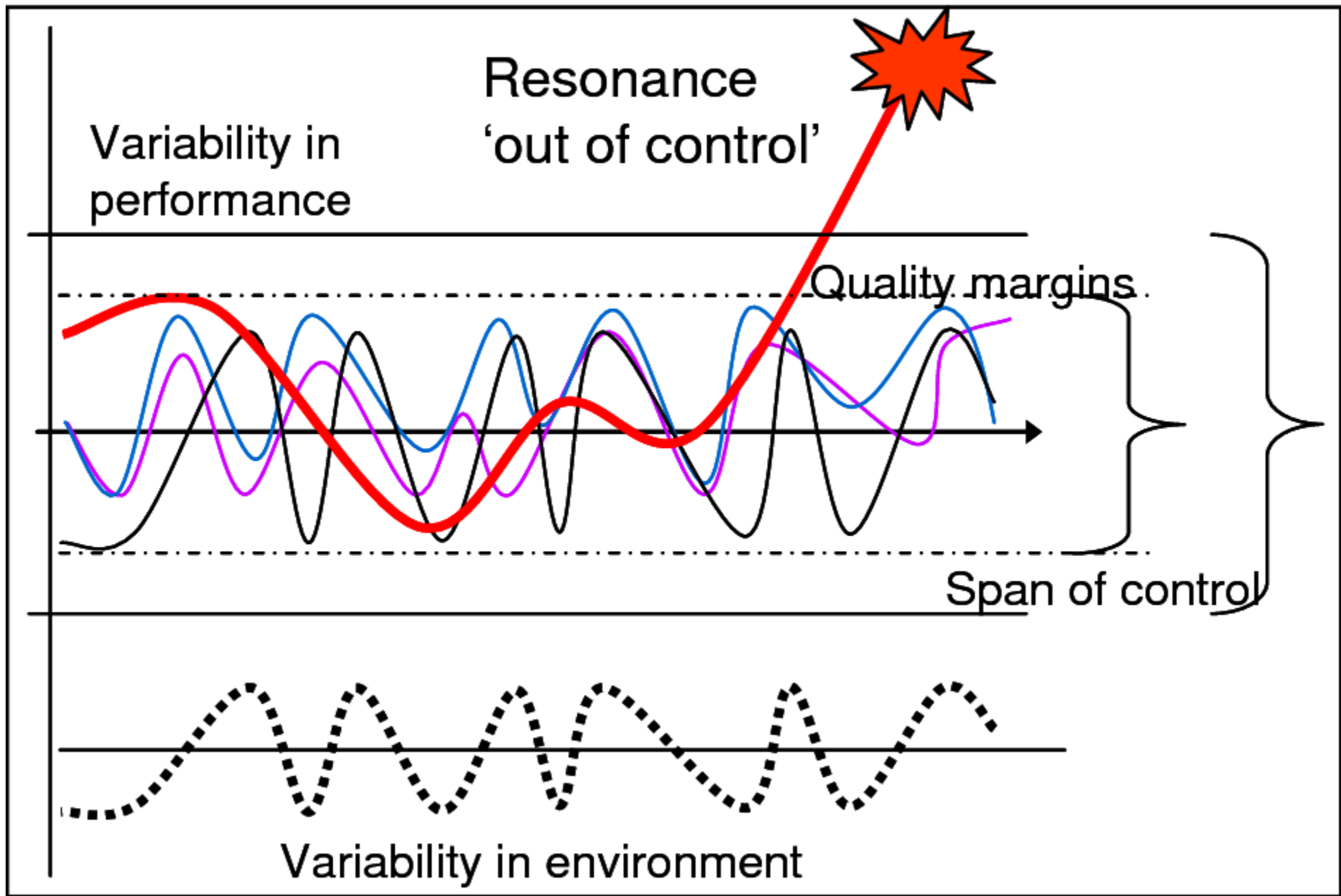
Experiential
learning
(supervised)

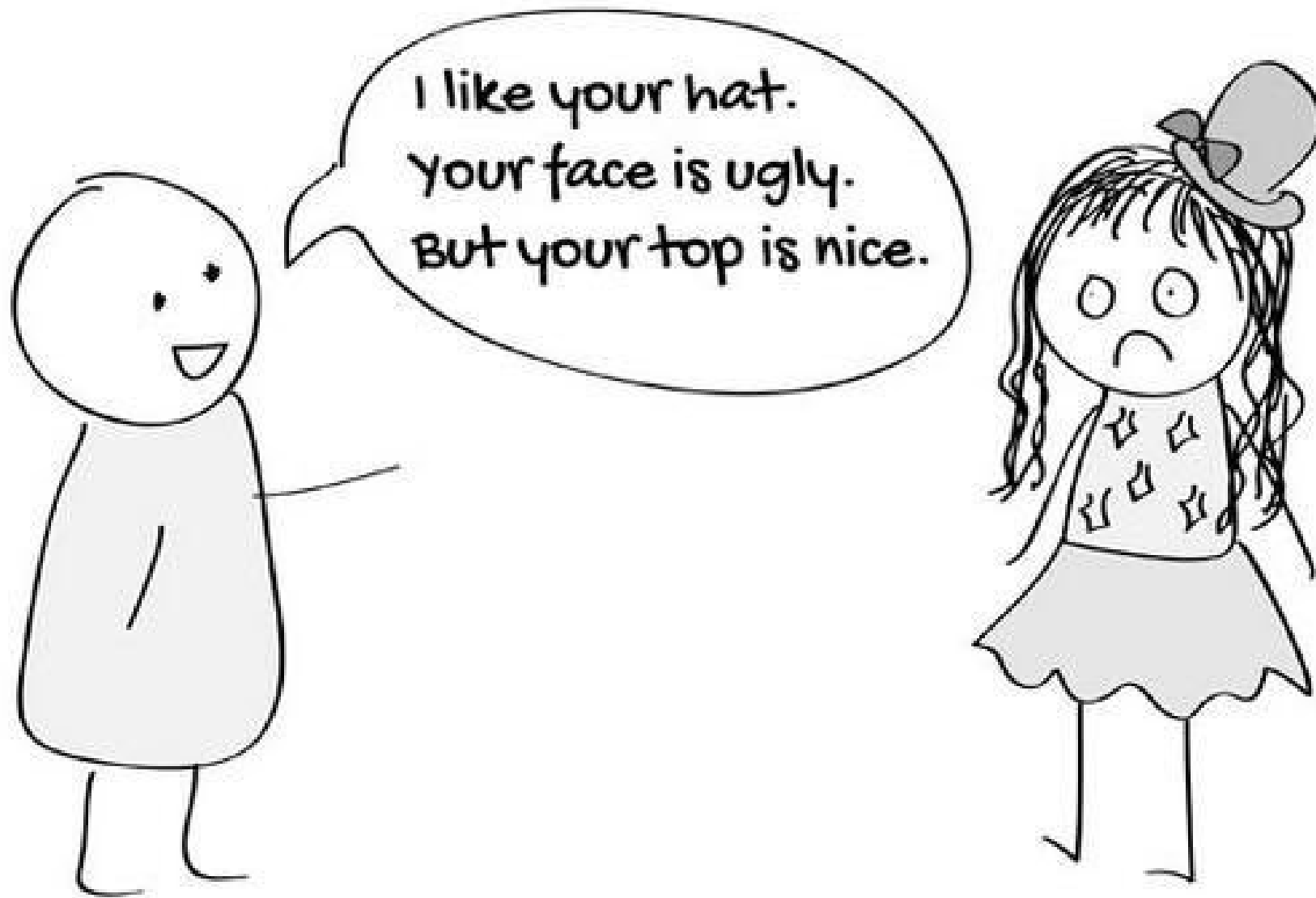
Intrinsic &
extrinsic
motivation

	Debriefing with good judgement
The effective debriefer	Creates a context for learning (& change)
Primary focus of the debrief	Internal – meanings & assumptions of both debriefer & trainee
How the trainee is seen	A meaning maker whose actions are consequential to specific assumptions and knowledge
Who has the truth of the situation?	Possibly neither, either or both
Who does not understand?	The debriefer; I see what you are doing or not doing and from my perspective, I don't get it or from my view it seems problematic, what am I missing here. Genuine report of puzzlement and inquiry into how the trainee's actions may make sense.

	Debriefing with good judgement
Basic stance towards the trainee	Respect for self (I have to take on what happened in this situation; that does lead me to think there were some problems but...)
	Respect for trainee (you are also a smart, well trained practitioner, trying to do the right thing, who has your own view on the situation) so...
	I am going to approach this as a genuine puzzle; not paralysis or indecision, but holding my own view tentatively. I seek clarity through honest inquiry (we both may learn something or change our minds); help me understand why you...?’
Typical message	‘I noticed X. I was concerned about that because Y. I wonder how you saw it?’

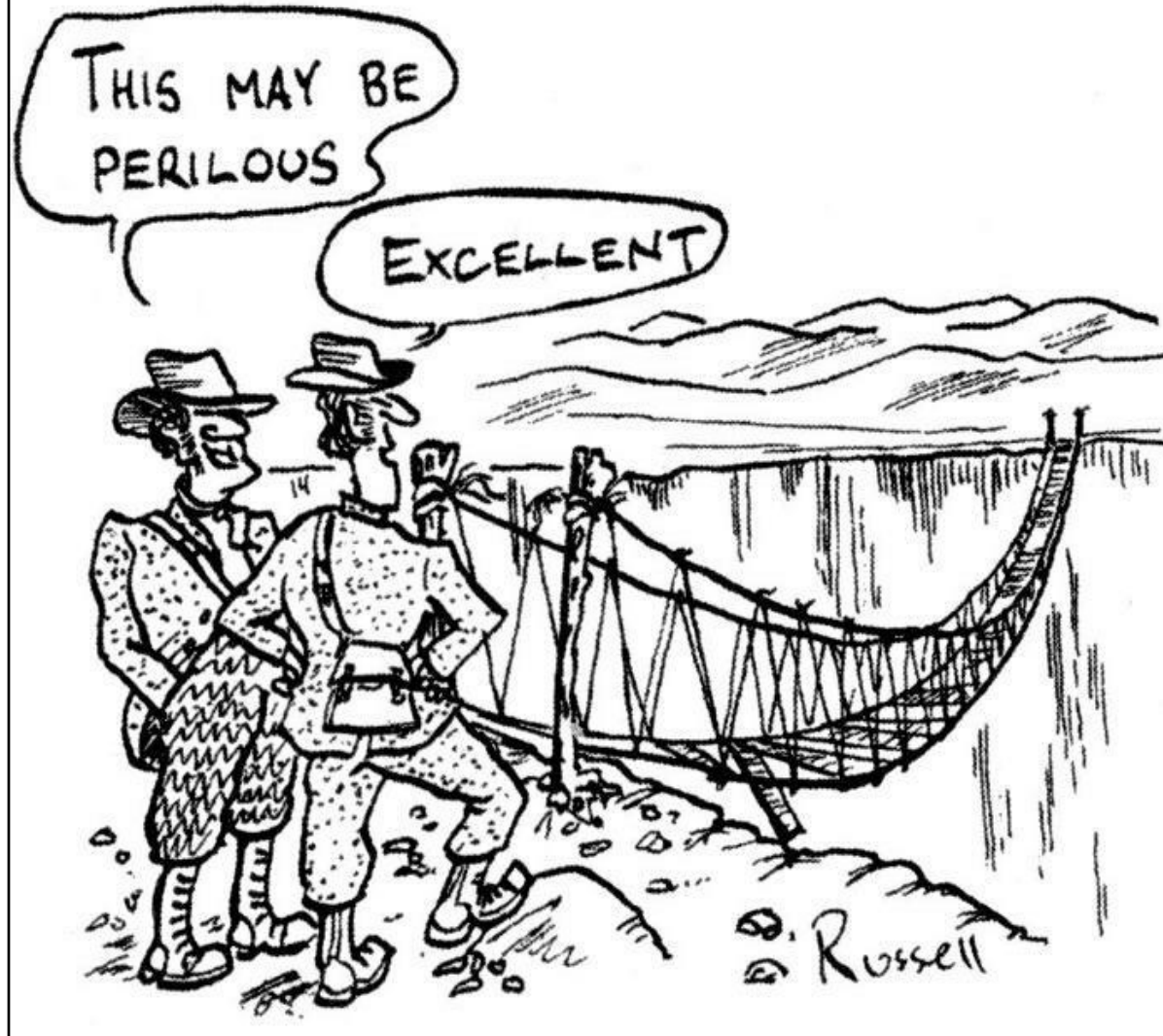
	Traditional Focus	Contemporary Focus
Definition of safety debriefing	Explore what went wrong	Explore what went right
Safety principle	Reactive, we respond when something happens, or is perceived as an unacceptable risk	Proactive, enable the participant(s) consider how they might anticipate and plan a strategy to improve performance
Explanations of error / harm	Slips, lapses, mistakes and violations are caused by failures & / or malfunctions. The purpose of the debrief is to enable the participant(s) to identify causes & contributory factors	Things basically happen in the same way, regardless of the outcome. The purpose of the debrief is to better understand how things usually go right as a basis for understanding and explaining how things occasionally go wrong.
Attitude to the 'human factor'	The participant(s) are predominantly seen as the mistake makers, a liability or a hazard – 'human error'	The participant(s) are seen as a resource that is necessary for safety, through system flexibility & resilience. Detailed exploration of 'work-as-done' offers powerful learning opportunities to both learners and facilitators.
Role of performance variability		





Keiko

Victorian risk assessment



Integrated safety / QI debriefing model

Constructivist, learner centered approach, embrace adult learning
(Kolb, Knowles)

Psychological and physical 'safe space', confidentiality (Maslow)

Cueing & probing / advocacy with inquiry / genuine confidentiality in
the learning conversation (Rudolph et al, Denning)

Structured debrief that explicitly includes key safety elements of
performance variability, from the perspective of the participant.
(Hollnagel, Shorrock)

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