Abstract

Problem: Working in the Pediatric Intensive Care Unit (PICU), staff encounter critical patient events without warning. Debriefing after adverse patient events has been shown to give staff the opportunity to process these events in an open, honest, and judgement-free environment. Debriefing has been recognized as a tool for detecting medical errors, improving team communication, providing emotional support, and analyzing team performance.

Methods: A descriptive, observational pilot study was used to implement the DISCERN tool into a large, midwestern, urban PICU. The aim of the quality improvement project was to achieve a debriefing tool completion rate of 20% over a one-month period. After an adverse patient event, a bedside debrief was led by a facilitator who followed the promptings on the DISCERN tool. The tool was then completed and returned to the charge nurse office. Once a week the tools were collected, and data was analyzed. A Qualtrics survey was then sent to staff after the data collection period.

Results: Four adverse patient events met criteria during the data collection period and four events were debriefed using the DISCERN tool (n=4, 100%). Themes were discovered after reviewing the completed tools. Six surveys were completed, and 100% of staff agreed that debriefing after adverse patient events necessary.

Implications for Practice: While the DISCERN tool provided great feedback and identified what went well during adverse patient events and areas for improvement, this information will further be used to create a new unit specific debriefing tool.