Using the STOP5 Debriefing Model to Increase Utilization of Debriefing Practice in the Emergency Department: A Quality Improvement Project

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Using the STOP5 Debriefing Model to Increase Utilization of Debriefing Practice in the Emergency Department: A Quality Improvement Project Proposal

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Abstract

**Background:** The practice of debriefing has been an important process in critical care settings to promote team unity as well as best care practices. Literature has shown that debriefing can not only influence quality care and improved operations, but the process can also influence the emotional support staff receive. These implications are particularly important for nurses that work in critical care settings as the job can often be stressful and lead to moral distress as well as the need for evidence-based care practices is crucial when a patient’s life is on the line. Literature supports that any form of debriefing is better than no form of debriefing.

**Local Problem:** In a critical access Emergency Department, 100% of staff nurses that were evaluated reported experiencing multiple critical incidents in a three month span with none being formally debriefed. Staff nurses also expressed the desire to debrief critical incidents and improve communication as well as safety in the microsystem.

**Methods:** In this quality improvement project, personal interviews as well as the assessment with the Perceived Stress Scale were completed with Emergency Department staff nurses to assess the perceptions on debriefing and perceived stress levels in April 2024 and then again in June of 2024.

**Intervention:** Education on what debriefing is, the current guidelines for debriefing at the macrosystem, formal debriefing models such as STOP5, and the benefits of debriefing was provided at the June 2024 staff meeting to the attending Emergency Department staff. The microsystem was also supplied with the STOP5 debriefing model for encouragement of the use of the practice following critical incidents.

**Results:** The results revealed that perceptions that debriefing could be completed in the microsystem improved by 66% and moderate to high perceived stress levels decreased by 43% from initial evaluation in April 2024 to following the implementation in June of 2024.

**Conclusion:** The findings of this quality improvement project support the literature that there are many benefits to debriefing in critical care settings. There was also an improvement debriefing perceptions and perceived stress in the microsystem following the completion of a full Plan, Do, Study, Act (PDSA) cycle in the Emergency Department. The continued support of the key stakeholders in the microsystem including the staff nurses, nurse managers, quality services department, and education department should propel the findings in this project forward to make more improvements in the microsystem’s debriefing practices increasing the use and improving communication and safety.

**Key Words:** Quality Improvement, Quality Services, Debriefing, Critical Access, Emergency Department, STOP5 (summarize the case, things that went well, opportunities for improvement, points of action and responsibilities), Perceived Stress Scale
Introduction

Problem Description

Debriefing is one of the most essential communication practices in clinical settings for educational purposes and staff support. Debriefing is the action of meeting in a group to discuss a specific event or patient situation that occurs in a clinical setting in order for members to reflect, receive feedback, and allow for emotional expression regarding the situation (Fegran et al., 2021). Debriefing can take place in any clinical setting and often the purpose is to review a critical event. The key components of the debriefing include the presence of an experienced and educated leader or facilitator, an environment in which professionals can discuss the case, education is provided during the meeting, evaluation of performances and self-reflection as well as time to express emotional responses (Toews et al., 2021). Debriefing can take place in many different environments, take different forms, and can be as formal as needed in order to reach the goal of addressing the traumatic stress or understanding improvement needed from the clinical event. Research has shown that the inclusion of some form of debriefing is better than no form of debriefing (Edwards et al., 2021). The initial state of the clinical microsystem in the Emergency Department was that debriefing was not a regularly occurring practice that only occurred with one physician out of the ten in the department and was still infrequent with this one provider. The nurses and manager in the microsystem expressed the need for debriefing to become a regular practice.

The benefits of debriefing include improvements in clinical practice for a healthcare team as well as individual skill reflection, clinical understanding, and emotional support (Fegran et al., 2021). Debriefing is especially important in settings where nurses have exposure to an
increased number of critical events or traumatic patient outcomes for example in the
Emergency Department. This increased stress of high acuity patients can take a toll on
healthcare professionals (Scott et al., 2021). Team STEPPS, a program of the Department of
Health and Human Services that provides evidence-based teamwork tools, stresses the
importance of debriefing not only in staff support but also in quality improvement and the
identification of needed evidence-based practices in clinical settings (AHRQ, 2023). Debriefing
gives the opportunity to assess what processes are working well and what education is needed
for staff (Edwards et al., 2021). Debriefing should be a regular practice in clinical microsystems,
especially the Emergency Department where there is a greater rate of exposure to critical
patients and emergent clinical events.

Available Knowledge

In critical care nursing there is a high stress environment for nurses to work, as well as a
high price to pay for any patient care errors or inadequate care processes. The work of critical
care nurses can cause moral distress, anxiety, substance or alcohol use, and depression that
ultimately lead to decreases in the quality of patient care (Griggs et al., 2023). There are high
incidents of burnout within critical care nursing related to the stress response (Contu & Thomas,
2020). The toll that critical and traumatic incidents can take on staff effects overall processes
and patient care (Griggs et al., 2023). The high performance of a critical care team and
advancement of protocols impacts clinical outcomes, patient and family experience, and team
wellness (Welch-Horan et al., 2022). An intervention to improve staff nurses’ mental health as
well as clinical processes in critical care settings is essential. The understanding of the
effectiveness of critical incident debriefing on nurse wellness and healthcare practices provides valuable information for critical care unit improvement.

**Search Methods**

The literature review on the impact of debriefing on nurses in critical care was conducted using three search databases. The databases included the Cumulative Index to Nursing and Allied Health Literature (CINAHL), the Cochrane Database of Systematic Reviews, and MedlinePlus. The key words used for the literature search included debrief, debriefing, emergency OR critical care, and nurse OR nursing. The limits applied to the search were peer reviewed academic journal articles as well as articles that were published within the last five years (2019-2024). When reviewing the initial results of 1,767 articles, 561 duplicates were removed, and article titles and abstracts were screened for the inclusion of the intervention of debriefing in nursing. The remaining 486 articles were assessed for eligibility based on the content of the article. The inclusion criteria included the practice of debriefing in nursing. The exclusion criteria included articles that did not focus on the impact of debriefing on nurses, addressed debriefing in situations other than critical incidents such as educational simulation, focused on nursing practices in settings other than critical care, and were not initially reported in the English language. The PRISMA flowsheet illustrating evidence included in this literature review is demonstrated in Appendix A.

**Critical Appraisal of Evidence**

The research articles included in the literature showed a relationship between debriefing of critical incidents and the impact on nurses in critical care settings. Most of the research regarding the influence of clinical debriefing in healthcare settings is reported in qualitative data
because of the questionnaire or interview methods used to understand the perceptions of nurses and effect on department processes. The research articles included in this literature review consisted of different models of debriefing critical incidents in a variety of situations such as during the first three months of the COVID-19 pandemic, specifically for cardiopulmonary resuscitation efforts in the emergency department (ED), with critical care nurses that can perform extracorporeal membrane oxygenation (ECMO), and an emergency department immediately prior to the outbreak of the COVID-19 pandemic.

A qualitative study from a hospital wide clinical debriefing initiative in critical care at a children’s hospital reported on the effects of debriefing in the high-stress first three months of the COVID-19 pandemic. In this article, Welch-Horan et al. (2022) analyzed the bi-weekly collection of survey responses collected after the use of the developed Debriefing In Suspected COVID-19 to Encourage Reflection and team learning (DISCOVER) tool following care for positive or suspected positive COVID-19 patients (Welch-Horan et al., 2022). The survey data following the use of the debriefing tool reported on what was discussed in the debrief such as what went well and what needed improvement in logistics, communication, team roles and responsibilities. The results of the study reported that there were emergency room and hospital wide issues with personal protective equipment (PPE), number of personnel, and clinical standards. This data helped the hospital realize the strengths of education, communication and coordination between teams, situational awareness, and leadership influenced improved quality domains for patients, family experience, and team wellness. The report added that the hospital continued to participate in voluntary debriefing using this tool because of the benefits experienced (Welch-Horan et al., 2022). This study had strengths as a result of the study design
by using a standardized debriefing tool and survey hospital wide. The weaknesses of the study included that it was level 6 evidence, a single qualitative study (University of Michigan, 2023). The article only covered data from one single medical center, the hospital reported that some units previously had a history of debriefing which may have influenced the utilization of the debriefing tool, there was minimal distinction and reporting for individual specialties in the hospital, the debrief was facilitated by different level care providers, and the facilitator recorded the debriefing which could have led to bias. The overall interpretation of the data was that clinical debriefing allowed for understanding the needs within the hospital and impacted the future process performances and quality outcomes.

A qualitative study performed by Coggins et al. (2020) in an Australian emergency department examined the content and topics discussed in clinical debriefs following critical incidents. A combination clinical debriefing approach of Immediate, Not for personal assessment, Fast facilitated feedback, Opportunity to ask questions (INFO) and Summarize case, Things that went well, Opportunities for improvement, Points of action (STOP5) strategies was developed after a pilot study (Coggins et al., 2020). The debriefing format was advertised for four weeks, and staff underwent 40 min trainings on facilitating the debriefing. The inclusion criteria were for debriefing in critical care of a clinical event within less than or equal to one hour with greater than or equal to three personnel. The exclusion was for events associated with extreme distress. There were 71 completed forms from nine months that were analyzed for content included in the debriefings. The researchers then compared if the topics discussed in the debriefs aligned with the decision making, technical skills, communication, resource utilization, leadership, situational awareness and teamwork topics that are a part of the
Promoting Excellence And Reflective Learning in Simulation (PEARLS) framework (Coggins et al., 2020). The study found that the topics discussed clinical debriefing in the emergency department did align with the PEARLS framework closely. The facility was also made aware of the most common topics discussed which were decision making and communication in order to understand the need for interventions and changes to existing protocols or processes (Coggins et al., 2020). The weaknesses of this study included that there was no set facilitator for debriefs, the data was from indirect observation from a member of the clinical debrief recording, and as the practice took place in a single institution there was no cross comparison. This study was level 6 evidence, a qualitative review (University of Michigan, 2023). In the overall findings of this article, the authors discussed that clinical debriefing was effective in covering the important topics required in debriefing in order to understand the needs for change and improvements that can be made in the emergency room setting.

A qualitative research article by Griggs et al. (2023), reported on the moral distress of 20 extracorporeal membrane oxygenation (ECMO) nurses before and after case review debriefings. The purpose of this study was to understand the impact of case debriefings on moral distress of nurses that provide critical care to patients that are in critical condition. The job of an ECMO nurse has been associated with high levels of moral distress and in some research, case reviews have been known to increase distress for some healthcare providers. The research was conducted using the Moral Distress Scale Revised (MDSR) to assess the frequency of moral distress and the level of disturbance before and after participants attended two 1-hour debriefing sessions. The results revealed no significant (p=0.84) change in MDSR frequency or intensity scores following case reviews, but the moral distress thermometer reported that there
was a significant (p<0.001) decrease in scores overtime for 80% of participants (Griggs et al., 2023). This research study was limited in the methods of intervention since perception was reevaluated after only two experiences with the debriefing process. The weaknesses also included that it was a form of level 6 evidence, there was a small sample size, the time frame was limited, and the debriefing method was not care team specific so some of the moral distress after the intervention was related to hearing the professionals’ peers’ distress (University of Michigan, 2023). The overall findings of this article did support that over time case review debriefing can reduce moral distress for ECMO critical care nurses.

In a qualitative research study, Contu and Thomas (2020), analyzed the qualitative well-being and perceptions of debriefing in a community hospital emergency department prior to the COVID-19 pandemic. The purpose of the research was to determine the mental health, perceptions of critical incidents, and openness to debriefing because of the high levels of burnout associated with emotional and physical health being impacted by traumatic events. With no formal debriefing process at the hospital, a survey using the Hospital Anxiety and Depression Scale (HADS) and the Professional Quality Of Life survey (ProQOL) questionnaires was dispersed and collected for four weeks in the emergency department. The responses included 39 out of 120 (32.5%) of employees. The results were that approximately half of the workers reported high anxiety and secondary traumatic stress, and moderate burnout (Contu & Thomas, 2020). The survey also presented results that all the staff benefitted from informal debriefs in a year and 79% of the staff wanted to discuss stressful events in the year (Contu & Thomas, 2020). The strengths of this study were that it specifically assessed well-being and perceptions of debriefing in a critical care setting that did not previously have this intervention established to
understand the need of a debriefing practice. The weaknesses were that this was a level 6 form of evidence, the researchers did not separate registered nurse results from physician assistants, the age of staff was not reported, there was a small sample size from a larger department included, and there was no comparison between an emergency department that had taken part in debriefing practice. The overall findings of this study included that there was significant mental health concern for emergency room professionals and that a significant amount reported wanting to debrief as well as had experienced helpful informal debriefing in the last year (Contu & Thomas, 2020).

An article by Lyman (2021), reported on the relationship between post-resuscitation debriefs and perceptions of teamwork in emergency department nurses. The relationship between debriefing and decreasing patient safety incidents, decreasing occupational distress, increasing focus, morale and professional commitment was well covered before this research article so the purpose was to examine how teamwork is effected with debriefing. The methods included a digital survey including 33 items from the Nursing Teamwork Survey (NST), being sent to 500 participants of the emergency nurses association. The results included 72 nurses (15.6%) responses to the survey after six weeks of distribution. The findings were that there was a positive relationship between debriefing and improvement of teamwork (Lyman, 2021). The strengths of this research included that it investigated another factor impacted by debriefing in emergency room nurses across America. The weaknesses of this study were that it was level 6 evidence, there was a low response rate, there was no clear distinction between the relationship of frequency of debriefings and teamwork or high teamwork impacting the frequency of debriefings, there was no interview data, and the study structure did not include
presurvey, intervention, post-survey. The overall findings of the article were that there was a positive relationship between debriefing and teamwork in the emergency department.

**Evidence Synthesis**

The search conducted in this literature review was performed to understand the impact of debriefing critical incidents on the practice of critical care nursing. It was found in different critical care settings with different methods of debriefing, there was significant impact on nurses’ mental health or systems operations (Lyman, 2021; Griggs et al., 2023; Welch-Horan et al., 2022). There is substantial evidence that nurses working in critical care have increased stress, anxiety, abnormal burnout, and increased moral distress, supporting the need for a helpful intervention (Contu & Thomas, 2020; Griggs et al., 2023). It was reported by Contu and Thomas (2020), that 100% of emergency room staff that filled out the debriefing perceptions and well-being survey reported informal discussions regarding critical incidents were useful and 79% reported wanting to discuss critical incidents with a team within the last year. The benefits of clinical debriefing on the mental health of critical care nurses were further supported by Sherry et al. (2023). The researchers reported that critical case debriefing over time decreased moral distress scores for 80% of participants that attended two virtual case debriefings (Griggs et al., 2023). Not only does clinical debriefing reduce the emotional stress felt by critical care nurses, but it also impacts the team dynamics and operational processes in critical care environments (Coggins et al., 2020; Lyman, 2021; Welch-Horan et al., 2022). Lyman (2021) reported the positive relationship between debriefing and increased teamwork from 72 emergency nurses association participants. A debriefing tool that was tested in an emergency department over nine months was reported to have successfully covered all of the important
debriefing criteria per the PEARLS tool and gave the facility valuable information for needed process changes (Coggins et al., 2020). A similar result was observed in the implication of debriefing intervention hospital wide in the first three months of the COVID-19 pandemic (Welch-Horan et al., 2022). Welch-Horan et al. (2022), reported that the use of the DISCOVER debriefing tool allowed the identification of specific areas of practice that needed change such as PPE supplies. The overall evidence supports that debriefing is a valuable tool in critical care settings to support the emotional well-being of nurses as well as improve clinical processes.

**Conclusion**

The research regarding clinical debriefing in critical care settings supported the need for regular debriefing practices to be performed in emergency department settings. In a critical access emergency department in northern, rural New Hampshire, no formal or frequent debriefing process was in place. The staff reported a desire to debrief and have support after particularly emotionally draining or stressful patient care incidents. The evidence provided in this literature review supported the positive impact critical incident debriefing can have on the stress of critical care nurses as well as impact the teamwork and team processes for a well-functioning ED. The implementation of a clinical debriefing practice in the emergency department through a quality improvement project will positively impact staff mental health and the process outcomes of the ED.

**Rationale**

The Plan, Do Study, Act (PDSA) cycle method was used for process analysis of the quality improvement project. The PDSA cycle method is an evidence-based practice that provides a framework for assessing the need for, implementing, and understanding the impact of quality
improvement projects (Nelson et al., 2007). In the planning stage, a Purpose, Patients, Professionals, Processes, and Patterns (5P) assessment was conducted in the microsystem to understand the purpose of the department, patients that are taken care of, professionals in the workplace, and common processes and patterns in order to understand the needs of the microsystem. The quality improvement data of the facility was accessed as well as the policies/guidelines in order to understand the current state of the hospital and microsystem. Upon discovery of the needs for improvement in the microsystem, further literature search and investigation of the problem was conducted. The proposed methods of intervention, study of intervention, and analysis of the data was also outlined. In May 2024, the proposal for the project was reviewed by the University of New Hampshire Department of Nursing Quality Review Committee and verified that the project met Institutional Review Board (IRB) exempt status as a quality improvement project. In June 2024, the implementation of the quality improvement project was commenced in the Do phase. The project was then assessed by gathering reassessment interviews on the staff perceptions of debriefing and perceived stress in the Study phase. In the final Act stage, the dissemination of the findings informed the next steps of adopting and modifying the process.

Specific Aims

The overall goal and global aim of this quality improvement project was to improve the debriefing process in the Emergency Department of a critical access hospital in northern New Hampshire. This project specifically worked to improve the nurses use of the initial debriefing guideline as well as their perceptions of the importance of debriefing. The process began with making staff aware of the current debriefing guideline by providing paper and electronic copies
as well as providing education on the Summarize case, Things that went well, Opportunities of Improvement, Points of Action (STOP5) model and ended with increased perceptions of debriefing and decreased stress for staff after high acuity events in the Emergency Department. Addressing the initial status of the debriefing process was imperative as staff stated there was a lack of support and a need for continued education to the new nurses of the department. Debriefing can have a powerful impact on staff satisfaction as well as decreased future incidents and improved patient outcomes. The specific aims were to increase the number of staff that believed debriefing could be used in the microsystem by 25% and to decrease staff Perceived Stress Ratings by 25%. The introduction of the guideline and education was be conducted June 18, 2024, and the reevaluation of the staff perceptions and perceived stress of the emergency department was conducted in the week to follow.

Methods

Context

The microsystem assessment was conducted on the Emergency Department of a critical access hospital that serves northern New Hampshire and northeast Vermont. A 5p microsystem assessment was conducted in order to understand the processes and the needs of the Emergency Department. The assessment information was used to formulate a quality improvement project specific to the changes needed in the microsystem.

Purpose

The purpose of the Emergency Department was to provide critical care to a diverse patient population in emergent and serious conditions. The aim of the Emergency Department (ED) aligned well with the mission and values of the hospital. The Emergency Department’s goal
was “providing high quality, patient and family centered, compassionate care” (LRH, 2024, p.1).

The macrosystem was a critical access hospital with limited resources so often the role of the ED was to stabilize the patient and determine their need for transport to referral hospitals, or admission to inpatient care. Another goal of the microsystem was to provide timely care and limit the amount of time patients were in triage or an Emergency Department stretcher.

**Patients**

The Emergency Department served over 9,800 adult and pediatric patients annually (LRH, 2024). The Emergency Department cared for patients of a wide variety of ages, clinical presentations, and medical backgrounds. The hospital also provided care for those with a wide range of social backgrounds and patients coming from different living situations that impact their health. The microsystem cared for patients that are 52% female and 48% male with an average age of 45 years old. Some of the most common diagnoses seen in the clinical setting were chest pain, abdominal pain, trauma, and respiratory distress. The most common discharge disposition for patients that were critically ill was for transport to a facility that could provide a higher level of care. The average length of stay for patients in the Emergency Department was 180 minutes. This information was collected through Discern Analytics®.

**Professionals**

The professionals within the Emergency Department all supported the same goal of providing timely, critical care to patients. The ED staff consisted of 18 staff nurses, six physicians, four nurse practitioners, and assistive personnel such as ED technicians and health unit coordinators when available. The majority of the staff were full time and some employed through a travel agency. From speaking with many staff members, the majority consistently
worked overtime to meet staffing needs as well as improve their pay (K. Red Elk, personal communication, February 8, 2024). The supporting diagnostic departments included radiology/imaging and the laboratory. The department also received significant support from the nursing supervisor when it was busy or there was need for helping transfer patients to the inpatient unit.

**Processes**

The routine processes in the Emergency Department ensured that patients were seen in a timely manner and received the care they needed as soon as possible. Some of the routine processes included triage, focused assessments, obtaining labs, obtaining imaging from computed tomography (CT) or X-ray, transferring patients to inpatient, coordinating acceptance from and transportation to other facilities, discharging patients home or to assisted living, and turning over rooms efficiently. It was important that the ED supported the processes with efficient communication and rapid care.

**Patterns**

The patterns that were routinely seen in the Emergency Department were related to the tight knit community of workers in a small department in the hospital. The staff stated that a recurring issue in the department was communication between staff members and management (K. Red Elk, personal communication, February 8, 2024). The main form of communication within the department was over email or text message. There was limited in-person communication and never routine staff meetings or check-ins. The ED also did not meet to debrief particularly difficult cases or patients that required serious medical care. There were no quality improvement projects that the hospital had in process, but the consistent collection
of data on patient care and time efficiency of the ED was essential in understanding the department and patients would benefit from change.

**Cost Benefit Analysis**

The nurses in the critical access Emergency Department (ED) expressed that they did not feel they debriefed critical incidents enough and did not have adequate emotional support following stressful or traumatic incidences. Addressing the debriefing process in the Emergency Department not only impacts staff mental health and department processes, but it also had the potential to improve the cost-effectiveness of the department and hospital. In the Emergency Department, 13% of patients were “Emergent” or higher acuity. The process for caring for critical patients was followed with moving on to the next patient. The development of improving the debriefing process would have minimal, if no financial cost to the Emergency Department and hospital. The cost would be in the form of increased time commitment for staff in addition to the work of caring for patients in the busy Emergency Department. There was potential for reduction in costs related to the mental health of workers as well as the decreased costs from medical errors (Ahsani-Estahbanati et al., 2022; Penev et al., 2023). According to Penev et al. (2023), the United States has expended more than $200 billion in annual healthcare utilization and decreased employee productivity related to mental illness. It was also reported that for average employers, sponsored healthcare premiums have increased 22% in the last five years increasing costs for companies (Penez et al., 2023). In addition to the increased medical costs for the hospital from the mental health of employees, increased medical errors related to burnout or ineffective processes or procedures is significant. According to Ahsani-Estahbanati et al. (2022), the United States has an annual expenditure of $20 billion related to medical errors.
The process of debriefing can contribute to decreasing hospital costs related to mental health of staff and reduce the potential for medical errors.

**Intervention**

The assessment of debriefing and staff perceptions in the Emergency Department took place in April 2024 through individual interviews and surveying with the Perceived Stress Scale (PSS) (State of NH EAP, 2023). This data was presented to the staff with the intervention plan during the June 2024 staff meeting. Information was given in a PowerPoint presentation by the project lead on the current state of debriefing in the ED, the benefits of debriefing, and the format of debriefing using the STOP5 model as seen in Appendix C (Walker et al., 2020). The information was also be distributed in an electronic document to the ED staff through the department manager via email. The reassessment of debriefing perceptions and staff stress levels took place the week following the intervention.

**Study of Intervention**

The initial state in the Emergency Department included a lack of debriefing, a perception that debriefing is beneficial in mental health of staff and team improvement, and a desire to increase the prevalence of debriefing. After the implementation of the debriefing intervention, the project lead conducted interviews with staff attended to reassess staff perceptions of debriefing and the PSS survey. Results of the interviews determined the effectiveness of the intervention in improving perceptions of debriefing and staff perceived stress at the critical access Emergency Department.
Measures

The Perceived Stress Scale was used to evaluate mental health and stress levels of nurses in the Emergency Department coupled with interview questions regarding perceptions of debriefing. The Perceived Stress Scale as seen in Appendix B, was originally developed in 1983 and has been proven to have moderate convergent validity and good reliability (0.78-0.90, p<0.01) (Taylor, 2015). The State of New Hampshire Employee Assistance Program (EAP) supplies the PSS on the NH Department of Administrative Services website in order to make the survey available for employer and employee use in the state of NH (NH DAS, 2023). The scale is encouraged to be used to assess an individual's perceived level of stress in conjunction with EAP services (State of NH EAP, 2023). This assessment tool will be valid and reliable to assess the stress of Emergency Department employees before debriefing is implemented and after the intervention.

Analysis

Results from the personal interviews and Perceived Stress Scale reported qualitative and quantitative data. The qualitative data from interview responses was analyzed to identify themes and patterns. Quantitative data reported on demographic data of staff as well as the responses of the PSS. The quantitative data on staff reported how many years the nurses had practiced and how many years the nurse had worked at the hospital. The quantitative numbers as a result of the PSS will determine the level of low, moderate, or high perceived stress based on the PSS instructions as seen in Appendix B (State of NH EAP, 2023). All the data collected from the initial assessment and reassessment of staff perceptions of debriefing and stress levels was used to report on the effectiveness of the intervention.
Ethical Considerations

The analysis of perceived stress as well as asking employees to discuss traumatic or stressful events in the Emergency Department had the potential to cause further staff distress. Staff may have also felt that the practice of debriefing was another requirement adding burden to their busy work shifts. This project had the potential for harm or distress for employees in the Emergency Department, but that had been discussed with management and education leaders. The hospital had a guideline in place to enact when a staff member is identified as having high stress levels that they were incapable of coping with and how to get that staff member the support that is needed. This proposal was approved by the Emergency Department manager as well as leadership in the Quality Services Department. Additionally, this proposal was approved by the University of New Hampshire Department of Nursing Quality Review Committee and recognized to be a quality improvement project exempt from Institutional Review Board evaluation.

Results

Initial Steps

During clinical practice at the critical access Emergency Department (ED), it was expressed in January of 2024 by the majority of staff members that debriefing was an essential practice that was not occurring as well as there was a need for improved communication practices on the unit. Upon identification of the quality improvement problem within the microsystem, interviews of staff and completion of the Perceived Stress Survey (PSS) were conducted in April 2024 in order to understand the current state of the microsystem as well as the severity of the issue. Figure 1 displays the flowchart of the process of the plan, do, and
study of the Plan, Do, Study, Act (PDSA) cycle. The process began with identifying the quality problem and ended with reassessment and data reporting of the microsystem following educational intervention.

**Figure 1**

*The flowchart representing the steps taken in the plan, do, study phases of the Plan, Do, Study, Act (PDSA) cycle for the quality improvement project.*

The initial assessment of the staff found that 100% of the staff experienced critical incidents within the last three months that were not debriefed and expressed the desire to debrief these incidents. The initial solution to the lack of debriefing in the ED was to create a policy in order to formalize the process and make it mandatory for staff to perform. This was abandoned related to the broad coverage the policy would require as it would be applied to the entire macrosystem. With this information, the implementation of providing microsystem specific education on the lengthy and detailed current guideline of debriefing in the ED as well as introduction of a simplified, direct model of a hot debrief was conducted at the June 2024 staff meeting. In the week
following the introduction of the education, the nursing staff was reassessed for perceptions of
debriefing within the unit as well as stress levels and the perception of the influence debriefing
would have on stress levels of staff.

**Process Measures and Outcomes**

During the implementation of the quality improvement project, there were eighteen
staff nurses employed in the Emergency Department, ten of which participated in the initial
evaluation of the microsystem and six of which completed the post-intervention assessment.
The demographic data of the nurses in the ED that participated in one or both portions of the QI
project are seen in Table 1. Of the eighteen nurses, there are ten full time and eight per diem.
All the nurses had an associate degree or higher. The average number of years’ experience as a
nurse was 12.1 years and the average number of years employed in the microsystem was 3.4
years. Two of the nurses included in the QI project were new graduate nurses with one year of
nursing experience while half (50%) of nurses had greater than ten years of experience as a
nurse.

**Table 1**

*Demographic data of microsystem nurses*

<table>
<thead>
<tr>
<th>Demographic Data</th>
<th>Total Sample (N=10) n (%)</th>
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<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Female</td>
<td>9 (90)</td>
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<tr>
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</tr>
<tr>
<td>18-49</td>
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<td>1 (10)</td>
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<td>0 (0)</td>
</tr>
<tr>
<td>80 or older</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>-------</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>10 (100)</td>
</tr>
<tr>
<td>Other</td>
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<tr>
<td>&lt; High School</td>
<td>0 (0)</td>
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<tr>
<td>HS or GED</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Some College</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Associate Degree</td>
<td>3 (30)</td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>6 (60)</td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>1 (10)</td>
</tr>
<tr>
<td>Doctorate</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Years as a Nurse</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1</td>
<td>2 (20)</td>
</tr>
<tr>
<td>&gt;1-5</td>
<td>1 (10)</td>
</tr>
<tr>
<td>&gt;5-10</td>
<td>2 (20)</td>
</tr>
<tr>
<td>&gt;10-15</td>
<td>2 (20)</td>
</tr>
<tr>
<td>&gt;15</td>
<td>3 (30)</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Years at Macrosystem</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1</td>
<td>4 (40)</td>
</tr>
<tr>
<td>&gt;1-5</td>
<td>4 (40)</td>
</tr>
<tr>
<td>5-10</td>
<td>1 (10)</td>
</tr>
<tr>
<td>&gt;10</td>
<td>1 (10)</td>
</tr>
</tbody>
</table>

The reassessment of the perceptions of debriefing in the Emergency Department and the perceived stress levels of the ED nurses was completed with six full time staff nurses. The Likert data from the Perceived Stress Survey (PSS) is presented in Table 2 to show the pre-intervention and post-intervention perceived stress levels of nurses in the microsystem. The survey data for questions 4, 5, 7, and 8 were reversed prior to entering into the table per instructions of the PSS. It was found that 70% of nurses had low perceived stress prior to the intervention and 83% low perceived stress following the intervention with less nurses participating.
Table 2

*Likert Scale data from responses to Perceived Stress Scale (PSS) questionnaire*

<table>
<thead>
<tr>
<th>PSS Question</th>
<th>Pre-Intervention (N=10)</th>
<th></th>
<th></th>
<th>Post-Intervention (N=6)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Range</td>
<td>Mean</td>
<td>SD</td>
<td>Range</td>
</tr>
<tr>
<td>1</td>
<td>1.42857143</td>
<td>1.13389342</td>
<td>0-5</td>
<td>1</td>
<td>1.26491106</td>
<td>0-5</td>
</tr>
<tr>
<td>2</td>
<td>0.85714286</td>
<td>1.06904497</td>
<td>0-5</td>
<td>0.5</td>
<td>0.54772256</td>
<td>0-5</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>1</td>
<td>0-5</td>
<td>1.5</td>
<td>1.04880885</td>
<td>0-5</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>1.41421356</td>
<td>0-5</td>
<td>0.66666667</td>
<td>0.51639778</td>
<td>0-5</td>
</tr>
<tr>
<td>5</td>
<td>0.85714286</td>
<td>1.21498579</td>
<td>0-5</td>
<td>1.33333333</td>
<td>1.21106014</td>
<td>0-5</td>
</tr>
<tr>
<td>6</td>
<td>0.42857143</td>
<td>0.53452248</td>
<td>0-5</td>
<td>0.66666667</td>
<td>0.51639778</td>
<td>0-5</td>
</tr>
<tr>
<td>7</td>
<td>1.42857143</td>
<td>1.51185789</td>
<td>0-5</td>
<td>0.5</td>
<td>0.83666003</td>
<td>0-5</td>
</tr>
<tr>
<td>8</td>
<td>0.57142857</td>
<td>0.53452248</td>
<td>0-5</td>
<td>1</td>
<td>0.89442719</td>
<td>0-5</td>
</tr>
<tr>
<td>9</td>
<td>1.57142857</td>
<td>0.97590007</td>
<td>0-5</td>
<td>1.16666667</td>
<td>1.16904519</td>
<td>0-5</td>
</tr>
<tr>
<td>10</td>
<td>0.42857143</td>
<td>0.53452248</td>
<td>0-5</td>
<td>1.16666667</td>
<td>1.16904519</td>
<td>0-5</td>
</tr>
<tr>
<td><strong>Total Score</strong></td>
<td><strong>9.57142857</strong></td>
<td><strong>4.39155033</strong></td>
<td><strong>0-40</strong></td>
<td><strong>9.5</strong></td>
<td><strong>4.54972527</strong></td>
<td><strong>0-40</strong></td>
</tr>
</tbody>
</table>
The interview data was simplified into common themes that were identified and reported in Table 3. The majority of feedback for critical incidents that should be addressed included phrases such as “child death” or “pediatric trauma.” The majority of value that was seen in debriefing was education followed by a learned benefit of debriefing with the educational intervention of emotional impact and supporting emotional responses. The staff also reported that increased use of debriefing would decrease stress levels of ED nurses. The overall influence of the educational intervention was seen in the takeaway that debriefing in the ED is more likely to occur using the STOP5 hot debriefing model.

Table 3

Common themes found in interview data of Emergency Department staff nurses
<table>
<thead>
<tr>
<th>Themes</th>
<th>Pre-Intervention (N=10) n=%</th>
<th>Post-Intervention (N=6) n=%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify educational benefit of debriefing</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Awareness of the current ED debriefing guideline</td>
<td>20</td>
<td>100</td>
</tr>
<tr>
<td>Identify emotional support benefit of debriefing</td>
<td>30</td>
<td>100</td>
</tr>
<tr>
<td>Identify STOP5 model as useful in increasing debriefing practice</td>
<td>0</td>
<td>67</td>
</tr>
<tr>
<td>Debriefing attainable in microsystem</td>
<td>60</td>
<td>100</td>
</tr>
<tr>
<td>Recognize critical incident as being a reason to debrief</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The assessment and reassessment data were collected with face-to-face interviews and completion of the Perceived Stress Survey questionnaire. This meant that the only data collection occurred when the project leader was present in the microsystem with the nurses that were also present. This limited the number of nurses that were reached related to the number of per diem staff on the unit as well as nurses that were absent from vacations during the assessment/reassessment time periods, and the nurses that worked staggering shifts. The number of nurses that were pre-assessed was ten out of the eighteen related to the nurses that were present at the time of collection. The post-intervention assessment was six out of the previously ten nurses related to the attendance to the June 2024 staff meeting where the intervention was implemented. The limited outreach of the intervention limited the number of nurses that were able to be reassessed.

**Associations**
This quality improvement project had support of the key stakeholders including the unit manager, Quality Services Critical Care representative, Education Manager, and staff nurses in the microsystem. The assessment of the microsystem was conducted in interviews rather than distributing a survey in order to increase the likelihood that staff nurses would participate. This did potentially limit the number of participants related to the inability of the project lead to personally interact with all eighteen staff nurses. With the implementation of the intervention, there was limited outreach because of the low attendance rate (30%) of staff nurses at the June 2024 staff meeting. Even with the key stakeholder involvement and support, the effect of the quality improvement project and the amount of data collected were limited by timeline and the involvement of the unit.

_Unintended Consequences_

The intended benefit of the quality improvement project was to improve the perceptions and use of debriefing in the microsystem as well as the stress levels of staff nurses. While the results of the study did show progress towards future improvement of debriefing practices, there was limited time between the “Do” and “Study” portions of the project in order to see the real effect of the intervention. This proposal of a new practice for the microsystem also leaves room for changes and future policies or processes that follow this direction or go in a completely different direction. In addition to the tight timeline and limited influence of the intervention, the assessment was also only conducted face to face which limited participation related to schedule challenges and could have persuaded staff responses when speaking directly with the project lead rather than anonymously submitting a survey.
Discussion

Summary

Key Findings

The purpose of this quality improvement project was to improve the perceptions of staff nurses surrounding debriefing in the Emergency Department and provide education on the practice as well as use the practice to reduce perceived stress levels of staff. The overall global aim focused on improving the debriefing practice in the ED so that there would be an increased use of debriefing after critical incidents. The specific aim was more closely related to the staff impact of debriefing. The specific aim for this quality improvement project was to increase the number of staff that believe debriefing can be used in the microsystem by 25% and to decrease staff Perceived Stress Ratings by 25%. The results of the quality improvement project met the specific aim because there were notable improvements in the perceptions of debriefing, staff education on debriefing, and reported perceived stress levels of the nursing staff. The key findings include that staff was now educated on the existing debriefing guideline that was previously not well known. The staff also understood the benefits of debriefing and different forms debriefing can take as well as the existence of debriefing models such as STOP5. The staff also reported that with the use of a model such as STOP5, there would be increased use of debriefing in the department, and it would be a more attainable goal. With tallying the scores from the Perceived Stress Scale questionnaire, there was also improvement in perceived stress scores with a decrease in number of staff reporting moderate to high stress and an increase in staff reporting low stress levels. The number of staff that had moderate to high perceived stress levels decreased by 43% from the initial evaluation to the post-intervention evaluation. The
perceptions of debriefing in the microsystem improved by 66% to result in 100% of the nurses interviewed believing that using a debriefing model would be attainable in the ED. These results are supportive of the literature that debriefing can improve stress levels of critical care nurses and that debriefing education is important in the act of establishing this practice in the microsystem as well as the beneficial impact it can have in a setting such as the ED. With more time to complete this quality improvement project as well as more staff involvement, the project would be stronger and may show promise for process changes where the use of debriefing has increased in the critical care setting.

**Relevance to Quality Improvement Model**

The implementation of the Plan, Do, Study, Act (PDSA) cycle was successful in this quality improvement project. The Plan stage began with the assessment of the microsystem using observation, staff interviews, and the Perceived Stress Scale. During the planning stage, a literature review was also conducted based on the problem identified and further review of information in the microsystem such as existing polices and guidelines was conducted. The Do stage was completed by providing education to the staff on debriefing and a specific debriefing model. Upon reassessment of the staff regarding perceptions of debriefing in the ED and the perceived stress levels, the data was studied and reported to show there was improvement and the specific aim was met. In the Act stage, this quality improvement project informs how the microsystem should move forward implementing the STOP5 debriefing model in practice as the staff has reported that the perception is this model would increase the use of debriefing in the ED as well as decrease stress levels of the ED nurses.

**Project Strengths**
The strengths of this quality improvement project include the inclusion of key stakeholders and the relevance of the intervention to the problem identified in the microsystem. The use of interdepartmental collaboration, communication, and cooperation were essential in thorough assessment of the microsystem, effective intervention strategies, and the likelihood this project will move further in the future. The assessment was also thorough related to the individualized element of one-to-one interviews as well as the use of a validated assessment tool. The intervention was relevant to the literature and showed promising groundwork for future developments in this practice for the microsystem. The strength of covering a baseline quality improvement project through a successful PDSA cycle sets the department up for future success in improving this practice.

**Interpretation**

**Outcomes**

The outcomes of this quality improvement project were that perceptions of debriefing improved, and the perceived stress levels of nursing staff decreased with the intervention. Providing education on debriefing practices and the benefits was the single intervention applied to directly cause the change in the perceptions of debriefing in the staff. The improved perceptions of debriefing reported by staff was not only displayed in the improved understanding of the benefits of debriefing, but staff also had a new understanding for how to conduct debriefing, what was expected in the microsystem, debriefing resources that are available, and the personal application to how debriefing can affect the well-being of critical care nurses. The outcome of decreased perceived stress levels was less likely directly related to the educational component, but more likely related to the decreased number of staff members...
that completed the post-assessment. The positive outcomes from this quality improvement project are reflective of the literature and support improved processes in the future of the microsystem.

**Comparison with Similar Research**

The findings of this quality improvement project are consistent with the literature on the impact of the presence of debriefing in critical care settings. One of the greatest concerns of the staff nurses that influenced the quality improvement project was that there was a lack of effective communication and cohesion within the Emergency Department and with intradepartmental collaboration (K. Red Elk, personal communication, April 3, 2024). There was also feedback that the nurses would like to debrief more but had low confidence that the practice could be implemented in the microsystem (K. Red Elk, personal communication, April 3, 2024). It was found with the intervention of debriefing education and implementation of a formalized debriefing practice in the microsystem that staff perceptions of debriefing improved and that the awareness of the benefits of debriefing such as improved communication and teamwork increased as well. These findings align with the literature that reports debriefing leads to changes in existing protocols, improvements in team performance, awareness of patient safety threats, and improved interdisciplinary understanding and knowledge (Coggins et al., 2020). The literature also reports that the use of a debriefing model such as the Immediate, Not for personal assessment, Fast facilitated feedback, Opportunity to ask questions (INFO) model, the Summarize the case, Things that went well, Opportunities for improvement, Points of action (STOP5) model, and the Debriefing In Suspected COVID-19 Encourage Reflection and team learning (DISCOVER) tool, improve the use of debriefing and encourage the intended
benefits of debriefing (Coggins et al., 2020). Additionally, the other component of the quality improvement project was the concern of mental health in critical care nurses. Debriefing allows for psychological stress and trauma to be addressed in nurses as well as literature reports that there is potential to lower the moral distress and anxiety in critical care and improve quality of life (Welch-Horan et al., 2022; Contu & Thomas, 2020). The amount of literature surrounding debriefing in critical care units is plentiful which further supports that the microsystem should continue to pursue implementation of this practice and support debriefing in the ED.

**Impact on Populations and System**

A change in the processes for debriefing critical incidents in the Emergency Department will not only influence the support and education needed for staff nurses, but it also has potential to influence macrosystem-wide practices and a positive impact on patient outcomes. In the entire macrosystem, debriefing is not a regularly used practice. The medical/surgical unit uses a safety huddle model at the beginning of every shift, but the critical care settings, Emergency Department and Intensive Care Unit, do not formally debrief or huddle regularly (R. Vashaw, personal communication, April 10, 2024). These other care settings would also benefit from a consistent debriefing practice. The patient population would benefit from a regular debriefing practice in the ED as debriefing has been proven to improve critical care nurse education and knowledge as well as informs need for quality improvement or implementation of evidence-based practices (Coggins et al., 2020; Welch-Horan et al., 2022). In the assessment of the microsystem, the majority of nurses expressed the most concerning critical incidents that should be debriefed were anything involving pediatrics and that there were many novice nurses in the unit (LRH ED nurses, personal communication, April 2024). The pediatric patient
population would specifically be impacted by the implementation of debriefing in this setting to encourage improved care for this patient population and traumatic stress support of nurses that can come with sensitive, emotionally difficult cases.

**Differences Between Observed and Anticipated Outcomes**

The anticipated outcome of this quality improvement project was to improve perceptions of debriefing within the Emergency Department therefore leading to increased use of debriefing practices and reduced perceived stress levels of ED staff nurses. In addition to the direct impact of the intervention, there was also intention that the microsystem would continue to explore debriefing practices and perform future quality improvement initiatives to increase the use of debriefing in the ED. The results of this quality improvement project are consistent with the anticipated outcomes as staff reported a positive perception of debriefing and increased perception that debriefing could be used in the ED as well as reduced perceived stress levels.

**Opportunity Costs and Strategic Tradeoffs**

The costs associated with systems that do not perform debriefing in order to improve medical care practices and reduce mental health concerns in critical care nurses outweigh the costs of implementing effective debriefing practices. As previously mentioned, the costs associated with medical errors includes $20 billion annually, and the cost of employee mental health care utilization is $200 billion annually (Ahsani-Estahbanati et al., 2022; Penev et al., 2023). There was no cost associated with the assessment of the microsystem, utilization of the Perceived Stress Scale, dissemination of the debriefing education, or study of the reassessment findings. There was no additional personnel or resources needed in the quality improvement
project or the need for staff to contribute additional hours outside of the regular schedule. Support from the key stakeholders including the microsystem nurses, department manager, quality services, and education all contributed to a positive impact with no tradeoffs required.

Limitations

The limitations of the quality improvement project included staff involvement, the methods of assessment, and timeline. These limitations provided restricted results as well as minimal ability to apply this quality improvement project to other settings. The quality improvement project was conducted in a critical access Emergency Department in rural New Hampshire with 18 staff nurses. The nurses that participated in the quality improvement project included ten for the initial assessment and six for the post-intervention reassessment. The limited number of participants does not support the ability of the quality improvement project to be applied to larger departments as well as restricts the validity of results. The method of assessment including face to face interviews was chosen with the intention of increasing the number of participating nurses. This assessment strategy could have limited the comfort of the staff to speak freely without bias. This also provided the limitation that assessment was only conducted when the project lead was on-site. The implementation of the intervention was also limited in attendance related to the low numbers of nurses at the June 2024 staff meeting. The timeline overall limited the quality improvement project because there was limited time for reassessment following the implementation. Moving forward, further Plan, Do, Study, Act (PDSA) cycles should be conducted and further implementation of debriefing in the ED will support the intended outcomes and improve the microsystem.
Conclusion

*Usefulness of Work*

This quality improvement project provides helpful baseline information for starting up a new debriefing practice in a critical access Emergency Department. This quality improvement project strictly followed all of the steps of the verified practice of Plan, Do, Study, Act (PDSA). This process allows for the reconstruction of this project as well as informs future PDSA cycles and quality improvement. The results that the critical access Emergency Department nurses have improved perceptions and stress levels when following education on debriefing practices is valuable information and promising evidence that the microsystem can improve communication and safety process with the inclusion of debriefing.

*Sustainability*

The sustainability of this quality improvement project is yet to be determined related to the compressed timeline of the PDSA cycle. Future PDSA cycles and evaluation of the microsystem will determine the impact of the assessment and implementation of this quality improvement project. The conclusion of this quality improvement project is that staff are motivated and more educated surrounding debriefing with more positive perceptions of completing the process within the microsystem and this is hoped to continue and amplify moving forward. The microsystem has been left with the tools to improve debriefing practices and future PDSA cycles will show the sustainability of this process change.

*Potential for Spread to Other Contexts*

This quality improvement project can be translated throughout the mesosystem, macrosystem, and comparable microsystems based on the positive and effective results as well
as the formal completion of the PDSA model. The quality improvement project can be
generalized in the areas of communication practices and safety for future work. This project also
informs the microsystem for the practices of education, leadership involvement in quality
improvement, and future PDSA cycle needs. The results of this project are limited related to the
minimal participation of staff but can be applied in larger settings to further improve the spread
and application to other settings and contexts.

**Implications for Practice and Further Study**

The quality improvement project advises implications for practice within the
microsystem as well as the need for further study of PDSA cycles. The results from this quality
improvement project show support for debriefing in the microsystem as well as reinforces the
need for this practice to be regularly implemented. This supplies the direction for future quality
improvement projects and PDSA cycles. With the implementation of increased debriefing
practices this also supports that the microsystem will have improvement team cohesion,
improved evidence-based practices, improved patient safety, and improved support for clinical
staff (Coggins et al., 2020).

**Suggested Next Steps**

The microsystem should continue to explore the use of debriefing and other practices to
improve communication and safety in the critical access Emergency Department. The future
PDSA cycles should include involvement of using the STOP5 debriefing model in a structured
debrief or another formalized debriefing model. The microsystem should also look to
implement a policy on debriefing, so it becomes a more wide-spread practice. This quality
improvement project sparked the conversation of debriefing practices within management,
quality services, and education. With the further collaboration of these departments as well as the buy-in from staff nurses, future PDSA cycles will also be successful. The ultimate goal is to increase the use of debriefing in this microsystem, so further PDSA cycles and quality improvement projects to inform this process and change should be completed.
References

https://www.ahrq.gov/teamstepps-program/index.html


https://littletonhealthcare.org/departments/emergency-department/

https://doi.org/10.1016/j.ienj.2021.101005


Appendix A

PRISMA Flowsheet of Literature on Debriefing for Nurses in Critical Care

Identification of studies via databases and registers

Identification

Records identified from*: Databases (n = 1,767)

Records removed before screening: Duplicate records removed (n = 561)

Records screened (n = 1,206)

Records irrelevant (n = 720)

Screening

Reports assessed for eligibility (n = 486)

Reports excluded:
  Debriefing non-critical events: (n = 250)
  Other type of nursing: (n = 160)
  Outside of U.S.: (n = 36)
  Not measuring outcomes of interest: (n = 35)

Included

Studies included in review (n = 5)
Appendix B
Perceived Stress Scale

A more precise measure of personal stress can be determined by using a variety of instruments that have been designed to help measure individual stress levels. The latter of these is called the Perceived Stress Scale.

The Perceived Stress Scale (PSS) is a classic stress assessment instrument. The tool, while originally developed in 1983, remains a popular choice for helping us understand how different situations affect our feelings and our perceived stress. The questions in this scale ask about your feelings and thoughts during the last month. In each case, you will be asked to indicate how often you felt or thought a certain way. Although some of the questions are similar, there are differences between them and you should treat each one as a separate question. The best approach is to answer fairly quickly. That is, don’t try to count up the number of times you felt a particular way; rather indicate the alternative that seems like a reasonable estimate.

For each question choose from the following alternatives:

<table>
<thead>
<tr>
<th>0 - never</th>
<th>1 - almost never</th>
<th>2 - sometimes</th>
<th>3 - fairly often</th>
<th>4 - very often</th>
</tr>
</thead>
</table>

1. In the last month, how often have you been upset because of something that happened unexpectedly?
2. In the last month, how often have you felt that you were unable to control the important things in your life?
3. In the last month, how often have you felt nervous and stressed?
4. In the last month, how often have you felt confident about your ability to handle your personal problems?
5. In the last month, how often have you felt that things were going your way?
6. In the last month, how often have you found that you could not cope with all the things that you had to do?
7. In the last month, how often have you been able to control irritations in your life?
8. In the last month, how often have you felt that you were on top of things?
9. In the last month, how often have you been angered because of things that happened that were outside of your control?
10. In the last month, how often have you felt difficult tasks were piling up that you could not overcome them?

Figuring Your PSS Score
You can determine your PSS score by following these directions:

1. First, reverse your scores for questions 4, 5, 7, and 8. On these 4 questions, change the scores like this:
   0 = 4, 1 = 3, 2 = 1, 3 = 4, 4 = 0.
2. Now add up your scores for each item to get a total. Your total score is ________.
3. Individual scores on the PSS can range from 0 to 40 with higher scores indicating higher perceived stress.
   - Scores ranging from 0-13 would be considered low stress.
   - Scores ranging from 14-20 would be considered moderate stress.
   - Scores ranging from 21-40 would be considered high perceived stress.

The Perceived Stress Scale is interesting and important because your perception of what is happening in your life is most important. Consider the idea that two individuals could have the exact same events and experiences in their lives for the past month. Depending on their perception, total score could put one of these individuals in the low stress category and the total score could put the second person in the high stress category.

Disclaimer: The scores on the following self-assessment do not reflect any particular diagnosis or course of treatment. They are meant as a tool to help assess your level of stress. If you have any further concerns about your current well being, you may contact EAP and talk confidentially to one of our specialists.
STOP for 5 Minutes

Thank the full team and ask “Is everyone ok?”
If YES then continue as below and STATE FIRST:
• We are going to have a 5 minute team debrief
• Purpose is to improve quality of patient care; it is not a blaming session
• Your participation is welcomed but not compulsory
• All information discussed during this debrief is confidential

STOP

Summarise the case
Things that went well
Opportunities to improve
Points to action and responsibilities

STOP

Enter E Number Here:

Please DO NOT Apply Addressograph Label

HOT DEBRIEF

Type of Case (tick)

Please list all staff members present

Date:

☐ Medic One
☐ Enhanced or Code
☐ Red Trauma Call
☐ Death in Resus
☐ Staff Triggered

Time:

Location:

This form completed by: ________________

Summarise the case

Things that went well

Opportunities to improve

EDINBURGH
EMERGENCY
MEDICINE

POINTS TO ACTION AND RESPONSIBILITIES

Include staff member to address each point

☐ HOT DEBRIEF not completed

Is a COLD DEBRIEF required?

YES ☐ NO ☐

Reason: ________________