**A Program Evaluation of a Nursing Leadership-Driven Clinical Debriefing Structure**

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**Abstract**

**Objective: To evaluate the effectiveness of a nursing leadership-led clinical debrief structure, focusing on the ability of nursing leaders to facilitate clinical debriefing and enhance its utilization in clinical practice.**

**Introduction: Healthcare professionals often face stressful clinical situations such as death and trauma, making clinical debriefing essential for reflecting on action, learning through interdisciplinary feedback, and identify patient care issues. Despite its benefits, clinical debriefing is underutilized. The Five E’s Model of Debriefing emphasizes the role of an experienced facilitator, but the ideal discipline for leading a debrief session remains unclear. Nursing leadership, with its strong interprofessional skills, could potentially enhance debriefing practice and increase its use.**

**Methods: A program evaluation was conducted on inpatient nursing units, excluding emergency and outpatient areas. Completed debrief forms, nursing surveys, and leadership evaluation were collected and analyzed to compare barrier to participation, satisfaction, and leadership performance.**

**Results: Out of 37 cardiac arrest events, 46% had a debrief session. Nursing leaders facilitated 76.5% of these sessions. The primary barrier to participation was a lack of awareness. Nursing leaders’ performance was satisfactory, with most nurses willing to integrate debriefing into practice. Most nursing leaders found the debriefing process valuable and are likely to adopt it as a standard practice.**

**Conclusion:** Debriefing is seen as a valuable process across all healthcare environments, while nursing leaders can effectively facilitate debrief sessions, their role alone does not guarantee increased utilization. Individual preferences among leaders regarding the practice of clinical debriefing can affect implementation. Facilitators need specialized training to improve debriefing quality and frequency.

*Keywords*: nursing leadership, clinical debriefing, healthcare management, nurse satisfaction, experienced facilitator, clinical event analysis, debriefing model, leadership impact

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Healthcare professionals work in a demanding environment that exposes them to death, trauma, violence, and other unexpected outcomes. These clinical events have been identified as contributing factors to work-related stress. Repeated exposure to these clinical events in tandem with elevated work-related stressors increases the risk of burnout for healthcare professionals (Sugarman et al., 2021). Healthcare professionals report burnout and work-related stress secondary to patient acuity, lack of resources, staffing constraints, and repeated exposure to critical events (Nerovich et al., 2023). These phenomena can directly contribute to a decreased quality of care and reduced patient satisfaction (Al-Majid et al., 2018). As a healthcare system, it is crucial for early recognition, intervention, and awareness of clinical events experienced at the bedside by our healthcare professionals.

A level III trauma center within the city of Warren, Michigan, serves a variety of adult-geriatric populations. In September 2023, the organization launched its first structured clinical event debrief process to address the emotional support needs of staff while promoting clinical reflection and quality improvement. This practice change was guided by the American Heart Association's strong recommendation for post-event debriefing as a standard practice operation (Conoscent et al., 2021; Rose & Cheng, 2018; Toews et al., 2021). An evaluation of the program can provide insight for further system-wide dissemination and advancement of knowledge around the phenomenon of clinical debriefing.

# **Background/Significance**

*Clinical debriefing* is an intervention that could be a worthwhile investment by the healthcare system to provide healthcare professionals an opportunity for reflection and identifying opportunities for improving performance and process. Clinical debriefing aims to facilitate a reflective discussion of actions and processes, provide the opportunity for learning through interpersonal feedback, and identify larger system-level issues in patient care (Hale et al., 2020). While debriefing in simulation-based education is well known, clinical debriefing in real-world healthcare has been an emerging topic within the last few years. Clinical debriefing has been associated with numerous benefits, not only for the organization but also for the personal benefits of healthcare professionals. Debriefing has been shown to increase the clinical performance of healthcare professionals, inform potential improvement to clinical processes, improve communication and teamwork, and support the team's emotional needs (Welch-Horan et al., 2022). Clinical debriefing can be facilitated through tools that guide leaders to identify growth and improvement. Implementing a guided clinical debrief may provide a more standardized approach as it offers a consistent structure (Phillips et al., 2023). Despite these findings and recommendations, the use of a formalized clinical debriefing process remains underutilized (Conoscent et al., 2021; Hale et al., 2020; Rose & Cheng, 2018; Sugarman et al., 2021; Toews et al., 2021).

## **Local Problem**

The Critical Care Clinical Nurse Specialist (CNS) at a Level III trauma center in Southeast Michigan identified the need to implement a formalized clinical event debriefing process. The idea for a clinical debrief structure was due to multiple staff requests to debrief despite having the resources available for the team to conduct a debriefing session. As a member of several review committees, the CNS identified opportunities in which a clinical debriefing could allow for real-time interdisciplinary reflection to improve clinical processes and communication. Before the implementation of the debriefing process, quality improvement opportunities related to critical events were identified through request meetings with hospital leadership and reviewed on a case-by-case basis. After reviewing incidents with healthcare team members, some individuals stated their desire to have a debriefing after stressful clinical events. This prompted the CNS to investigate the occurrences of debriefing after clinical events. It was found that the clinical debrief rarely occurred and, if conducted, was only offered after a cardiopulmonary arrest. The current form instituted at the facility also failed to acknowledge the emotional support needs of the staff. These findings prompted the creation of an interdisciplinary quality improvement team to establish a formalized clinical debrief that addressed opportunities for improvement and the emotional support needs of staff following any critical event within the facility. In September 2023, the interdisciplinary team implemented the new formalized clinical debrief process. Clinical debriefing is now required for every cardiopulmonary arrest and upon staff request, but it is easily accessible for any clinical event. Hospital leadership was identified as the optimal debrief facilitator to lead the reflective discussions and address staff well-being.

# **Problem Statement**

The hospital organization recently implemented a newly created clinical event debriefing process. This is the first structured process for clinical debriefing implemented within the hospital. Clinical debriefing has been shown to improve clinical performance, improve patient outcomes, and reduce stress among participating associates; however, debriefing is still widely underutilized within the hospital setting. Stakeholders' buy-in and organizational culture are essential to sustain the practice of clinical debriefing. It is important to provide hospital leadership with a comprehensive evaluation of the debriefing pilot project. The organization must evaluate the clinical debriefing structure and its barriers to optimize the process of clinical debriefing and maximize the potential benefits for the individual staff, teams, systems, and patients.

# **Clinical Questions**

There are three main questions associated with this evaluation: (1) Is the clinical debrief process being utilized; (2) Are nursing leaders actively participating in the debrief of the clinical events and can they be considered as experienced facilitator; (3) What is nursing staff’s perceptions of the clinical debriefing process? Additional questions that are desired to be known about the clinical debrief process include:

* What are the associated barriers to conducting a clinical debrief?
* Is there a difference in satisfaction of clinical debriefing between years or experience and unit population?
* Does the nursing leader as an experience facilitator increase the utilization of clinical debriefing in clinical practice?

# **Literature Review**

## **Search Methods, Terms, and Study Selection**

The preliminary literature review established that identifying a debriefing framework when developing a debriefing process is essential. The systematic literature review aimed to identify existing frameworks to facilitate a formalized debriefing process while examining the use of debriefing for emotional support and quality improvement. The systematic literature review used CINAHL, Pubmed, and ProQuest databases. The literature review search was conducted using the following terms in consultation with a nursing librarian: "critical event" OR "critical incident" OR resuscitation OR "cardiopulmonary resuscitation" AND debrief OR "clinical debriefing." The terms used in the literature search must be in the article's abstract. The articles had to be published from 2018 to the present day. For literature selection, the articles had to meet the inclusion criteria. Inclusion criteria include that the articles deal with the formalized debriefing process in an acute inpatient setting, have an available version written in English, and have been peer-reviewed. Articles considered could be from a qualitative/descriptive study or any higher level of evidence. Studies that focused on the pediatric population were considered when identifying existing debrief frameworks to assess if their results could be generalizable to the adult inpatient setting. Exclusion criteria included articles written in languages other than English, expert opinion papers, and other whitepaper sources, debriefing after simulated clinical events, having the article's main topic not related to a formalized debrief process or framework, and articles that only consisted of an abstract. This literature review focuses on clinical debriefing versus simulation debriefing to integrate quality improvement and healthcare professionals' emotional experiences regarding critical events. The articles used for the literature review were selected first by the title, then by reading the abstract and the whole text.

## **Body of Evidence**

After the literature search and selection were completed, seven journal articles were reviewed to compare clinical debriefing frameworks and their integration of quality improvement and emotional support. To establish the level of evidence for each article, the Polit-Beck evidence hierarchy/level of evidence scale for therapy questions was used (Polit & Beck, 2020). The level of evidence for the selected articles ranged from V to VII. The seven articles comprised three systematic reviews of qualitative studies, three qualitative studies, and one observational study. Based on the data present within the articles, four main themes were identified to assist with the evaluation of implementing a structured clinical debriefing process: (1) debriefing framework and tools, (2) debriefing inclusion criteria, (3) barriers to conducting a clinical debriefing session, and (4) the emotional and well-being aspects of debriefing.

### ***Framework and Tools***

Twenty-four different frameworks and tools were identified within the literature search. Of the four studies, all but one identified the critical framework on which their clinical debriefing process was based. The two systematic reviews focused on identifying debriefing frameworks within the literature to compare the feasibility and attributes needed to implement a clinical debriefing process successfully. The conceptual analysis article did not reference any debriefing frameworks but created the five E's model for analyzing debriefing frameworks, which was used within both systematic reviews (Toews et al., 2021). The five E's model considers an effective debriefing process when all attributes are met. These attributes include experience facilitators, environment, education, evaluation, and emotions. All identified tools within this literature review were intended to be used in the acute care setting, while three did not state their intended clinical environment. Twelve tools were intended for use in the emergency department, three were intended for use in an intensive care unit, and six were intended for a wide-spread range across the clinical setting (Coggins et al., 2020; Conoscent et al., 2021; Hale et al., 2020; Phillips et al., 2023; Rose & Cheng, 2018; Sugarman et al., 2021). Ten tools were to be explicitly used in a neonatal or pediatric setting (Hale et al., 2020; Phillips et al., 2023). When evaluating the 24 identified frameworks based on the five E's model, experience facilitators are the first element of debriefing. Thirteen frameworks identified a designated facilitator for debriefing sessions (Phillips et al., 2023). The role of the debriefing leader ranged from any member of the clinical event team to a senior nurse, physician, fellow, or clinical psychologist. The second element of a debrief includes the environment in which debriefing occurs. The time the clinical debriefing session was conducted varied depending on the desired tool. However, seven identified frameworks stated that a debriefing session would occur immediately after the event (Coggins et al., 2020; Hale et al., 2020; Phillips et al., 2023). The average length of the debriefing session ranged from five to ten minutes (Phillips et al., 2023). The environment required for debriefing discussed the session's physical location and duration and included the psychological environment. The psychological environment is described as the intent of each debrief framework to create a safe learning environment. Sixteen studies included statements relating the debriefing environment as a "blame-free" zone; however, only six debriefing tools made any statement regarding the efforts to keep the debriefing session confidential (Hale et al., 2020; Phillips et al., 2023). The attempt to evaluate the efforts of each debriefing framework was based on its ability to identify required changes and the tool's ability to identify how to implement the identified changes. All twenty-four frameworks identified necessary practice changes, but only five addressed the interdisciplinary teams' attempts to identify how the change may need to be implemented (Hale et al., 2020; Phillips et al., 2023). Emotion is the final element within the five E's model, which involves the attempt of the debriefing tool to address the well-being of the participants. Only nine frameworks address the well-being of participating staff, while eight provide a resource for follow-up well-being support (Phillips et al., 2023).

Based on the results of the literature search, six frameworks were identified as the most commonly used. These include the PEARLS approach to clinical debriefing, DISCERN, INFO, TAKE STOCK, STOP5, and REFLECT. Rose & Cheng (2018) identified that the DISCERN tool was used as a model during the creation of the INFO framework. The TAKE STOCK tool was modeled after the STOP5 tool (Sugarman et al., 2021). One study used the STOP5 framework and concluded that the PEARLS framework would be modifiable and feasible to perform clinical-based debriefing versus simulation-based (Coggins et al., 2020). However, no significant differences were reported in ease of use or the support of the debriefing process. The five E's model for analyzing debriefing frameworks will be used to compare the six commonly mentioned frameworks in the literature review. Regarding identifying an experienced facilitator, REFLECT, DISCERN, and INFO determined that senior clinicians like charge nurses and fellows would be recommended. STOP5 presents the idea that any resuscitation team member can be the facilitator, while PEARLS and TAKE STOCK failed to identify any recommended facilitator. All six frameworks set a recommended physical and psychological environment for conducting the debriefing session. All six of these frameworks used the standard Plus-Delta method as an approach to debriefing. This self-assessment model allows the participants to self-reflect to identify limitations in individual and team performances and system-level issues without assigning blame to one individual. According to Conoscent et al. (2021), REFLECT was the most straightforward tool for implementing a debriefing process due to its focus on obtaining direct interpersonal feedback. As described within the five E's model, to meet the criteria for evaluation, tools need to be able to identify required changes and identify how to implement change. While all frameworks could identify required practice changes, only PEARLS, TAKE STOCK, and STOP5 could identify the necessary steps to implement change (Phillips et al., 2023). PEARLS and STOP5 identified a specific staff member to follow up on recommended changes identified within the debriefing session. At the same time, the TAKE STOCK framework implemented quality improvement review forms to ensure the issues are being addressed (Phillips et al., 2023). The emotions attribute is also broken down into two parts. This includes addressing well-being during the debriefing session and the ability to follow up on well-being issues. STOP5, TAKE STOCK, and PEARLS were the only frameworks to attempt to address staff well-being; however, DISCERN and INFO provided psychology referrals on the form to staff who may need them (Phillips et al., 2023). REFLECT failed to acknowledge any part of the staff's well-being (Zinns et al., 2020).

### ***Criteria for Initiation***

The initiation criteria describe what clinical events would prompt staff to perform a clinical debrief session. Based on the twenty-four identified frameworks, all but one tool outlined criteria for initiating a debrief (Phillips et al., 2023). Most tools stated that "major clinical events" were the criteria for initiating a clinical debrief (Phillips et al., 2023). Major clinical events included cardiac arrest, intubation, or adverse outcomes such as unexpected death. Five of the tools stated that any clinical event could trigger a debrief, while six tools also included "staff request" as an acceptable criterion for the initiation of a debriefing (Hale et al., 2020; Phillips et al., 2023). Based on the six most identified debriefing frameworks stated above, STOP5, TAKE STOCK, INFO, and PEARLS allowed for major clinical events and staff requests to be included in the initiation criteria (Rose & Cheng, 2018; Sugarman et al., 2021). DISCERN was only intended for significant events, and REFLECT failed to state its debriefing criteria (Hale et al., 2020).

### ***Barrier to Implementation***

While the perceived helpfulness by staff regarding the use of debriefing on well-being and clinical competence has been documented throughout the literature, barriers to its implementation still exist. This literature review discovered four different barriers to clinical debriefing utilization. The absence of a clear protocol and structure for debriefing was identified as a barrier in three studies (Conoscent et al., 2021; Hale et al., 2020; Phillips et al., 2023). This barrier occurred when facilities did not have a framework or tool built within their operational procedures. The lack of a trained facilitator was an additional barrier identified in the literature (Conoscent et al., 2021; Rose & Cheng, 2018). The inability to have a strong debriefing facilitator negatively affected the perception in which participants found the debriefing not to be beneficial. Lacking a trained facilitator impacted communication within the multidisciplinary team, and one study reported that exchanging suggestions without passing judgment was an occurring issue (Conoscent et al., 2021). Studies that included training for their designated debriefing facilitator did not report this as a barrier to their implementation. The perceived lack of time by the debriefing participants was the most cited barrier to implementing and utilizing a clinical debriefing session (Hale et al., 2020; Rose & Cheng, 2018; Sugarman et al., 2021). Within the implementation of the TAKE STOCK debriefing tools, 94.1% of stakeholders stated that "time pressure" after a clinical event was a significant barrier to conducting a debriefing session (Sugarman et al., 2021). The unrelenting care demands required by staff to perform adequate patient care impeded the utilization of debriefing. Finally, Sugarman et al. (2021) was the only study to identify that current hospital culture and reluctance due to perceived emotional sensitivity were barriers to a clinical debriefing's utilization.

### ***Emotions and Well-being***

Implementing a debriefing process should consider the clinical and potential emotional benefits. The five Es describe emotions as a core component of a clinical debrief framework, starting with the staff's psychological well-being, which is addressed by the debriefing facilitator and followed up (Toews et al., 2021). However, this literature review shows that addressing the well-being of staff is not always considered. Sugarman et al. (2021) propose that the ability of the debriefing to facilitate "emotional venting" can promote well-being among participants and diffuse potential built-up frustrations. As time has been identified as a potential barrier to debriefing, time can also be interpreted as a barrier to addressing well-being. As most tools recommend a debrief duration of less than 10 minutes, fully exploring the emotions of associates within a clinical debrief may be limited (Phillips et al., 2023). Nonetheless, neglecting to address emotions in a clinical debrief can have negative consequences. When unprocessed emotions are not acknowledged, this may lead to greater incidences of work-related stress, leading to occupational burnout and affecting patient care (Al-Majid et al., 2018; Sugarman et al., 2021). Therefore, emotions should be included within the debrief discussion to promote the overall effectiveness of clinical event debriefing while providing a follow-up process for staff who require it to promote staff well-being.

## **Discussion**

A trauma level III hospital in Southeast Michigan has designed and implemented its new clinical debrief process. This systematic literature review aimed to identify a formative evaluation process to identify staff's perceived emotional well-being and quality improvement support while identifying any potential barriers to utilizing a formalized debriefing process. The systematic literature review explored the strengths and weaknesses of twenty-four different clinical debriefing tools designed to be used in various acute care settings. Using the five Es framework for debriefing evaluation provides an in-depth understanding of what is being addressed in the tool and the methods for doing so. All five attributes, namely, educated/experienced facilitator, environment, education, evaluation, and emotions, should be addressed within a clinical debrief (Toews et al., 2021).

To continue with the evaluation of a debriefing process, one has to acknowledge the lack of program evaluations. Based on the literature selection, it's clear that most of the existing literature regarding clinical debriefing in acute care settings has focused on implementing the debriefing framework. Because most studies emphasize their results based on implementation and fail to capture the long-term effects of the debriefing process, there is limited clarity for persons seeking to implement a debriefing process. However, the literature identifies essential concepts to consider for evaluating a clinical debrief process in the acute care setting. This has been done through the Five E's model, which indicates that educated/experienced facilitator, environment, education, evaluation, and emotions. Identifying the Five E's model in literature, yet the lack of literature based on the evaluation of debriefing frameworks signals a gap towards the structured implementation of a clinical debriefing process.

Another gap in the literature is the limited validation and comparison between frameworks. Within the literature review, twenty-four different frameworks existed, yet there was little validation or generalization within these frameworks to suggest their sustainability outside of the organization for which they were created. Since the debrief structure has to meet the unique needs of the individual facility, data cannot be generalizable to other populations. Studies are often restricted to anecdotal data due to the nature of the clinical debrief's intent (Sugarman et al., 2021). A lack of consistency in the measures used has impacted some of the studies used in this literature review to compare tools. It is essential to collect descriptive, self-reported assessment data to ensure that the debriefing structure meets the needs of its stakeholders, but this creates a unique problem for researchers when assessing each tool's reliance on producing similar outcomes. Toews et al. (2020) also identified that an obstacle within the literature is the irregularity and inconsistency of debriefing in clinical settings, as barriers to clinical culture may vary depending on location. Future studies should continue to explore comparative results to assess the feasibility and validity of debriefing tools to confirm the benefits of staff well-being and clinical outcomes.

# **Organizational Assessment**

Adopting a structured clinical debriefing process is a multidisciplinary approach that requires the support of nursing leadership and bedside nursing staff, physicians, and other support services. In order to provide staff with effective facilitators, it was determined by a multidisciplinary team that nursing leaders and house supervisors would be the optimal choice for facilitating clinical debriefing sessions. Nursing leadership would be expected to lead debriefs during regular working hours, while the house supervisors would cover weekends and nighttime hours. Once the forms are completed, the collected forms will be sent to the Nursing Quality Council for further data analysis and potential quality improvement. A macrosystem SWOT analysis was conducted to explore and identify internal and external characteristics that will influence the implementation of the clinical debrief process.

## **Strengths**

The strengths of implementing the structured debriefing process are its support for nursing leadership and its origins rooted in the nursing staff's requests to debrief. The intent for the debriefing process was started by several staff members' requests to debrief after clinical events to improve their skills and knowledge. Due to the nature of this project being driven by the desires of nursing staff requests, it can be assumed that there is a level of support from the nursing staff to support its implementation and evaluation. Nursing directors were involved in the multidisciplinary team. Due to the active engagement from nursing leadership, the project has been given the resources it needs to be instituted for a hospital-wide implementation. The only projected costs associated with the program are printing the debriefing tools and distributing them to all code carts within the hospital. Completing a debriefing session requires only five to ten minutes of the multidisciplinary team's time, which should not cause significant delays in patient care.

## **Weakness**

A few weaknesses have been identified within the implementation of the debriefing process and requires re-assessment in the evaluation process. One foreseen weakness is the lack of understanding and awareness that some staff may have. While the need for debriefing is identified by nursing staff requests, not all hospital employees know there is a formal process for the debriefing. This may lead to a lack of interprofessional support and collaboration to encourage participation across all providers. Since this debriefing process is accessible to all clinical situations, staff may not understand that they have the power to request a debrief at any time. While education has been created and sent to all nursing staff, non-nursing staff lack the same accessibility to implement education. Our advanced practice providers and resident staff receive education only via email. This creates a barrier to our implementation as, while email is the primary source of communication, email is overutilized, which causes vital messages to go unnoticed. Without the known ability of our provider staff to request or participate in debriefing sessions, support for staff requests may go unnoticed or underappreciated. Nursing leadership buy-in may vary across different units and populations which may decrease utilization. Nursing leaders may also have a different level of buy-in from those nurses requesting the debriefing structure and process which may lead to a lack of an experienced facilitator.

## **Opportunity**

Implementing the new structured debriefing process allows staff to address the emotional support and well-being of others and provide them with support resources. This creates the most significant opportunity for the organization and requires attention in the program evaluation. Due to the debriefing tool's reference to support resources, staff can better utilize support services, which will optimize the benefits for individual staff, patients, and the entire healthcare system. Negative emotions from stressful clinical events can affect clinical decision-making and contribute to burnout (Jiffry et al., 2023). The ability for the debriefing session to occur soon after stressful events and aid in the transition from high stress to a typical working environment can reduce fatigue, anxiety, and burnout and contribute to higher nursing satisfaction and a reduction in voluntary turnout (Jiffry et al., 2023). Clinical debriefing has also promoted quality improvement (Conoscent et al., 2021; Phillips et al., 2023; Sugarman et al., 2021). This allows the organization to identify cost-effective initiatives to promote patient outcomes and process improvement. The organization has multiple resources to address the well-being of the associates. These resources include a nursing wellness and staff engagement committee, a nurse-driven crisis intervention team to address staff's emotional support, and chaplain services. While these resources are available to staff, their utilization remains low. A debrief tool can help connect staff to appropriate resources to promote wellness and emotional support.

## **Threats**

The primary threat to clinical debriefing is the inability of structured debriefing to meet the staff’s needs, creating a sense of unrecognized importance to prioritizing wellness, causing a negative organization perception and hindering recruitment efforts. As stated within the literature review, the inability of the debriefing process to meet the needs, goals, and preferences is a barrier to its implementation. If the newly implemented structure does not meet the desired needs of the organization, then a loss of support from leadership will soon follow. This will create a domino effect where encouragement to staff to conduct debriefing sessions will occur, and the debriefing process will fail to be adopted as a practice culture within the organization. However, suppose the organization does not attempt to implement a debriefing process that works within the organization's practice culture. In that case, this may lead to gaps in staff skills, system failures, and substandard care for future patients (Toews et al., 2021). Another threat is the organizations' ability to be competitive within the healthcare market. Other organizations within the Southeast Michigan region have implemented well-adopted support services for hospital employees. In return, these organizations are highly respected by their associates as the effective emotional services provided give the perception that staff well-being is essential. Suppose the organization fails to address the emotional support needs of its staff. In that case, this will continue to negatively impact the organization and potentially create a reputation among the healthcare community as an organization that does not prioritize its staff's well-being.

# **Theoretical and Conceptual Frameworks**

Implementing a clinical debriefing process is comprehensive and involves multiple resources and disciplines to work effectively. Evaluating the clinical debriefing process is not different and requires the guidance of a theoretical and conceptual framework. The logic model will provide the overall organization of the program evaluation and include the input, activities, and outcomes that occurred. The logic model will help plan for the resources and activities that are necessary for the multidisciplinary team conducting the program evaluation and plan for the anticipated outcomes that can affect the clinical debriefing’s sustainability (Appendix A).

## **Theory of Reflective Practice in Nursing**

The Theory of Reflective Practice in Nursing is a middle-range theory that highlights the potential of reflection to optimize nursing practice. The theory assumes that a person consists of multiple dimensions, including physical, cognitive, emotional, social, and spiritual; these dimensions are affected by events or clinical situations that affect the person, the processes, and results (Galutira, 2018). Through the process of reflection, a person can analyze personal feelings, thoughts, or actions to identify one's triggers and use the process to learn and grow to develop new skills to better their lives and others. The theory promotes the idea that reflection brings about personal and professional development, resulting in improved care outcomes (Galutira, 2018). Then, through these positive outcomes, reflection will be integrated into the day-to-day clinical practice. Clinical debriefing is a multidisciplinary reflective process that acknowledges that there are strengths, weaknesses, and emotional support needs after a high-stressed clinical situation. Clinical debriefing allows real-time learning, growth, and support to improve patient outcomes while developing a supportive workplace culture.

## **5 E's of Debriefing**

The five E's of Debriefing describe the critical characteristics of clinical debriefing. The five E's were identified according to their frequency of occurrence and the negative impacts in their absence (Toews et al., 2021). These five attributes are stressed as the goals of clinical debriefing and are necessary for the productivity of the debrief. The five attributes include:

* Educated/Experienced facilitator: designate an educated or experienced facilitator to lead the debrief.
* Environment: provide a psychologically safe and supportive environment for respectful review and exchange of information.
* Education: incorporate clinical knowledge and professional education.
* Evaluation: review the event for areas of improvement. Set attainable goals and re-evaluate.
* Emotions: address the emotions of healthcare personnel involved in the event and follow-up as required.

The five E's of Debriefing model will act as the conceptual framework and will be used to guide the evaluation to ensure that all key attributes are uniquely identified within its structure and determine its effects on utilizing a leadership-driven clinical debriefing structure.

# **Purpose of the Project**

Clinical debriefing is an emerging practice and preferred method to facilitate a reflective discussion among healthcare professionals. Clinical debriefs have been shown to improve clinical performance, improve patient outcomes, and reduce stress among participating associates; however, debriefing is still widely underutilized within the hospital setting. Stakeholder buy-in and organizational culture are essential to sustain the practice of clinical debriefing. A program evaluation of the existing debriefing structure, process and outcomes can influence hospital policy and administrative support. Monitoring of staff feedback is assessed to determine the overall impact of debriefing in improving the health care team’s well-being, patient care, and organizational outcomes, while identifying potential barriers to its utilization.

This program evaluation seeks to appraise the utilization and feasibility of the newly implemented framework for facilitating a clinical debrief. Therefore, the purpose of this multidisciplinary, program evaluation is to:

1. Assess the feasibility of conducting a clinical debrief after a high-stressed clinical event through peer surveys.
2. Assess the utilization of the clinical debrief tool by examining the number of documented debrief sessions based on type of clinical event (cardiopulmonary arrest, rapid response, code stroke.
3. Determine the ability of the clinical debrief session to address the associate's well-being and the use of emotional support resources.
4. Assess the ability of the clinical debrief session and tool to identify opportunities for practice changes through the reported strengths and weaknesses of the clinical event within the completed documents.
5. Determine the organizational barriers to conducting a clinical debrief.
6. Determine if there is a cost-effectiveness associated with clinical debriefing as it relates to its ability to address associates' well-being and identify quality improvement.
7. Determine if the identified leader is the most appropriate for clinical debriefing.
8. Assess if the clinical debriefing process meets the five E's model's key attributes of clinical debriefing.
9. Determine if a multidisciplinary approach to debriefing is occurring.

# **Method**

## **Project Design**

This project is a program evaluation with a mixed-methods design which evaluated the recently implemented clinical debriefing structure through the help of a multidisciplinary team. The project's overall purpose was to evaluate the utilization and effectiveness of a nursing leadership-driven clinical debrief. Due to the inability to obtain baseline data before implementing the clinical debriefing process, there was no preliminary data. Data evaluated was obtained after the implementation of the clinical debriefing process. The program evaluation was conducted over four months. A project timeline will be developed to determine the projected project completion (Appendix B).

## **Ethical Considerations**

While there is a potential for staff to encounter retraumatization due to the reflective discussion of high-stressed clinical events, a systematic review consisting of thirteen studies found no reported evidence of any negative impacts of debriefing, including retraumatization (Scott et al., 2022). The clinical debrief process is a confidential peer review and a privileged document of the hospital organization, and any data collected during the evaluation was treated as such. The intent of the evaluation surveys was to identify the healthcare professional’s perception of the clinical debriefing process as well as the performance of the debriefing facilitator. Participation in the evaluation was completely voluntary and confidential. No individual identifiers were collected or reported in the data. Participants were encouraged to drop out of the study at any time if they no longer felt it was in their best interest to participate. Staff were informed of the minimal risk involved with participating in the evaluation process. Internal Review Board (IRB) applications were submitted to both Ascension Health System and the University of Detroit Mercy. Both institutions exempted this study from IRB review by its determination that this study is not research involving human subjects.

## **Setting and Sample**

The program evaluation was conducted on the inpatient units. The evaluation did not include the emergency department, clinical decision unit, and other outpatient procedural areas. The survey participants included any nursing and nursing support associates on the inpatient units as well as nursing leadership which includes unit managers and house supervisors. All completed debrief forms within the four-month evaluation period were considered in the final analysis.

## **Data Collection**

Data collection occurred for both quantitative measures and qualitative measures. A multidisciplinary team was developed to identify target strategies for implementing the data collection process. First, a quality liaison and chair of the Nursing Quality Committee provided the Project Director with copies of all completed debrief forms within a four-month evaluation period. The remaining members of the multidisciplinary team aided in the distribution of the evaluation survey QR codes. The Project Director was responsible for disseminating findings and identifying themes within the completed forms and surveys.

Quantitative data was primarily obtained through the completed debrief forms (Appendix C). A generated report of all cardiopulmonary arrests and rapid responses was obtained. Clinical debriefing can be quantifiable using both the debrief forms and the generated report. While the debrief forms consist of other clinical circumstances for conducting a clinical debrief (code stroke, workplace violence events, and staff request), there is no available method to determine their frequency. However, since all code strokes are initially paged as a rapid response in the inpatient units, any completed debrief for code strokes were counted towards a rapid response. Other quantitative data collected through the form included the number of participants, the identified debrief leader, the duration of debriefing sessions, the use of emotional support services, and distinct attributes of identified strength and improvement for the clinical event. These distinct attributes include clinical care, teamwork, communication, and leadership.

Qualitative data was primarily obtained through the evaluation survey, which included the optional written area where participants freely wrote their thoughts regarding the clinical debriefing process. Evaluation surveys were sent to nursing and nursing support staff as well as nursing leadership (Appendix D). This allowed for a richer evaluation not only from the perspective of the participants but all the designated debriefing facilitators. Qualitative data was obtained through staffs identified emotional support needs through the completed debrief forms.

## **Data Analysis Plan**

Descriptive statistics were utilized to analyze the patient populations and the characteristics of the participants. According to Toews et al., (2021), the five E's are abstract but provide direction for empirical measurement. Therefore, an analysis of the collected data emphasized the impact of each key attribute identified with the five E's framework. The collected quantitative and qualitative data from the debrief forms and surveys aid in the measurable success of a leadership-driven debrief structure. Likert scale data was displayed through frequencies and means, focusing on each key attribute affected the clinical debrief process. A thematic analysis was conducted to identify themes regarding the participants' perceptions of the debriefing process. A Kruskal-Wallis test was conducted to determine if there are significant differences on program satisfaction and likelihood to adopt in practice between years of experience and unit population. The Kruskal Wallis test is the non-parametric alternative to a one-way ANOVA which makes this an appropriate statistical analysis when assessing the difference between a dependent variable and an independent variable with two or more groups when the assumption of normality is violated (Intellectus Statistics). A significance level of 0.05 was used to determine if there are significant differences on the dependent variable between the level of the independent variable (Intellectus Statistics). All descriptive statistics and non-parametric tests were conducted using Intellectus Statistics software.

The evaluation of the outcome measures include:

1. The total number of completed clinical debrief sessions.
2. The number of debriefing sessions completed with an identified debrief leader as nursing leadership.
3. The ability of the facilitator to meet all key elements of debriefing.
4. Satisfaction of the session by the facilitators and participants.
5. Utilization of support resources from staff.
6. The percentage of staff participation and awareness of clinical debriefing.
7. Identified reported barriers to implementing a clinical debrief session.

# **Results**

## **Clinical Debrief Sessions**

The clinical debrief form was only a requirement after a cardiopulmonary arrest event. However, the form was available for other stressful clinical events, including rapid responses, strokes, workplace violence events, and at any time a staff requested. Based on the forms gathered from the Nursing Quality Committee, a clinical debrief session was only being conducted following a cardiopulmonary arrest event. Thirty-seven cardiopulmonary arrest events occurred within the four-month implementation period. Of the thirty-seven possible clinical debrief sessions, only seventeen of the clinical debrief forms were completed. The clinical debrief process has had a 46% (n=17) utilization rate. Nursing leadership accounted for 76.5% (n=13) of the clinical debrief facilitators, while the remaining 23.5% (n=4) were made up of other healthcare professionals, including advanced practice providers and physicians. Nursing leadership is an overall representation of two different positions: house supervisor and clinical nurse manager. Of the thirteen clinical debrief sessions led by nursing leadership, twelve (92.3%) were conducted by the clinical nurse manager, and only one was led by the house supervisor. The average length of the clinical debrief sessions was 4.8 minutes, with the longest reported time being 14 minutes. The clinical debrief forms collected identified that each session was multidisciplinary, and the average number of participants was six. Teamwork (n= 13, 76.5%) was the most identified strength during the debrief sessions. Some comments included "appropriate number of compressors" and "smooth transitions between compressors." Communication (n= 8, 47.1%) was the most identified opportunity for improvement. Communication comments included crowd control and closed-loop communication. It was reported in six cases that there were "too many people in the room," causing loud noise levels and affecting communication. Concerning addressing emotional support needs, only six (35.3%) clinical debrief sessions documented the emotional support needs of staff members and three (17.6%) occurrences where Chaplin services were requested.

## **Nursing and Nursing Support Evaluations**

 For evaluation, the data is represented as frequencies and percentages. Crosstabulation of unit populations with position and barrier to participation was examined (see Table 1). This purpose was to connect unit populations' specific data with the nursing leadership responses of similar unit populations. A crosstabulation of unit population with satisfaction was also conducted (see Table 2). This was done to evaluate if the nursing leader's performance in incorporating the five critical attributes of clinical debriefing varies among levels of experience, which, in turn, impacts the satisfaction of clinical debriefing.

**Table 1**: Frequency table for unit population with position and barriers to participation

|  |  |
| --- | --- |
|   | Unit Population |
| Variables | Critical Care (n= 18) | Medical/Surgical (n= 27) | Cardiac Telemetry (n= 25) | Total (n= 70) |
| No. of participants in Clinical Debriefing | 10 (55.6) | 13 (48.1) | 9 (36.0) | 32 (45.7) |
| **Position** |  |  |  |  |
|  Registered Nurse | 14 (77.8) | 18 (66.7) | 23 (92.0) | 55 (78.6) |
|  Unlicensed Assistive Personal | 4 (23.2) | 9 (33.3) | 2 (8.0) | 15 (21.4) |
| **Barriers to Clinical Debriefing** |  |  |  |  |
|  Choice not to participate | 0 (0.0) | 4 (14.8) | 0 (0.0) | 4 (5.7) |
|  Team unaware of the Clinical Debrief process | 3 (16.7) | 7 (25.9) | 4 (16.0) | 14 (20.0) |
|  Absence of an experience facilitator | 3 (16.7) | 0 (0.0) | 3 (12.0) | 6 (8.6) |
|  Time Constraints | 1 (5.6) | 5 (18.5) | 7 (28.0) | 13 (18.6) |
|  Patient Care Needs | 2 (11.1) | 2 (7.4) | 2 (8.0) | 6 (8.6) |
|  Team Dispersion | 1 (5.6) | 1 (3.7) | 2 (8.0) | 4 (5.7) |
|  Team Declined | 0 (0.0) | 0 (0.0) | 1 (4.0) | 1 (1.4) |

 Seventy registered nurses (RN) and unlicensed assistive personnel (UAP) participated in the evaluation survey. Eighteen (25.7%) nurses identified as working within the critical care population, twenty-seven (38.6%) were from the medical/surgical population, and twenty-five (35.7%) were from the cardiac telemetry population. Thirty-two (45.7%) associates participated in a clinical debrief session. Ten (55.5%) of them were from critical care, thirteen (48.1%) were from medical/surgical units, and nine (36.0%) were from cardiac telemetry units. Barriers to participation were divided into seven different selections: declined to participate, team unaware of the clinical debrief process, absence of an experienced facilitator, time constraint, patient care needs, team dispersion, and the team declined. The most identified barrier to participating in a clinical debrief was a lack of awareness of the process (n=14, 20.0%). This was mainly prominent in the medical/surgical units, where seven (25.9%) associates stated this as a barrier. This was also the most reported barrier for the medical/surgical associates. Time constraint was also a frequently reported barrier to participation, with thirteen (18.6%) associates identifying this as a barrier. Time constraints were mainly reported as a barrier in the cardiac telemetry population (n=7, 28.0%) and were this population's highest reported barrier. Associates declining to participate in a clinical debrief were only reported in the medical/surgical population (n=4, 14.8%). Of the four associates who desired not to participate, one was a UAP, and the other three were RNs. A total of six (8.6%) associates identified the absence of an experienced facilitator (nursing leadership) as a barrier to participation. Patient care as a barrier to participation was equally distributed among each unit population, with two associates from each unit identifying this as a barrier. Team decline was the least reported barrier to participation (n=1, 1.4%).

**Table 2**: Frequency table for unit population with 5 E’s of clinical debriefing, and satisfaction

The questions in Table 2 represent the key attributes for successful clinical debriefing according to the Five E's Model of Clinical Debriefing (figure A). Based on the results of those associates who participated, the debrief facilitators met satisfactorily in all key attributes of clinical debriefing. The debrief facilitators scored the highest in Emotions, specifically by addressing the well-being of participants and providing additional support resources when needed (4.62). The lowest overall key attribute was the environment, with the debrief facilitator's ability to encourage participation from all associates (4.34). This was also the lowest-performing attribute for associates in the medical/surgical population. For associates in the cardiac telemetry units, the debrief facilitator performed the highest in their ability to provide a psychologically safe environment and staff with an opportunity for personal and professional growth (4.78). For those associates who worked in the critical care units, the ability of the debrief facilitator to provide clarity regarding the clinical event (4.30) was the lowest performing aspect for the facilitator.

**Figure A**: Survey questions and their corresponding key attributes

## **Satisfaction**

 Satisfaction with clinical debriefing was assessed with two questions: (1) overall experience and (2) likelihood to adopt in practice. These questions were only asked to those who participated in a clinical debrief session (n=32). The score is based on a Likert Scale, with five being very satisfied and one being very dissatisfied. Overall experience and likelihood to adopt in practice were crosstabulated with unit population and years of experience (see Table 2 & Table 3). The overall experience was 4.25, and the overall likelihood of adopting into practice was 4.53.

**Table 3**: Frequency table for years of expereince with years of experience and satisfaction

|  |  |
| --- | --- |
|   | Years of Experience |
| Variables | 1-4 years (n= 8) | 5-9 years (n= 13) | 10 years or more (n= 11) | Total (n= 32) |
| **Satisfaction** |  |  |  |  |
|  Overall Experience | 4.00 | 4.23 | 4.45 | 4.25 |
|  Likelihood to adopt in practice | 4.50 | 4.31 | 4.82 | 4.53 |

### ***Satisfaction and Unit Population***

For overall experience, there was no discernible difference between unit populations with a satisfactory score achieved. The highest satisfaction came from the cardiac telemetry associates (4.44), and the medical/surgical associates were the least satisfied but still had a score of 4.15. There was no discernible difference between unit populations when examining the likelihood of adopting into practice. The highest likelihood of adoption into practice came from the cardiac telemetry associates (4.78), and the lowest-scoring unit was from the critical care population (4.20). The nonparametric statistical test, the Kruskal-Wallis Test, was performed to assess if there was a statistically significant difference in both satisfaction and likeness of adopting into practice with the unit population. The results for both tests were insignificant, based on an alpha value of 0.05 (Tables 4 & 5).

**Table 4:** Kruskal Wallis Rank Sum Test for Overall Experience by Unit

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Level | Mean Rank | *x*² | *df* | *p* |
| Medical/surgical | 15.23 | 0.50 | 2 | 0.781 |
| Cardiac Telemetry | 17.33 |  |  |  |
| Critical Care | 17.4 |   |   |   |

**Table 5**: Kruskal Wallis Rank Sum Test for Adoption into Practice by Unit

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Level | Mean Rank | *x*² | *df* | *p* |
| Medical/surgical | 15.92 | 0.68 | 2 | 0.711 |
| Cardiac Telemetry | 18.28 |  |  |  |
| Critical Care | 15.6 |   |   |   |

### ***Satisfaction and Years of Experience***

 The overall experience and the likelihood of adopting into practice based on years of experience achieved satisfactory scores based on the Likert Scale. Associates with ten years or more of experience (n=11) were more satisfied (4.45) with their experience with clinical debriefing, as well as were more likely to adopt clinical debriefing into practice (4.82) than associates with less than ten years of experience. The nonparametric statistical test, the Kruskal-Wallis Test, was performed to assess if there was a statistically significant difference in both satisfaction and likeness of adopting into practice with years of experience. The results for both tests were insignificant, based on an alpha value of 0.05 (Tables 6 & 7).

**Table 6**: Kruskal Wallis Rak Sum Test for Overall Experience by Years of Experience

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Level | Mean Rank | *x*² | *df* | *p* |
| 10 years or more | 17.95 | 0.67 | 2 | 0.714 |
| 5-9 years | 16.35 |  |  |  |
| 1-4 years | 14.75 |   |   |   |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Level | Mean Rank | *x*² | *df* | *p* |
| 10 years or more | 18.86 | 1.62 | 2 | 0.445 |
| 5-9 years | 15.08 |  |  |  |
| 1-4 years | 15.56 |   |   |   |

**Table 7**: Kruskal Wallis Ranks Sum Test for Adoption into Practice by Years of Experience

## **Nursing Leadership Evaluations**

Only six nursing leaders completed the clinical debrief evaluation. All six nursing leaders held the clinical nurse manager position, and each unit population had two representatives complete the survey. Out of the six participants, three indicated that they did facilitate a clinical debrief session, and the remaining three did not facilitate a debrief session. The most significant barrier identified among the six nursing leaders to facilitating a clinical debrief was team dispersion (n=3, 50.0%). The critical care clinical nurse managers identified that they chose not to participate in a clinical debrief session. The overall experience with the leaders who conducted a clinical debrief session was very satisfactory (n=3, 5.0). However, the likelihood of adopting into the unit's practice was only 3.83 (n=6). This is attributed to the low likelihood of adopting a score for critical care (n=2, 2.0).

# **Discussion**

## **Associate’s Experience**

Three distinct in-patient unit populations were evaluated in this study: critical care, medical/surgical, and cardiac telemetry. Despite the Kruskal-Wallis Test determining that there was no statistical significance between unit population and satisfaction of clinical debriefing, the test shows the clinical significance that satisfaction was similar between all populations, therefore indicating that clinical debriefing can be a valuable intervention for all unit populations. Most of the existing literature regarding clinical debriefing focuses on the phenomenon in the emergency department, intensive care unit, or pediatric environment. The data suggests that the phenomenon of clinical debriefing can and should be intended for any in-patient population. Interestingly, satisfaction scores for clinical debriefing were higher in the cardiac telemetry population compared to the critical care population. This may indicate that staff working in the adult acute in-patient setting find more value in the phenomenon of clinical debriefing compared to those associates working in the critical care population. Since so much of the existing knowledge regarding clinical debriefing focuses on what is considered a "more stressful" work environment like critical care and emergency medicine, the adult medical/surgical population tends to be unaccounted for yet can still experience the same stress-related unexpected clinical outcomes. One associate who participated in a clinical debriefing said, "The staff is very thankful and appreciative for the time to debrief."

The study divided satisfaction into two approaches: (1) the overall experience of participating in a clinical debrief and (2) the likelihood of adopting clinical debriefing into practice. Interestingly, both questions scored within a satisfactory range. Nevertheless, the likelihood of adopting into practice scores was higher regarding the overall experience for medical/surgical and cardiac telemetry populations. This finding suggests that staff understand the importance and relevance of clinical debriefing in bedside practice even though they may not have had an enjoyable experience. This concept is consistent and proven within the literature as multiple studies have reported staff's ability to recognize the usefulness of clinical debriefing to promote well-being, professional growth, and quality of care (Conoscent et al., 2021; Jiffry et al., 2023; Rose & Cheng, 2018; Sugarman et al., 2021). When comparing the associate's experience in clinical debriefing with years of experience, we again found no statistical significance between the groups, yet the average rating was satisfactory. These findings suggest the exact correlation with clinical debriefing, as did the unit population; associates find the clinical debriefing process beneficial regardless of their years of experience. In this study, associates with ten years or more of experience were more satisfied with their experience and were more likely to adopt it into practice than any other experience group. There is a preconceived bias associated with clinical debriefing that staff with less experience and those who work in more critical, high-stress environments will benefit primarily from clinical debriefing, and this may play a role in why there is little knowledge regarding clinical debriefing outside of the critical care, emergency medicine, and pediatric populations. However, this study has shown that clinical debriefing can be valuable to healthcare workers regardless of their years of experience or the consistency in which they experience unexpected high-stress work-related events. More research is needed to evaluate the phenomenon of clinical debriefing in the acute care in-patient setting to help ensure that staff who experience high-stress work-related events are being provided an opportunity to participate in a clinical debriefing.

## **Nursing Leadership and Clinical Debriefing**

The facilitator plays a crucial role in the success of clinical debriefing and is one of the five key attributes (Phillips et al., 2023; Toews et al., 2021). The lack of a trained facilitator is among the most cited barriers in clinical debriefing. The deficiency within the role can lead to dissatisfaction with clinical debriefing and potential harm to participants (Phillips et al., 2023; Toews et al., 2021). While the experienced facilitator is identified as a key component of clinical debriefing, there needs to be clear evidence to suggest the best discipline to adopt in this role. Previous studies have identified clinical staff, residents, fellows, attending physicians, and charge nurses as potential facilitators. In this study, nursing leadership was assigned to the role of an experienced facilitator, and the ability of the nursing leader to successfully perform this role and increase clinical debriefing utilization in practice was examined. To the author's knowledge, this is the first clinical debrief process with nursing leadership identified as the experienced facilitator.

### ***Nursing Leadership and Utilization***

 One of the core issues regarding implementing clinical debriefing is improving its utilization within the clinical bedside practice. Multiple studies have reported that clinical debriefing is not widely utilized (Conoscent et al., 2021; Hale et al., 2020; Phillips et al., 2023). While debriefing tools have been widely utilized to standardize the debriefing process to promote consistency and feasibility for utilization, the ability of the facilitator to promote this practice can also increase utilization. Sandhu et al. (2014) stated that hospital administration often inadequately supports clinical debriefing. Support is required from the organization to integrate clinical debriefing practices sustainably. Toews et al. (2021) suggest that nursing leadership's ability to "impact organizational culture" may optimize efficiency and improve the overall utilization of clinical debriefing.

This study identifies the nursing leadership role as a clinical nurse manager or a house supervisor. The house supervisor will cover when a unit manager is absent (night shift, weekends, holidays). The house supervisor was already responsible for responding to all cardiac arrest events within the hospital as part of the rapid response team to facilitate bed placement. Since the study only found a 47% completion rate for clinical debriefing, it questions not only the nursing leader's role but also the organization's support. The clinical nurse manager was the most identified facilitator, while the house supervisor was only identified once. The cardiac telemetry population identified that a lack of an experienced facilitator was a repeated barrier (n=3, 12%). However, the leadership evaluations reported no barrier to facilitation for the cardiac telemetry population. Since no house supervisors completed these surveys, there was no support from this nursing leadership position, which may have impacted the utilization of clinical debriefing. This study can also question the support of the clinical nurse manager for the critical care population since the two nursing leaders identified within the survey stated a lack of desire to facilitate a clinical debrief session. Critical care was another unit population to identify the lack of a facilitator as a barrier to participation. Based on these results, the role of nursing leadership as an experience facilitator does not inherently increase the utilization of clinical debriefing. The role of nursing leadership may have the ability to impact organizational culture in positive and negative ways. The individual preferences of the nursing leaders can impact the utilization within each unit. Organizations need to examine their current debriefing process and the support given by nursing leaders to evaluate necessary changes within the process to continue promoting clinical debriefing in practice.

### ***Nursing Leadership as an Experienced Facilitator***

 The Five E's of Clinical Debriefing model was used as an empiric method to measure the success of nursing leadership as an experienced facilitator. A series of questions represents each key element in the five E's model (see Figure A). Based on the ranking of each of those questions based on the Likert Scale, the study can determine the success of the facilitator. Based on the data presented in Table 2, this study supports nursing leadership as an experienced facilitator.

 Nursing leadership scored satisfactorily in all five aspects, indicating that the nursing leader can be an effective facilitator. When comparing the five E's by unit, cardiac telemetry had the highest evaluation score in all key attributes for the facilitator. The cardiac telemetry population also has the highest satisfaction score for the overall experience and the likelihood of adopting it into practice. These findings allow for the assumption that the experienced facilitator can play a vital role in the satisfaction of clinical debriefing. Toews et al. (2021) noted that dissatisfaction is commonly associated with poor communication and organization and is likely to result from the debrief facilitator. This study has proven that this concept is genuine. Cardiac telemetry associates gave the facilitators the highest score for question one (4.67), representing the idea that an organized session requires an experienced facilitator. The high score in this section is reflected in the overall experience (4.44). We subsequently see the opposite happening with the medical/surgical associates. The score for question one in the medical/surgical population was 4.23, the lowest of the unit populations. The medical/surgical population also had the lowest score for overall experience (4.15). While each category remains overall satisfactory, there is a correlation between the perceived organization of the clinical debrief session and the overall satisfaction, which can be attributed to the experienced facilitator. When examining the satisfaction of the unit populations compared to the nursing leader's performance as an experienced facilitator, the data shows that the attitude of the nursing leader regarding clinical debriefing may also impact staff satisfaction and participation. In the critical care population, two clinical nurse managers noted a lack of desire to participate in clinical debriefing as well as a desire to adopt into their practice. The critical care population also had the lowest score for the likelihood of adoption (4.20) compared to the other unit populations. The correlation may indicate that while nursing leadership may perform as an effective facilitator, the individual preferences of the nursing leader can affect the overall attitude of the clinical debrief practice. Healthcare professionals who receive debriefing education are more willing to participate and initiate clinical debriefing practices (Toews et al., 2021). This increase in education and level of experience can influence the quality and effectiveness of debriefing, which, in turn, will further increase the effectiveness of the experienced facilitator and participation of healthcare workers (Toews et al., 2021). While the nursing leadership role can be an effective facilitator, leaders who need more understanding of the importance of clinical debriefing should receive further training to increase their knowledge and skills to strengthen the facilitator role further.

# **Recommendations and Sustainability Plan**

The program evaluation has proven that nursing leadership can be effective facilitators of clinical debriefing yet can still result in low utilization. Recommendations provided from the program evaluation are based on the goal to improve utilization while maintaining nursing leadership as the primary facilitator. The recommendations are based on two main themes: (1) accessibility to debriefing form and (2) continuous education of staff.

1. While this program evaluation did not take into account the form’s availability or the lack thereof, ensuring easy access to clinical debriefing tools will aid in the facilitation and utilization of clinical debriefing within practice. The multidisciplinary team recommends that the clinical debrief forms be added to the daily code cart checklist to help ensure that all code carts are being stocked with the forms. To help with accessibility, the clinical debrief forms should be an orderable item from the print shops to all each unit to stock and maintain their own supply of clinical debrief forms. Allowing each unit the access to order clinical debrief forms when needed will allow for a quicker restock time and put less dependance on one individual being responsible for the restocking process.
2. Towes et al (2021) states that individuals who receive clinical debriefing education are more likely to participate in the practice. Integration of the clinical debrief process into mock codes and ACLS skills courses will aid in educating new and existing associates to further adopt clinical debriefing utilization into clinical practice.
3. Clinical debriefing should also be incorporated into the training/orientation process for nursing leadership to further strengthen the role of the nursing leaders as effective facilitators. While this program evaluation encourages the nursing leader to maintain the role as the primary facilitator, it is important to acknowledge that healthcare workers provided with debriefing education can have the skills to lead and implement sustained debriefing practices. Incorporating widespread education on facilitating a clinical debriefing will have multiple benefits: increase the multidisciplinary approach to clinical debriefing, promote a debriefing culture, and address the need of more debrief facilitator coverage.

With the clinical debrief process being reviewed through a nursing committee in the organization, continuous evaluation needs to continue in order to improve the structure and promote sustainable reflective practice. The identified barrier discovered within the data analysis should be considered to further enrich the clinical debrief process and ensure that all staff can debrief after stressful clinical events. 1) Quality Improvement projects derived from the debrief sessions should be reported to organizational leaders, allowing for an associated cost-benefit of clinical debriefing and improved patient outcomes. 2) Costs associated with implementing a clinical debriefing process should be defined by the average clinical debrief duration and productivity. With an average time of 4.8 minutes, clinical debriefing has minimal disruption into a unit's productivity and, therefore, has minimal costs to the organization. 3) Development of a policy on debriefing should be readily accessible to further engrain the need for clinical debriefing into the organization’s culture. 4) Consideration for the movement of this pilot project to other hospital system locations will further highlight the need for clinical debriefing practices.

# **Implications for Practice**

The conduction of a program evaluation of a nursing leadership-driven clinical debriefing structure will further enhance and complement the existing literature and knowledge of promoting the implementation of a clinical debrief structure. The irregularity and inconsistency of debriefing in clinical practice can often be attributed to inadequate support by hospital administration; therefore, nursing leadership may be considered an effective facilitator due to the ability to impact organizational culture and reduce 'negative psychological consequences' for staff (Toews et al., 2021). By evaluating the overall impact of the clinical debrief structure, we can determine whether or not it is plausible to assume that nursing leadership can optimize the efficiency and delivery of a multidisciplinary clinical debriefing. To the author's knowledge, no other nursing leadership-led clinical debrief structures have been evaluated or reported within the existing literature, making this a critical study to help guide the practice of future implementations of clinical debriefing.

# **Conclusion**

Clinical debriefing is a worthwhile holistic intervention that positively impacts the involved staff. However, the existing literature on clinical debriefing focuses on the critical care, pediatric, and emergency department populations. This program evaluation finds that clinical debriefing is beneficial and desired by all health professionals despite the patient population in which they work. Future studies need to focus on clinical practice environments outside of the critical care, pediatric, and emergency populations to understand further the ability of clinical debriefing to impact the entire hospital organization and staff satisfaction.

The role of the experience facilitator is an essential component of the debriefing practice. It can primarily play a role in the overall occurrence rates and the quality of clinical debriefing in the clinical setting. Despite this knowledge, more is needed to know about the best discipline to facilitate debriefing and improve utilization. Using the Five E’s of the Debriefing model, nursing leadership can successfully incorporate all key components to facilitate a clinical debrief session effectively, making the nursing leader a potentially effective facilitator. Regardless of the nursing leader’s ability to facilitate, the role of nursing leadership as the experienced facilitator does not inherently improve the utilization in clinical practice. Individual preferences of the nursing leaders can vary, inhibiting the standardization of clinical debriefing throughout the hospital organization. Debrief facilitators should also receive training and education, regardless of their discipline, to further strengthen their understanding and to improve the occurrence and quality of clinical debriefing. When selecting an experienced facilitator role, organizations should also consider the need to provide 24-hour coverage as clinical events have the ability to occur at any time, and the lack of a facilitator’s presence to conduct a debriefing session may be a barrier to its implementation.

# **Limitations**

There are several limitations to this study. The lead investigator for the program evaluation is also the lead implementor of the clinical debrief pilot which may impose unintended bias. Healthcare associates were asked to recollect their past clinical debrief participation experience, which may have skewed some of the data reported. Future studies may consider conducting their evaluation immediately after the clinical debrief session to ensure that associates reporting their perception of the experience are not misinformed due to the inability to recall their debriefing experience correctly. The study reported that other healthcare disciplines besides nursing leadership led four clinical debrief sessions. The associates who participated in these clinical debrief sessions were not identified and excluded from the survey, which may have affected the effectiveness of the nursing leadership role in effectively facilitating a clinical debrief session.  Nursing leaders own personal feelings towards clinical debriefing is a limitation of this study and an anticipated bias to the program outcomes. This was apparent in the critical care units that facilitators saw no need for clinical debriefing and was reflected by the staff.

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# **Appendix A: Logic Model**



# **Appendix B: Project Timeline**

|  |  |
| --- | --- |
| **Project Milestones** | **Est. Month of Completion** |
| **Jan** | **Feb** | **Mar** | **Apr** | **May** | **Jun** | **Jul** | **Aug** |
| Project Proposal Approved by Chair | **X** |  |  |  |  |  |  |  |
| IRB Submission | **X** |  |  |  |  |  |  |  |
| IRB Approval |  | **X** |  |  |  |  |  |  |
| Receive copies of completed debrief forms from Quality liaison |  |  | **X** |  |  |  |  |  |
| Review survey with chair and evaluation committee and implement |  |  | **X** |  |  |  |  |  |
| Data collection  |  |  | **X** | **X** | **X** | **X** |  |  |
| Mid project review with evaluation committee and chair |  |  |  |  | **X** |  |  |  |
| Project completion meeting |  |  |  |  |  | **X** |  |  |
| Data analysis and final write up |  |  |  |  |  |  | **X** |  |
| Dissemination of Results |  |  |  |  |  |  |  | **X** |

# **Appendix C: Clinical Event Debrief Form**

# **Appendix D**

## **Nursing & Nursing Support Evaluation Survey QR Code**



## **Nursing Leadership Evaluation Survey QR Code**

