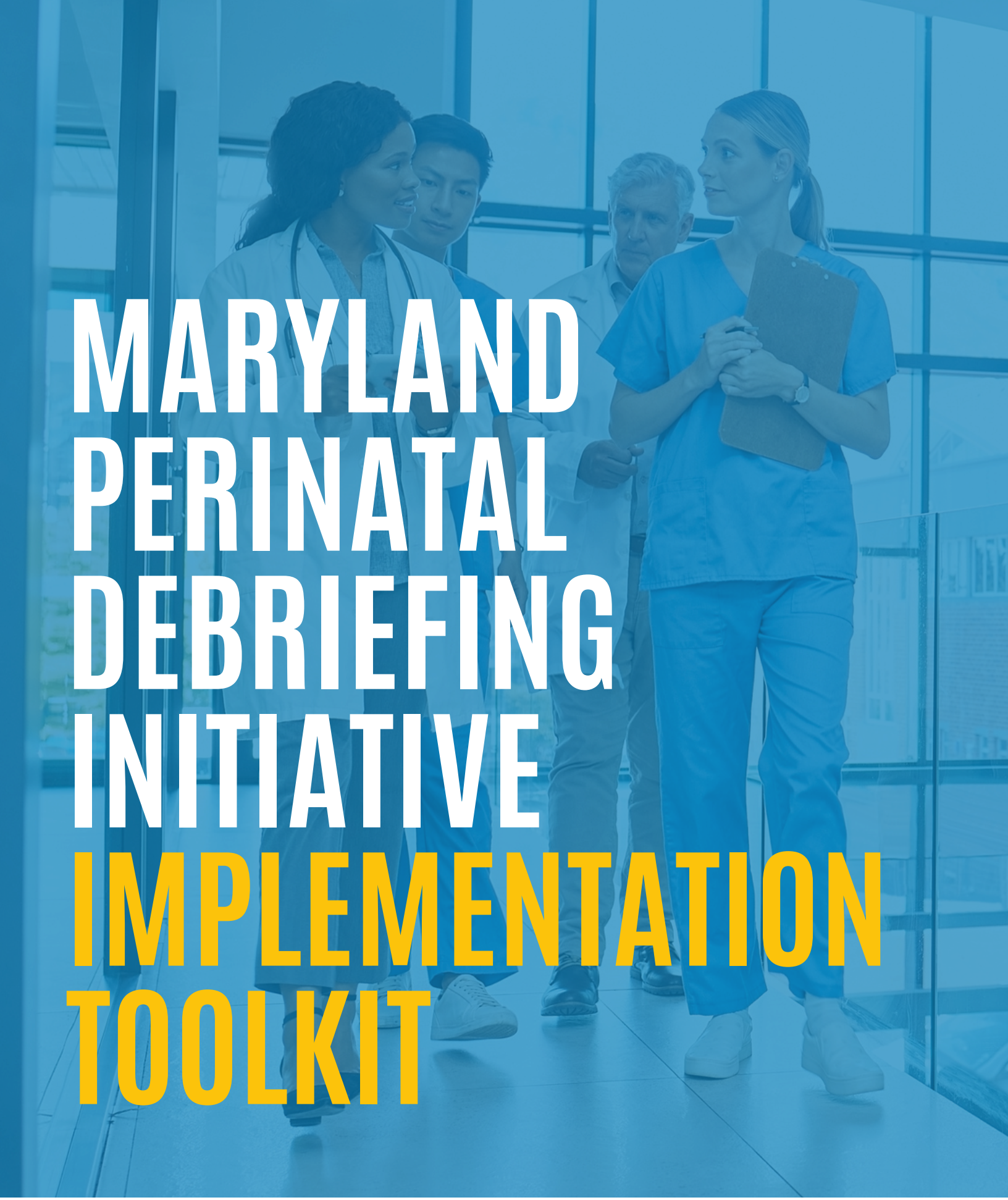

MARYLAND PERINATAL DEBRIEFING INITIATIVE

IMPLEMENTATION TOOLKIT

MD MOM
Maryland Maternal Health Innovation Program

Maryland Patient Safety Center

"Health care providers are often 'second victims' of traumatic childbirth events and should be adequately supported by their organizations to alleviate occupational stress and burnout."
(Shorey et al., 2022)

This toolkit was designed by

Adriane Burgess, PhD, RNC-OB, CCE, C-ONQS, C-EFM, FAWHONN
Senior Director of Innovation in Patient Safety and Quality
Maryland Patient Safety Center
aburgess@marylandpatientsafety.org

Maggie Runyon, MSN, RNC-OB, C-EFM, CYT-200
Founding Executive Director
Your BIRTH Partners
maggine@yourbirthpartners.org

Tara Ryan Kosmas MSN, RN, NC-BC, CHSE, SOAR
Executive Director
Debriefing the Front Lines, Inc.
tara@debriefingthefrontlinesinc.org

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Inclusive Language

This toolkit in some cases uses the terms "women" and "mothers" or "maternal" to describe people who are pregnant or recently experienced pregnancy. We acknowledge that not all people who experience pregnancy identify as women or mothers. We believe all birthing people are equally deserving of respectful, patient-centered, quality health care.

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I. Background

Rates of maternal morbidity and mortality continue to increase and there are significant disparities in these outcomes. These events negatively impact patients and families and require healthcare organizations to put systems in place to ensure patients and their families receive emotional support after these events. Additionally, these events also require thoughtful review to assess opportunities to improve the quality and safety of care provided to birthing people.

In 2020, The Maryland Maternal Health Innovation Program (MDMOM) called for birthing hospitals across the state to create multidisciplinary review committees to ensure cases of severe maternal morbidity are reviewed to determine preventability and opportunities to improve at the patient, provider and system level.

In 2024, the Maryland Perinatal Quality Collaborative began an initiative to improve the quality of care related to obstetric hemorrhage. As part of this work, birthing hospitals across Maryland are working to ensure their labor and delivery departments have established a standardized process to conduct debriefs with patients after a severe event.

Although work has begun to standardize hospitals' response to and support of patients and families after a severe event it is important to recognize the significant impact that witnessing traumatic events has on the perinatal nurses and providers caring for these patients. Witnessing traumatic events is expected in healthcare but may be expected to occur less often in obstetric and neonatal settings due to the overall well-being and age of the patient population. Research has reported a wide range of prevalence rates (12.6% to 96.9%) of exposure to traumatic experiences among maternity care providers (Nieuwenhuijze et al., 2024). In a 2021 study by Nicholls and colleagues of 288 labor and delivery nurses, most respondents (84.7%) reported witnessing a traumatic birth.

Research has used varying definitions when classifying a perinatal event as traumatic and there is considerable variation in what is considered a traumatic perinatal event. In their review of the literature, Nieuwenhuijze and colleagues (2024) reported on this variation in operational definitions and reported that some studies defined traumatic events broadly as "events for which the respondents 'did not feel adequately prepared' or that they 'found upsetting or overwhelming.'" Other studies left it to the responder to indicate if they felt the event was "traumatic." Best practices within trauma-informed care promote this type of self-identification in recognition of the nuances surrounding psychological trauma (Huang et al., 2014).

Sheen et al. (2022) reported that maternal or neonatal deaths/stillbirths, hemorrhage and events involving a difficult delivery, as well as any other events that were sudden and unpredictable, had a high perceived preventability, and/or involved acute sensory experiences and high emotionality contributed to trauma perception This variation in the perceptions among theindividuals' studied highlights that events perceived as traumatic may vary from individual to individual based on many intrinsic and extrinsic factors, and therefore it is integral to normalize and ensure awareness of strategies known to mitigate the emotional impact of these events.

The impact of severe maternal and neonatal events on clinicians should not be minimized. Experiencing a traumatic birth may affect nurse and provider self-confidence, professional self-efficacy, retention, cause feelings of guilt/shame and result in absenteeism, and physical and psychological distress (Aydın, R., & Aktaş, S., 2021; Kruper et al., 2021; Rivera-Chiauzzi et al., 2022; Santana-Domínguez et al., 2022). Therefore, it is important to acknowledge and address the impact of these events on nurses and providers in perinatal settings (Uddin, Ayers, Khine, & Webb, 2022).

After an event, respondents' trauma may be compounded in the absence of support. This directly influences their ability to cope effectively and may result in them leaving the profession (Sheen et al., 2022; Shorey et al., 2022). Several studies have shown that nurses and health care providers desire support after a serious event, yet healthcare organizations often offer inadequate emotional support (Burlison et al., 2017; Crawford & Williams, 2024; Shorey et al., 2022). Therefore, health care organizations need to invest in creating strategies to ensure healthcare workers have access to resources for emotional support (Burlison et al., 2017; Crawford & Williams, 2024).

Interventions to Address Trauma in Perinatal Clinicians

Several interventions have been described in the literature as potentially supporting perinatal nurses and providers in coping after experiencing a traumatic perinatal event including the following:

- Acknowledgement of trauma and the need for open retaliation-free communication training on the nature of traumatic events
- Self-help for early stress responses
- Processing support and rapid access to trauma-focused psychological input (where required)
- A peaceful location for recovering a sense of psychological safety
- Extra staffing resources
- Additional time off the unit
- Just culture
- Collegial support
- Peer-to-peer responders
- Structured case conferences for emotional debriefing
- Initiating a Code Lavender response team or cart (Crawford & Williams, 2024; DeMarco & Resnicoff, 2024; Kruper et al., 2021)

National Partnership for Maternal Safety: Consensus Bundle on Support After a Severe Maternal Event

In 2021 the National Partnership for Maternal Safety created a Consensus Bundle on Support After a Severe Maternal Event. The bundle, like others, was organized into four domains: Readiness, Recognition, Response, and Reporting and Systems Learning and provided guidance on best practices in support after a severe event for all involved including providers and nurses.

II. Debriefing

Debriefing after a severe event is a structured process in which healthcare teams or organizations come together to reflect on and discuss a particularly traumatic or high-stress incident, such as a patient death, medical error, or other critical event. Debriefing serves a trifold purpose: ensuring safety of patients and staff alike, improving quality, and enhancing retention. The goal of debriefing is to provide emotional support, enhance understanding of what occurred, and identify insights and processes that enhance future practice.

Key Elements of Debriefing After a Severe Event:

1. **Emotional Support:** The debriefing process acknowledges the traumatic experience, facilitates the expression of team members' emotions, encourages their emotional processing, and provides support from colleagues and supervisors. This process effectively mitigates the risk of burnout or trauma.
2. **Review of the Incident:** The team reviews the event in a non-punitive, objective manner with a focus on understanding what happened, why it happened, and how it can be prevented in the future, considering both immediate and long-term courses of action.
3. **Identification of Strengths and Areas for Process Improvement:** While acknowledging the emotional impact, the team also identifies positive aspects of the response and areas that may need improvement in procedures or communication.
4. **Stress Relief and Coping:** Debriefing offers the team a co-created space for individuals to share coping strategies and offer mutual support, helping staff manage the stress and emotional toll of the event.
5. **Actionable Insights:** The debriefing process aims to identify any systemic issues or procedural gaps that could be addressed to staff well-becoming and improve patient care to prevent similar events in the future.

Debriefing can be formal or informal but is typically facilitated immediately following and within the first 10 minutes of the event to acknowledge and to help staff process the situation while it is still fresh in their minds. It is an essential component of reducing moral injury and maintaining psychological safety and resilience in healthcare settings.

III. Accreditation, Professional Societies, and Debriefing

Debriefing is encouraged by the Joint Commission and the Alliance for Innovation in Maternal Healthcare (AIM) as part of the broader strategy to improve care delivery and prevent adverse outcomes. This is especially relevant in the context of maternal safety and perinatal care, where debriefing helps healthcare teams learn from high-risk events and identify potential areas for improvement.

According to the Elements of Performance in Maternal Safety the Joint Commission (2019) organizations must have criteria for when a team debrief is required immediately after a case of severe hemorrhage and create criteria for when a team debrief is required in severe hypertension/preeclampsia

Standard PC.06.01.01: Reduce the likelihood of harm related to maternal hemorrhage

- EP 2: Develop written evidence-based procedures for stage-based management of pregnant and postpartum patients who experience maternal hemorrhage that includes criteria for when a team debrief is required immediately after a case of severe hemorrhage.

Standard PC.06.03.01: Reduce the likelihood of harm related to maternal severe hypertension/ preeclampsia.

- EP 2: Develop written evidence-based procedures for managing pregnant and postpartum patients with severe hypertension/preeclampsia that includes criteria for when a team debrief is required.

When describing debrief requirements, The Joint Commission focuses solely on debriefing for its value in assessing the team's adherence to perinatal procedures and the opportunity for it to be improved. However, effective debriefing strategies can simultaneously provide space to improve quality and safety and offer emotional support and resources to affected staff members.

IV. Initiative Aim and Objectives

This initiative was created in recognition of the gap in available resources in this space, the impact on quality and safety, and the need for nurse and provider support after a severe perinatal event.

Aim:

The *aim* of this initiative is to foster a unit culture that prioritizes debriefing after perinatal adverse events to enhance quality improvement, acknowledge successes, and promote psychological safety. Through this, the initiative seeks to normalize the integration of emotional support resources to strengthen mental health, resilience, and well-being among healthcare professionals.

Objectives:

Participating organizations will:

- Evaluate the current state of perinatal debriefing on their units.
- Provide education on best practices in debriefing to those who lead perinatal debriefs.
- Create an organization-specific list of resources for emotional support available for nurses and providers.
- Develop tools to support the implementation of a comprehensive perinatal debriefing program.
- Strengthen unit-based workflows to ensure the standardized implementation of debriefing after adverse perinatal events and to ensure opportunities to improve perinatal quality and safety are identified and actioned.
- Normalize the importance of accessing emotional support to strengthen resilience and prevent burnout and compassion fatigue among staff on their unit.

V. Using the Toolkit

The toolkit outlines steps toward the implementation of a standardized perinatal debriefing program that is centered around ensuring healthcare provider wellbeing, cultivating a psychologically safe environment to uncover opportunities to improve the quality and safety of care and ensure nurses and providers are connected with resources for emotional support. The toolkit includes 7 steps to implementation. Details on how to fully implement each step are outlined in the next section of the toolkit.

☐ Step 1: Assessing Organizational Readiness

☐ Bring together your debriefing initiative core team and schedule meetings to discuss implementation.
☐ Evaluate unit safety culture.
☐ Assess and document current state of debriefing workflows.
☐ Informally assess the provider and nurses' feelings and attitudes towards your current debriefing process.
☐ Collate and test organizational resources available for emotional support after a serious event.
☐ Assess teams' use of and feelings towards the available resources for emotional support.
☐ Engage other teams as appropriate to ensure their awareness of your work in this space (e.g. RISE, Chaplain, EAP).

☐ Step 2: Welcome Journey

☐ Introduce providers and staff to the background on the initiative, importance of debriefing, and share "Welcome" video from consultants.
    ☐ Share at providers department meetings.
    ☐ Share at nursing staff meetings.
☐ Normalize use of resources for emotional support.
☐ Create a unit culture that supports relaxation.
    ☐ Consider creating unit code lavender cart.
    ☐ Consider creating a "serenity lounge" "lavender lounge" "tranquility room."
☐ Meet internally as a team to create and document your ideal state of debriefing.
    ☐ Draft future-state process map.

☐ Step 3: Future State of Debriefing

□ Create and document your ideal state of debriefing (process mapping).

☐ Step 4: Training and Reimagining Debriefing

□ Site Champions attend March in person training at the Maryland Patient Safety Center.
□ Site Champions meet internally as a team to review, amend, and finalize a future-state process map and create debriefing standard work.
□ Site Champions meet to create a training plan which outlines how debriefing facilitators will be trained to facilitate perinatal debriefs, consider sustainability of this approach.

☐ Step 5: Implementation of Standardized Debrief after Severe Perintal Events

□ Train designated staff/providers to lead perinatal debriefs.
□ Educate staff and providers on the new debriefing strategy/workflow.
□ Choose a date to implement.
□ Check in with the debriefing facilitators weekly/biweekly to ask for feedback on implementation.
□ Share and collect feedback on debriefing at staff meetings and department meetings.
□ Continue to normalize the use of emotional support resources at meetings with staff and providers and in interactions with the team.

☐ Step 6: Evaluation of Debriefing -- Measuring Impact and Driving Improvement

☐ Foundational Planning

□ Identify project lead(s) responsible for evaluation and data collection.
□ Define clear goals of debriefing (e.g., improve communication, reduce repeat events, support staff well-being)—*What drove you to join this initiative?*
□ Align evaluation strategy with organizational priorities and quality/safety metrics.

☐ Define What to Measure

□ Select **process measures** (e.g., % of events with debriefs, time to debrief, participation rates).
□ Select **outcome measures** (e.g., staff psychological safety, system issues identified, event recurrence).
□ Identify tools or surveys to measure teamwork, safety climate, and staff perceptions.
□ Determine how system-level learning and follow-up actions from debriefs will be tracked.

☐ Develop Data Collection Plan

□ Decide how and when data will be collected (e.g., after each debrief, monthly summaries, quarterly surveys).
□ Identify responsible person(s) for data entry, tracking, and reporting.
□ Develop a standardized form or platform for logging debrief frequency, participants, and findings.
□ Establish a secure process for collecting anonymous staff feedback.

☐ Baseline and Benchmarking

□ Collect baseline data on current debriefing practices (e.g. frequency, satisfaction, teamwork perceptions) (this was completed in Step 1).
□ Identify target benchmarks or improvement goals over time.

☐ Review and Reporting

□ Create a schedule for reviewing and sharing evaluation data on debriefing with leadership and staff.
□ Use data to inform improvements to the debriefing process or tools.
□ Celebrate successes, lessons learned, and changes implemented as a result.

Step 7: Sustaining the Work

□ Continue to normalize the use of emotional support resources.
□ Incorporate evaluation measures into regular QAPI or safety committee review.
□ Reassess debriefing tools (e.g. standard work, policy, script) and metrics annually to ensure continued relevance.
□ Celebrate improvements and communicate impact of debriefing to maintain engagement—***need to keep talking about it.***
□ Ensure you have a process to train new debriefing facilitators.
□ Continue to engage all staff in debriefing embedded in simulation, competency days etc.

You may use this checklist to track your progress through this toolkit.

Step 1:
Assessing Organizational Readiness

a. Bring together your debriefing initiative core team

Bring together your debriefing initiative core team and schedule regular meetings to discuss the work. The workgroup should include those participating in the initiative as debriefing site champions as well as perinatal nurse and provider leaders advancing this effort.

Dedicate time for the team to engage in this work and reflect on opportunities to improve. Collaborate within the workgroup to decide how best to distribute the work necessary to complete each component of each step of the program. The organization's debriefing core team will co-create a timeline for completion of each step of the program based on guidelines set forth by the initiative leaders and hold each other accountable for completing their assigned work in a timely fashion. Engage and invite additional key stakeholders as appropriate to gather feedback on the current state of the debriefing workflow.

b. Asess safety culture

To begin this work, site champions will assess their organizational readiness to implement a standardized perinatal debriefing program. Begin by better understanding your unit's safety culture. A safety culture prioritizes trust, transparency, and open communication. When team members feel they can communicate concerns without fear of retribution, they are more likely to speak up about issues, share feedback, and make suggestions, all of which are essential components of psychological safety.

Psychological safety thrives in an environment where people are not afraid to take interpersonal risks, such as expressing dissenting opinions or admitting mistakes, because they believe they won't be ridiculed or penalized.

A **safety culture** should include:

- **Supportive Leadership.** Leaders in a safety culture model behaviors that promote psychological safety by showing empathy, providing consistent feedback, and actively listening to team members' concerns. When leadership shows that they value safety (both physical and psychological), team members are more likely to feel comfortable sharing ideas, asking questions, and challenging the status quo.
- **Encouraging Inclusivity.** A safety culture ensures that all team members, regardless of their role or background, feel equally valued. When individuals know they are part of an inclusive environment where their opinions matter, they are more likely to take risks that foster innovation and growth—key elements of psychological safety.
- **Psychological Safety to Promote Learning from Mistakes.** In a culture focused on safety, mistakes are seen as opportunities for learning rather than as failures to be punished. This is crucial for psychological safety because it enables employees to take risks, innovate, and grow without fear of negative consequences.
- **Well-being and Support Systems.** A safety culture promotes well-being by ensuring that employees feel physically and psychologically supported. When employees are confident in their safety—both physical and emotional —they are more likely to engage fully and participate in collaborative efforts.

Psychological safety is closely linked to mental health. Employees who know their workplace cares about their overall well-being are more likely to feel supported and secure in expressing themselves.

To assess your unit's safety culture, consider conducting a Safety Culture Survey, or reviewing results from the most recent one conducted. Consider conducting one-on-one interviews of employees at all levels of the unit to gain deeper insights into the safety culture. This approach allows employees to speak more freely about their experiences, concerns, and suggestions. Or consider holding focus groups: gathering small groups of employees to discuss safety-related topics. Encourage open dialogue about their perceptions of the work environment, safety practices, and the effectiveness of safety protocols.

Reflection Questions

- Do staff have trust in leadership regarding safety matters?
- Do staff feel psychologically safe, can they speak up without fear?
- If staff do not feel psychologically safe, what are the barriers preventing this?

c. Assess and document current state of debriefing workflows

As a team, document what you believe to be the current workflow related to your debriefing process.

- As a team, discuss what you believe to be the current debriefing workflow. Review your units' current policies and procedures related to debriefing. Observe your current debrief. Discuss as a team what you observed and gaps in policy.
- Create a process map. You can use programs like Canva, Visio or PowerPoint or freehand to create this. A process map is a visual representation of the steps involved in a particular process or workflow. It outlines the sequence of activities, decisions, and interactions required to complete a task or achieve a goal, often with a focus on improving efficiency, identifying bottlenecks, and ensuring consistency. Process maps use standardized symbols to represent different types of actions and decisions, making the process easy to understand and analyze.
- Ask those who regularly lead debriefs to review your process map to determine if it reflects the current state

Learn more about how to create a process map or flow chart from the Institute for Healthcare Improvement

Reflection Questions

- Does your debriefing policy/guideline reflect work as done or work as imagined?
- If you do not have a debriefing policy or guideline, do you need one?

d. Informally assess providers' feelings and attitudes

Informally assess providers' feelings and attitudes regarding the current debriefing process. For any quality improvement initiative to be effective, you must gain buy-in from the nurse and providers who will be participating. They must feel that the initiative is valuable. What would make this program valuable to participants? A change in process? A change in outcome? Something else? Be prepared to share these with the program consultants during office hours before the training!

e. Collate and test organizational resources available for emotional support after a serious event

A unit that supports both physical and mental health is often more likely to have a positive safety culture. The use of emotional support resources by nurses and healthcare providers is vital for maintaining their mental and emotional well-being in the face of the often stressful and emotionally demanding nature of their work. These resources play a key role in preventing burnout, improving job satisfaction, and fostering resilience. Review the existence and effectiveness of your organization's wellness programs.

Access to resources for emotional support is important. However, if the resources are not accessible AND used then they are unable to have a positive impact.

Reflection Questions

- In the current state, how do leaders identify if stress or burnout affects safety behaviors and if nurses and providers need respite?
- How and where will you post these resources to ensure that staff are aware of and have access to these resources?
- How will you follow up with staff after a potentially traumatic event to ensure needed resources are accessed?

f. Assess team's use of and feelings towards the available resources for emotional support

In addition to documenting the current workflow involved, you should informally assess providers' feelings and attitudes of the current debriefing process. Understanding healthcare providers' views of the current debriefing process is essential for improving the effectiveness of debriefings and enhancing patient safety, team collaboration, and staff well-being. Healthcare providers play a central role in debriefing, as they are directly involved in patient care and are often the ones processing emotionally challenging or high-stress events. Their feedback can offer critical insights into how the process is functioning and where it might be improved. Consider asking individuals on your team to provide feedback about the current debrief process. You may want to consider allowing them to provide anonymous feedback. Some questions to consider as you assess the current state of debriefing on your unit.

Some questions to consider as you assess the current state of debriefing on your unit:

Questions	Notes
What is your unit's compliance with current debriefing processes?	
How are debriefs tracked? By whom?	
Do you have criteria for when a debrief should occur?	
How do others lead debriefs? • Do they adhere to the organization's debriefing guide? • Do participants feel safe participating? • Are corresponding forms completed? • Are adverse events reports sumbitted? • Are events regularly reported to leadership? • How are staff informed of the findings, opportunities to improve, and corresponding changes made from the debrief?	

Step 2: Welcome Journey

a. Gaining Buy-In to the Initiative

The **Perinatal Debriefing Program** is a dedicated opportunity to build a structured program at your organization that supports quality and safety and ensures nursing staff and providers are connected with emotional support after an adverse event. Gaining buy-in for a quality improvement (QI) project is crucial because it ensures that the project has the support, resources, and commitment necessary to succeed. When key stakeholders, including leadership, staff, and other involved parties are on board with a QI project, it aligns the initiative with the organization's overall goals and priorities. This makes it easier to integrate the project into the existing workflow.

During this step of the program, site champions will work to gain ***buy-in*** for the program from nursing staff and providers.

Promote Engagement and Participation. It is imperative that everyone involved understands the value and importance of the project to ensure their active participation. Taking the time to share about the program, answer questions, and foster discussion about barriers to implementation can help overcome resistance to change. Change can be difficult, especially in healthcare settings where processes are well-established. Gaining buy-in helps reduce resistance because individuals are more likely to embrace changes when they understand the purpose, benefits, and expected outcomes. It also allows you to address concerns and clarify misconceptions early on.

Encourage Sustainability. A QI project isn't successful unless the improvements stick. By securing buy-in, especially from leadership, you help to ensure that the changes will be sustained over time. Leaders can help champion the project long-term, reinforcing its importance and maintaining momentum after initial implementation.

Foster a Collaborative Culture. When team members feel involved and valued in the decision-making process, it fosters a culture of collaboration and continuous improvement. Buy-in encourages open communication, feedback, and collective problem-solving, all of which are necessary for ongoing quality improvement. Ensure that you have asked for feedback to understand the current state but also when crafting the future state of the process.

Improve Accountability. With buy-in, everyone involved becomes more accountable for the success of the project. Leaders and stakeholders are more likely to hold individuals and teams responsible for meeting goals, staying on track, and ensuring that outcomes are achieved.

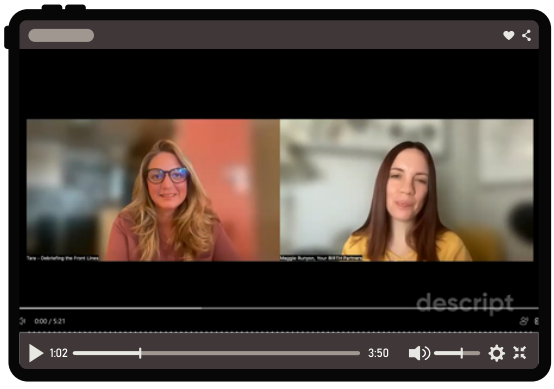
Enhance Evaluation and Success Metrics. When there's buy-in, stakeholders are more likely to invest in evaluating the progress of the project, making adjustments as needed, and measuring success. This commitment to evaluation helps identify what is working and where improvements can still be made.

This step of the project is ***CRITICAL***; it is paramount that you actively engage staff and providers in this work prior to implementing the new process! Debriefing helps to ensure that every voice is heard and supports providers in feeling respected, understood, and empowered. Including them in the work from the start helps to reinforce your respect for them as part of the team and that their feedback is valued.

b. Welcome Video

To support you in engaging staff and providers in participating we have created a short "Welcome Video" to share with your nurses and providers.

- ·The welcome video outlines the initiative, why we started, and why it will be helpful to your organization.
- ·Please share this video at a staff meeting prior to the in-person training on March 20th and send it out via email to all staff to ensure those who did not attend the meeting receive the video.



Access the Welcome Video

c. Normalize Accessing Emotional Support Resources

It is important to begin to normalize the use of resources for emotional support by members of your team. This will help as you prepare to implement a more streamlined and standardized debriefing process and elicit buy in from staff.

Normalizing the use of emotional support resources by healthcare providers is an important step in fostering a culture of well-being and mental health awareness within healthcare settings. It helps to address the emotional challenges healthcare workers often face and ensures they receive the support they need to provide the best care for their patients.

There are many valid forms of emotional support, and a variety of resources should be made available to your team. It is important to present resources without bias and to avoid stigmatizing the use of any or all resources. The destigmatization of emotional support resources should occur through several means:

- **Leadership Advocacy**
  - ***Visible Support from Leadership:*** Healthcare leaders should publicly advocate for emotional support resources. When leaders model the use of these resources and discuss mental health openly, it sets a tone that seeking help is acceptable, valued, and essential.
  - ***Routine Acknowledgement:*** Encourage leaders to include mental health and emotional well-being as part of regular conversations in team meetings, newsletters, and training sessions.
- **Integrate Emotional Support into Professional Development**
  - ***Workshops and Training:*** Include emotional resilience and self-care training in professional development programs. Educating healthcare providers on how to manage stress, prevent burnout, and seek emotional support normalizes the practice.
  - ***Regular Check-ins:*** Make emotional well-being part of regular performance reviews, staff meetings, and team evaluations, ensuring that clinicians have a space to discuss their emotional challenges and stressors.
- **Accessible and Visible Resources**
  - ***Clearly Promote Support Services:*** Ensure that emotional support services (e.g., counseling, peer support programs, mental health hotlines) are easily accessible and visible to all staff. Create a clear, user-friendly way to access resources that doesn't feel stigmatizing.
  - ***Confidentiality Assurance:*** Clinicians should be assured that their emotional well-being and any use of emotional support services will be confidential.

- **Create a Peer Support System**
  - ***Peer Mentoring:*** Develop peer support networks where healthcare clinicians can lean on colleagues who have been trained to provide emotional support. This can reduce the stigma around seeking help, as it fosters a sense of community and shared experience.
  - ***Well-being Debriefing Sessions:*** Implement well-being debriefings as reflective sessions to discuss emotional responses to difficult situations, challenging cases, patient loss and stressful shifts.
- **Foster a Culture of Self-Care**
  - ***Normalize Taking Breaks:*** Encourage and normalize taking time for mental health breaks during the workday. Just as healthcare workers are encouraged to take physical breaks, emotional and mental wellness breaks should be equally prioritized. Similarly, create a culture of support for PTO requests.
  - ***Role Models:*** Leaders and senior staff should demonstrate self-care and emotional well-being practices, such as taking breaks, attending counseling, participating in wellness programs, and using PTO to set an example for others.
- **Reduce Stigma Through Communication**
  - ***Open Conversations:*** Facilitate open discussions about emotional challenges in healthcare. Highlight that experiencing stress, grief, or burnout is common, and seeking support is a sign of strength, not weakness.
  - ***Promote Mental Health Awareness:*** Use campaigns, newsletters, posters to promote emotional support services, share testimonials from healthcare staff who have benefited from emotional support, and educate about the importance of mental health.

By taking these actions, healthcare organizations can break the stigma surrounding emotional support, making it a normalized and integral part of the healthcare culture. This, in turn, can help reduce burnout, increase job satisfaction, and improve overall patient care as healthcare providers are better supported in managing their own emotional well-being. Review **Appendix A** for a list of Emotional Support Resources available.

Reflection Questions

- How will you begin to normalize your staff accessing resources on the unit?
- Can you embed this during your routine check-ins with staff, staff meetings?
- Where will you store the list of emotional resources you identified?
- How and when are resources shared with staff? (Do you think it is effective? Are there gaps?)
- Do you feel comfortable discussing emotional wellbeing during performance evaluation or during your one-on-ones? If not, how can you strengthen those skills?
- What barriers do you think exist to do this?
- What additional training might unit leaders need?

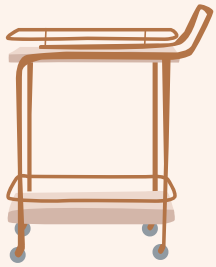
d. Creating a unit culture that supports relaxation

Creating a Code Lavender Cart or Serenity Lounge emphasizes to staff the level of importance that leadership places on mental health and creating a more sustainable compassionate working environment. Creating a calming hospital environment for healthcare staff contributes to their well-being, job satisfaction, and promotes the provision of safe and quality patient care.

A **Code Lavender Cart** is a concept used in healthcare settings, particularly in hospitals, to support the emotional well-being of healthcare staff, such as nurses, doctors, and other team members. The "Code Lavender" term is often associated with the need to offer emotional or psychological support to staff who are experiencing stress, trauma, or overwhelming emotions due to the demands of their work, particularly in high-stress environments like labor and delivery, emergency departments, or intensive care units.

A **Code Lavender Cart** is a physical cart that is stocked with items to help staff cope with stress or emotional strain. The contents of the cart may vary, but common items include:

- Relaxing or stress-relief tools (e.g., stress balls, aromatherapy oils, soothing lotions)
- Snacks, tea, or beverages for comfort
- Journals for reflection or writing
- Information on mental health resources
- Comfort items like blankets or calming music
- Relaxation techniques or guided meditation
- Resources on coping strategies or mindfulness



The Code Lavender Cart can be deployed when a healthcare worker requests emotional support after a difficult event, such as a traumatic patient outcome or high-stress situation. The goal is to provide immediate comfort, encourage self-care, and help staff regain emotional resilience, improving their ability to continue their work and reduce burnout.

Code Lavender Resources

- Code Lavender: A Tool for staff support
- Code Lavender toolkit.pdf

“Serenity Lounge” or “Lavender Lounge” or “Tranquility Room” are all terms to refer to a dedicated space on the unit for staff to recenter, rest, and process. These rooms provide staff with tools and resources to care for their emotional and mental wellbeing while recognizing the scheduling demands of inpatient care. Research has shown that holistic approaches (such as mindfulness training, “serenity lounges,” massage chairs, aromatherapy, and green space) have been shown to reduce nurses' anxiety, stress, and burnout (Pagador et al., 2022). Yet there are barriers to the utilization of these rooms such as poor staffing, high acuity patient loads and unit census. These barriers are the same factors that perpetuate burnout. Therefore, in addition to implementing holistic factors, such as serenity lounges, it is paramount that the hospital leadership consider strategies to ensure patient safety and quality by creating work environments that are built on a safety culture.

Serenity Room Resources:

- Cedars Sinai Serenity Lounge Study
- Pagador, Florida MSN, CMSRN; Barone, Melanie MSN, CNML; Manoukian, Mana MSN, RN, AGCNS-BC; Xu, Wenrui MPH; Kim, Linda PhD, MSN, RN, PHN, CPHQ. Effective Holistic Approaches to Reducing Nurse Stress and Burnout During COVID-19. AJN, American Journal of Nursing 122(5):p 40-47, May 2022. | DOI: 10.1097/01.NAJ.0000830744.96819.dc
- Stephanie A. Smith, Lynne Kokoczka, Constance Cottrell; Utility of a “Lavender Lounge” to Reduce Stress Among Critical Care Registered Nurses: A Cross-Sectional Study. Am J Crit Care 1 May 2023; 32 (3): 198–204. doi: https://doi.org/10.4037/ajcc2023721
- Mileski, M., McClay, R., Kruse, C. S., Topinka, J. B., Heinemann, K., & Vargas, B. (2024). Using Serenity Rooms and Similar Tools to Improve the Workplace during COVID-19: A Rapid Review. Nursing reports (Pavia, Italy), 14(1), 376–389. https://doi.org/10.3390/nursrep14010029

Reflection Questions

- Do you think you could implement either of these ideas? Think outside the box...which resources could be altered to support this goal?
- Where do staff go to decompress after a serious maternal newborn event on your unit?
- Does your unit have a culture of supporting clinicians to step away for a true break to regulate after a challenging experience or as a preventative measure?

Step 3: Future State of Debriefing

a. Create and document your ideal state of debriefing

In Step 1 of the toolkit, you worked to outline and process map the current state of debriefing on your unit. Understanding the current state (work as done) is crucial for any quality improvement (QI) project because it serves as the foundation for understanding where you are before you can make meaningful progress toward where you want to be.

Creating an ideal state process map involves visualizing the best possible version of a process, focusing on efficiency, quality, and safety. The steps include reviewing the current state, collaborating with stakeholders, designing an optimized process, mapping it, and validating it. After implementation, continuous monitoring and improvement are key to ensuring the ideal process delivers long-term success.

Schedule a meeting of your key stakeholders to create the ideal state process map. The below outlines the steps to the creation of an ideal state process map.

1. To Begin, Review the Current State Process Map

- **Understand the Baseline:** Before designing the ideal state, carefully review as a team, the current state process map you created in Step 1. Identify areas of inefficiency, bottlenecks, or pain points that need to be addressed in the ideal state.
- **Determine Key Goals:** Based on the areas identified for improvement, clarify the goals of the ideal state of debriefing and begin to consider how you measure that you have achieved your goal. Goals may include ensuring that:
  - Debriefs occur after all severe perinatal events.
  - Opportunities for improvement are shared with leadership.
  - Great work is celebrated.
  - Staff feel supported.
  - Staff are connected with resources for emotional support.

2. Define the Purpose and Scope of the Ideal State

- **Set Clear Objectives:** Clearly define what the ideal state should achieve.
- **Establish Boundaries:** Determine the start and end points of the process. This will help you focus on the specific steps that need to be optimized.

3. Engage Stakeholders in the Design Process

- **Collaborate with Key Players:** Involve team members, department heads, and other stakeholders in the design of the ideal state.
- **Solicit Input from Frontline Staff:** Those who are directly involved in the process will have invaluable insights into what improvements will make the biggest difference. They are the ones executing the process and can suggest realistic and feasible changes for the ideal state.

4. Design the Ideal Process

- **Eliminate Bottlenecks:** Identify the steps in the current process where delays or inefficiencies occur and re-engineer those steps to eliminate or reduce those issues in the ideal process.
- **Reduce Waste and Redundancy:** Eliminate unnecessary steps and redundancies. Streamline tasks to reduce wasted time, resources, or effort.
- **Improve Communication:** Look for opportunities to improve communication between stakeholders (e.g., between departments or between staff and patients). For instance, using digital systems for real-time data sharing may improve coordination.
- **Focus on Quality and Safety:** Integrate safety checks, quality standards, and patient care improvements into every step of the process. Ensure that quality measures are built into the work flow to prevent mistakes or oversights.

5. Map the Ideal Process

- **Use Standard Process Mapping Symbols:** Just like the current state process map, use a flowchart to design the ideal state.
- **Arrange Steps Logically:** Organize the steps in a clear, logical sequence that reflects the optimal flow of the process. Each step should contribute to efficiency, quality, or safety improvements.
- **Include Expected Outcomes:** Highlight where each step contributes to achieving the ideal state's objectives, such as reducing time or enhancing patient experience.

Step 4:
Training and Reimagining Debriefing

a. In-Person Training

Debriefing originated from the military and became prominent during World War II under Brigadier General Samuel L.A. Marshall, who implemented structured debriefing to gather data from soldiers returning from missions. These were called After Action Reviews. The debriefing provided valuable insights to support future military operations. These learnings were transferred to other fields such as aviation, education and healthcare. In healthcare debriefing first became widely used by anesthesia.

Healthcare providers believe that formal training is needed to facilitate a debriefing (Kam et al., 2022). 96% of participating organizations surveyed reported that those currently facilitating debriefs have never received training on how to debrief.

Each participating organization will attend the in-person training on March 20th, 2025, at the Maryland Patient Safety Center 6820 Deerpath Rd Elkridge Maryland from 8-4p. The agenda for the day can be found here.

The objectives for the training are:

- Explain how debriefing contributes to improved quality of care, patient safety, team communication, emotional well-being, and mental health of healthcare providers.
- Demonstrate the use of evidence-based tools and frameworks to guide a successful debriefing process.
- Explore strategies that foster psychological safety so that the team can process their experiences, regulate their nervous systems, and build resilience.

b. Debriefing in Perinatal Care: Rationale, Objectives, and Addressing Gaps in Implementation

The primary objective of debriefing is not to assign blame or identify error but to facilitate a collaborative discussion among the care team regarding the actions and thought processes involved in a specific patient care scenario. This enables the team to process emotionally challenging events through self-reflection surrounding actions and feelings.

By engaging in this reflective process, the team can enhance their confidence and foster a supportive dynamic. Additionally, the debrief serves as an opportunity to identify potential areas for improvement that can be incorporated into future care practices that enhance patient safety.

***Nomenclature*:** It is important to ensure standardized nomenclature when discussing debriefing and clearly differentiate between when and how each of the concepts should be used and implemented.

Post-event debriefs or a "hot debrief" occur in real time or shortly after the critical event and may be held in an impromptu location.

- All staff members involved should be invited.
- Attendance is voluntary.
  - Requires active participation from participants.
  - Participation may be stressful therefore debriefing as a team may not always be appropriate.
- Primary intent is to identify improvement but also can highlight how to replicate successful performance.
- Does not focus on individual performance but rather systems.
- Aims to improve teamwork, communication, and emotional well-being.

A **"cold debrief"** occurs later in the day or week and is often held in a different space than the clinical environment.
(Edwards et al., 2021)

For the purposes of this training, we are focusing on educating site champions on training debriefing facilitators on completing a post-event debrief or hot debrief; however, if a hot debrief is not feasible, we encourage debriefing facilitators to seek out the opportunity to perform a cold debrief with whoever is available at the end of the shift.

c. Debriefing Guidelines

Ideally a hot debrief should occur after every serious event. The intention of the debrief is to support post-event learning for future outcomes and strategies designed to minimize the psychological consequences of traumatic events..

Examples of clinical scenarios where a post-event debrief (hot debrief) should occur include but are not limited to:

- ·Seizure
- ·Unexpected Fetal or Neonatal Death
- ·Cardiac arrest
- ·Neonatal resuscitation (define per organizational standards)
- ·Stat/Emergency C/S
- ·Shoulder Dystocia
- ·Cord Prolapse
- ·Fetal Distress
- ·PPH (define per organizational standards)
- ·Disruptive/hostile behavior
- ·Unexpected Maternal/neonatal transport

It is important to note that a debrief can occur after any event in which staff ask for a debrief. Staff should be aware that this is available to them.

Ideally, the debrief is led by someone trained in the facilitation of debriefing. It is integral that the debriefing facilitator maintains an emotionally safe space throughout; this includes awareness of tone and body language when leading a debrief.

A post-event (hot) debrief should occur as soon after the event as possible, ideally within 15 minutes. We acknowledge the barriers to this recommendation and the need to prioritize other responsibilities. However, an attempt should be made to relieve the care team once the patient is stable to allow the debrief to occur. If not doable, consider a cold debrief when feasible, or at the end of the shift.

A debrief should include the entire team involved in the event and should be multidisciplinary. However, participation is voluntarily as it may be stressful.

The debrief should take place in a private and quiet place so that those involved feel open to share their feelings, thoughts, and emotions.

The debrief should be approximately 10 but no longer than 15 minutes in length. It serves as a method to acknowledge, discuss, process, recover, and normalize the use of supportive resources. In most cases, a comprehensive multidisciplinary review of the case will occur later. Subsequently, the debrief should not include prolonged discussions of systems issues without an immediate solution. These can be counterproductive and can lead to frustration.

d. ADPRN Debriefing Framework

Acknowledging, Discussing, Processing, Recovering, Nourishing and Normalizing

Post-event debriefings are most effective when structured and facilitated. Many debriefing tools exist, with some tailored to specific settings, yet no one tool has been recognized as the most effective. The use of structured debriefing tools has been shown to support the implementation of effective debriefing practices, providing a framework for focused discussions, identifying learning opportunities, and promoting safer care. Debriefing tools have the dual role of providing both focused, performance-oriented feedback as well providing a structure to address the emotional wellbeing of team members (Kam et al., 2022). Therefore, tools or debriefing facilitators that do not address the emotionality of the event and its impact on nurses and providers may inadvertently miss an opportunity to support workforce resilience and wellbeing in addition to patient safety.

ADPRN is a debriefing **structure and script** that healthcare workers can use when facilitating a systems focused debriefing to identify issues, maximize improvements in patient quality and safety while fostering psychological safety. ADPRN is adapted from Promoting Excellence and Reflective Learning in Simulation (PEARLS, 2018) and National League of Nursing (NLN, 2105) Critical Conversations Guide to Teaching Thinking.

ADPRN serves as a guide for healthcare workers during debriefings, emphasizing the importance of ***acknowledging*** our humanity, openly ***discussing*** quality and safety measures in a retaliation free environment, ***processing*** experiences and emotions while focusing on ***recovering*** a sense of safety through co-regulation in a peer-to-peer environment thus ***nourishing*** oneself and ***normalizing*** the use of supportive mental health resources to ensure healthcare workers can care for themselves and provide dignified, safe, quality patient care.

On the next pages, **Figure 1** provides a script to begin a debrief and **Figure 2** outlines the objectives and script for each phase a debrief using the ADPRN framework.

Figure 1: ADPRN: Debriefing Framework for Healthcare Workers

The Debriefing Facilitator uses this time to invite team members into the space through words and body language.

1. The Basic Assumption Statement

"We believe that everyone on this team is intelligent, capable, cares about doing their best, and wants to improve."

Center for Medical Simulation, 2021.

2. Gratitude Statement

"Thank you for taking care of this patient."

3. Intention Statement

"The intention of the debriefing is to recognize our shared humanity, acknowledge the emotional and physical challenges each person faces, and offer mutual respect and empathy as we discuss our perspectives with a focus on education, quality improvement and emotional processing among peers in a confidential space."

debriefingthefrontlinesinc.org

Figure 2: ADPRN Debrief Phases

ADPRN: Debriefing Framework for Healthcare Workers

ADPRN®	Objective	Task	Script
Acknowledge	Recognize our shared humanity and the impact of our experiences. Create a shared mental model by reiterating the purpose of debriefing.	Prepare the team for the debriefing with a focus on creating psychological safety and clearly defining intention and purpose.	The intention of the debriefing is to recognize our shared humanity, acknowledge the emotional and physical challenges each person faces, and offer mutual respect and empathy as we discuss our perspectives with a focus on education, quality improvement, and emotional processing among peers in a confidential space. *Option: Debriefing Facilitator reads or offers the option for the team to read out loud together.*
Discuss	Openly talk about quality and safety measures in a non-retaliatory environment. **Suggested System Categories:** Tools and Technology, Communication, Environment, Processes	While acknowledging the emotional impact, the team also identifies positive aspects of the response and areas that may need improvement in procedures or communication. Work through the suggested categories as applicable to uncover system issues and opportunities to discuss how this experience might influence practice moving forward.	During the debriefing discussion, we'll share our perspectives on quality and safety. This allows us to identify system issues and discuss how this experience may influence future practice. We'll also examine communication, equipment, and process improvements. **Tools and Technology:** Were there any concerns related to the tools and technology used during care? **Communication:** How did the communication pathway impact patient care? How could communication be more efficient? **Environment:** What issues, if any, did you experience with equipment? How did staffing affect this event? **Processes:** Where could processes be improved?
Process	Share experiences and explore emotions to better understand feelings and validate the individual and collective experience.	Name emotion in the presence of teammates.	We're now moving into open conversation surrounding our feelings and sharing of experiences. How did caring for this patient make you feel? *or* Describe how caring for this patient made you feel.
Recover a sense of safety	Focus on regaining a sense of safety through co-regulation within our team utilizing a strengths-based approach.	Foster co-created space for individuals to share coping strategies (neuro drills) and offer mutual support, helping staff manage the stress and emotional toll of the event.	What do you need at this moment? *or* How can you access (internal/felt sense of safety) at this moment?
Nourish +Normalize	Close the debrief while promoting self-care, collegial check in's and normalizing the utilization of mental health resources and support systems.	Close the debrief and follow the process to share additional support resources.	We recognize that this debriefing may not be enough and want to normalize the use of additional support by sharing these resources.

e. After the Completion of the Debrief

After the completion of the debrief using the ADPRN script, the debriefing facilitator or their designee should complete the organization's debriefing tool and submit to the designated perinatal leader for review and follow up. If the case meets criteria, the debriefing facilitator or the designee should submit an adverse event report through the safety event reporting system.

The perinatal leader should follow up with staff involved in the event to check in on their emotional well-being, offer support resources, and ensure they feel heard, supported, and safe to speak openly about the experience.

f. Debriefing Standard Work

Unfortunately, debriefing after critical events only takes place a fraction of the time (Arriaga et al., 2020; Imperio et al., 2024). Many barriers exist to implementing debriefing in healthcare settings, including conflicting patient care issues, time, fear of judgement from colleagues, wanting a more senior person to initiate the debrief, and lack of administrative support (Arriaga et al 2020; Helms et al, 2024; Imperio et al., 2024). Although real-time post-event (hot) debriefing can be challenging to implement, it is an effective tool for clinical education, quality improvement, and systems learning (Edwards et al., 2021). Because of its significant benefits, and because it can be completed quickly, efforts should be taken to support its implementation.

During the in-person training, site champions will also have time to work on finalizing their training plan and ideal state process map. The ideal state process map should be used as a framework to develop your debriefing standard work. In quality improvement (QI), standard work refers to a set of established, documented procedures or processes that define the best-known method for performing a specific task or activity consistently and efficiently. It provides a baseline for performance by outlining the steps, responsibilities, and expectations for completing a task in a way that optimizes quality and safety.

A template for a Debriefing Standard Work can be found **here.**

To ensure that opportunities for improving the quality and safety of care identified during the debrief are effectively addressed, it is essential that standard work includes clear steps for completing and submitting both the debriefing form and the adverse event report. Building psychological safety and trust within the team is key — they must feel confident that their contributions to the debrief will lead to tangible improvements. As the team gains trust that their feedback leads to action, this will further strengthen their confidence in the process and foster an environment of continuous improvement.

g. Create a training plan to train the trainer

After attending the in-person training, your debriefing team will need to determine who you will select to train to lead debriefs. Consider the Qualities of a Skilled Debriefing Facilitator outlined in **Appendix B.**

Creating a Training Plan involves developing a structured approach that equips selected trainers with the necessary skills, knowledge, and resources to effectively teach others.

An example Training Plan template is linked **here.**

Step 5: Implementation of Standardized Debriefing After Severe Perinatal Events

Debriefing after severe perinatal events such as hemorrhage, shoulder dystocia, or severe hypertension is a powerful tool to support emotional well-being, strengthen team communication, and identify opportunities for improvement. Yet, in many healthcare settings, debriefing remains **inconsistently practiced or entirely absent.**

Several barriers contribute to the lack of standardized debriefing:

- Lack of training on how to conduct effective debriefs
- Limited time and space amid busy clinical workflows
- Absence of psychological safety, where team members may feel hesitant to speak openly
- Unclear ownership or leadership of the debriefing process
- No formalized workflow or trigger that prompts a debrief to occur

Without a structured, team-supported approach, debriefing often becomes an afterthought—leaving staff unsupported, system issues unaddressed, and valuable learning unrealized.

Establishing a standardized debriefing process ensures every team member has the opportunity to reflect, recover, and contribute to a culture of safety and learning. It clarifies when and how debriefing should happen, who should lead it, and what tools or questions should guide the discussion. Standardization also reinforces the message that emotional support and continuous improvement are core elements of perinatal safety—not optional extras.

By addressing the barriers and embedding debriefing into routine practice, healthcare organizations demonstrate their commitment to both patient and provider well-being, while reducing preventable harm through reflection and learning.

a. Train Debriefing Facilitators

Training of Debriefing Facilitators should be completed by June 2025. Ensure that all facilitators are well-trained and equipped to manage both the clinical aspects of the debriefing (e.g., reviewing the event) and the emotional support elements.

Components of the training should include, *at a minimum*, training on :

- The debriefing standard work
- The debriefing policy/guideline
- The debriefing form
- How and when to submit an adverse event report
- The ADPRN framework
  - The debriefing script
- Strategies to creating a psychologically safe space
- Available emotional support resources

Training Resources:

- Clinicians' Reactions to Adverse Events in Perinatal Care: The Role of Group Debriefing
- Integrating Mindfulness and Neuro Drills into Unit Culture
- Scenarios to Simulate Debriefs

When implementing the debriefing program, it's essential to consider various factors, including the number of facilitators, power dynamics, and other elements that impact psychological safety.

- **Plan for sufficient facilitators to cover all shifts**. It's crucial to have enough trained facilitators available to support debriefs on all shifts (day, evening, and night). This ensures that no matter when a serious or adverse event occurs, there are trained individuals to facilitate the debriefing.

- **Neutralize power dynamics** by using facilitators when possible who are not part of the event, emphasizing equal participation, and promoting a non-judgmental environment. Facilitators should be trained to minimize the influence of power dynamics during debriefings. This can be achieved by encouraging all voices to be heard equally and creating a structured, safe space for discussion that emphasizes equality, where all participants are encouraged to share openly.

- **Ensure psychological safety** through ground rules, confidentiality, empathy, and a focus on learning and improvement rather than blame. Using non-judgmental and supportive language is key to ensuring psychological safety for all participants.

- **Offer ongoing emotional support** and resources for staff who need further assistance after the debriefing session. Leverage newly created resources to connect to organizational resources such as RISE or EAP.

b. Structural Measures Checklist for Standardized Perinatal Debriefing

Creating a structured approach to debriefing after severe perinatal events is essential to ensure that the process occurs consistently and meaningfully, and supports both patient safety and provider well-being. Without a standardized structure, debriefing is often missed due to time constraints, lack of training, unclear responsibilities, or discomfort in discussing adverse events.

A defined process helps to normalize debriefing, promote psychological safety, and ensure key issues are identified and addressed. It clarifies who should lead and participate, integrates into existing workflows, and turns frontline experiences into learning opportunities. Most importantly, a structured approach demonstrates an organization's commitment to continuous improvement, emotional support for staff, and a culture of safety.

Below is a list of structural measures you can use to assess *readiness for implementation.*

Policy & Governance

- ☐ A formal, written policy or protocol exists for conducting debriefings after severe perinatal events
- ☐ A standard work exists to support the implementation of debriefings
- ☐ Clear criteria are defined for which types of events require debriefing
- ☐ Roles and responsibilities (e.g., facilitator, recorder) are clearly defined in the protocol
- ☐ Debriefing processes are integrated into broader quality/safety policies (e.g., M&M, RCA, QI cycles)
- ☐ Policies support a blame-free, psychologically safe environment for participants

Training & Education

- ☐ A standardized training curriculum/module has been developed or adopted for debriefing facilitators
- ☐ Initial training has been completed by a core group of staff (e.g., provider champions)
- ☐ Regular refreshers or ongoing training sessions are scheduled
- ☐ Debriefing principles and awareness of emotional support resources are incorporated into orientation and annual competency training
- ☐ Simulation-based training scenarios include structured debriefing practice

Staffing & Support

□ Multidisciplinary staff are engaged and represented in debriefing implementation (e.g., OB, neonatology, nursing, anesthesia)
□ A team of trained debriefing champions has been established across shifts or units
□ Leadership has expressed visible support and sponsorship of the debriefing initiative
□ Staff have access to mental health, peer support, or critical incident stress debriefing services

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Tools & Resources

□ Structured debriefing templates, forms, or checklists are available to all staff
□ A fidelity or quality checklist is available to assess how well the debrief follows the standard format
□ A physical or virtual space is designated for conducting debriefs in a confidential setting

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Data & Technology

□ A system is in place to track debriefing events (manual log, shared document, or EMR form)
□ Data collection tools capture who participated, what was discussed, and follow-up actions
□ A method exists to analyze trends, themes, or system issues from debriefs
□ There is a plan or dashboard to regularly review debriefing data
□ Findings from debriefs are looped back into QI processes or communicated with leadership

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Resources & Infrastructure

□ Staff time is protected or allocated for conducting debriefings
□ Budget or administrative support has been allocated to sustain the initiative (eg. For debriefing training and updates, for code lavender cart, for debriefs that may occur outside of work time...)
□ There is a designated coordinator or point person responsible for oversight and accountability

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Step 6: Evaluating Debriefing: Measuring Impact and Driving Improvement

Implementing debriefing is a critical step in fostering a culture of safety—but ensuring that it is effective and sustainable requires thoughtful evaluation. Evaluating debriefing allows organizations to assess how consistently debriefs are occurring, who is participating, and whether the process is achieving its intended goals—such as emotional support, systems learning, and improved communication.

By tracking key process and outcome measures, organizations can identify gaps, celebrate strengths, and continuously refine their approach. Evaluation also reinforces accountability and helps leaders to understand the impact of debriefing on team dynamics, provider well-being, and patient safety outcomes.

In this step of the toolkit, we outline practical strategies to evaluate debriefing efforts and ensure they are meaningful, inclusive, and aligned with your organizations perinatal safety goals.

Process Measures

Process measures assesss whether and how consistently the debriefing is being implemented. These help you to track the execution of the intervention, not its result.

- % of severe events followed by a standardized debrief within X hours
- % of staff trained in debriefing protocol
- % of debriefs that followed structured format (fidelity checklists)
- Participation rates by role (nurses, OB)

Outcome Measures

Outcome measures assess the impact or results of debriefing—both on people and systems. Some examples of outcome measures you can use to evaluate the impact of debriefing are:

- Staff perception of teamwork and communication (assessed via survey)
- Psychological safety/climate improvements (assessed via survey)
- Identification of system gaps or actionable insights from debriefs
- Change in morbidity or adverse event recurrence (if tracked over time)

Measure	How to Measure	Example Metric

Staff perception of teamwork and communication 	• Use validated surveys such as:
	  ◦ AHRQ Surveys on Patient Safety Culture (SOPS)
	  ◦ Safety Attitudes Questionnaire (SAQ)
	  ◦ TeamSTEPPS Teamwork Perceptions Questionnaire (T-TPQ)
	• Administer pre- and post-implementation or on a regular interval (e.g., annually or quarterly).
	• Focus on key domains: teamwork, communication openness, handoffs, and feedback.
		• % of staff who "strongly agree" or "agree" that communication among team members is effective (baseline vs. follow-up).

Psychological Safety and Safety Climate 	• Include questions in staff surveys related to psychological safety, such as:
	  ◦ "I feel safe speaking up about patient care concerns."
	  ◦ "My input is valued by my team."
	• Use tools like:
	  ◦ Customized climate assessments tied to debriefing experiences
		• Mean score on a 5-point Likert scale measuring psychological safety before and after debriefing implementation.

Identification of System Gaps or Actionable Insights 	• Track the number and type of system-level issues identified during debriefs. • Categorize findings using a structured template (e.g., communication, policy, staffing, equipment). • Track number of action items created and resolved.	• Number of system issues identified per debrief, and % that led to documented follow-up or process change.
Change in Morbidity or Adverse Event Recurrence 	• Track rates of specific clinical outcomes over time • Use internal safety event reporting systems to track the recurrence of similar events after debriefing implementation. • Evaluate trends before and after starting routine debriefs (time-series analysis if possible).	• Frequency of shoulder dystocia with neonatal injury (over time) • Rate of PPH with transfusion (over time)

Together, process measures tell you if debriefing is happening the way it should, while outcome measures tell you if it's making a difference. Tracking both helps guide adjustments and demonstrate value.

Step 7: Sustaining the Work

While many organizations implement debriefing processes in response to sentinel events or as part of regulatory mandates, sustaining these practices over time is essential to ensuring lasting culture change, continuous learning, and staff well-being. Sustaining a quality improvement initiative is just as critical as launching it. In the context of implementing structured debriefing after severe perinatal events, long-term sustainment ensures that improvements in communication, psychological safety, and system learning become standard practice rather than one-time efforts. Without a strategy for sustainment, early gains can fade due to competing priorities, staff turnover, or lack of reinforcement. Without structures to embed debriefing into clinical workflows and systems of support, even the most effective debriefing programs may falter due to staffing challenges, competing priorities, or lack of leadership engagement. Sustainability requires a shift from viewing debriefing as a reactive measure to embracing it as a proactive safety and wellness strategy.

> "We can't revert to the old way of doing things!"

This toolkit is designed to support perinatal leaders and improvement teams in embedding debriefing into routine workflows, maintaining engagement, and continuously monitoring progress. Sustainment not only maximizes the return on investment in training and resources but also strengthens organizational culture, staff resilience, and patient safety outcomes over time.

a. Sustaining Debriefing Practices After Adverse Perinatal Events

Sustained improvement efforts are most successful when they become part of the organizational culture, receive ongoing support, and are continually adapted based on frontline feedback. The Institute for Healthcare Improvement (IHI) emphasizes that sustainability should be planned for from the outset, recommending strategies such as embedding the effort into infrastructure, aligning it with strategic priorities, and leveraging internal champions to maintain momentum (Nolan et al., 2005).

Leadership must remain committed

- Maintain visible support of debriefing and lean into the use of emotional support resources from senior leaders and perinatal champions.
- Include debriefing in regular safety and quality updates.
- Leadership should, celebrate wins and share the impact of debriefing on staff and patient care—prioritize this in staff meetings and newsletters.
- Align debriefing with leadership priorities, show how debriefing supports patient safety goals, accreditation requirements, and culture of safety metrics.

Frontline staff must stay engaged

- Provide ongoing training on the structured debriefing tool and the importance of debriefing.
- Train multiple team members (including nurses, physicians, midwives) to lead or facilitate debriefs.
- Refresh skills during annual simulations or drills.

Ownership

- Designate roles and responsibilities (e.g., charge nurse initiates, team lead facilitates, unit manager tracks).
- Consider creating a small oversight group to review debriefing frequency and quality.

Feedback – Celebrate & Recognize

- Collect aggregate themes and system insights from debriefs and close the feedback loop with staff. Visibility builds credibility.
- Share themes, system learnings, and improvement actions from debriefs (anonymized) with staff. Regularly!
- Publicly acknowledge when debriefs lead to meaningful changes in practice or culture. Recognition reinforces value.
- Reinforce how debriefing helps drive real change.
- Create a feedback loop where staff feel heard and supported. Follow your standard work— how does information from the debriefing form result in change?

☑ Embed in Safety Culture

- Align debriefing with larger initiatives (e.g., AIM bundles, maternal safety goals).
- Promote psychological safety: model openness, reflection, and accountability.
- Make debriefing part of how your team learns and heals after high-stress events.

☑ Ensure Accessibility

- Provide easy access to debriefing forms, tools, and facilitation guides.
- Allow for flexibility in when and how debriefs are conducted (hot vs. cold debrief).

☑ Leverage Technology

- Use EMR documentation templates or digital dashboards to track debriefing completion and findings.
- Consider integrating into learning management systems for training and reporting.
- Integrate into QI Infrastructure: Include debriefing data in safety and quality dashboards. Tie it to existing QI initiatives such as maternal morbidity or respectful care efforts.

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MDMOM

Maryland Maternal Health Innovation Program

Johns Hopkins University

615 North Wolfe Street
Baltimore, MD 21205

mdmom.org

Appendix A: Additional Resources for Emotional Support

Peer Support Resources

American Academy of Experts in Traumatic Stress - offers online support groups for emergency responders and health care professionals.

Debriefing the Front Lines - provides debriefing of single incident and cumulative care taking trauma, emotional wellness offerings, sobriety support and CE workshops to nurses working the bedside and beyond.

Don't Clock Out - is a mental health non-profit founded dedicated to supporting healthcare workers through the impacts of moral distress. Weekly virtual support groups for healthcare workers take place every Monday at 7pm EST. Nursing specific peer support groups for CNA's, nursing students and nurses of all specialties take place every Thursday at 7pm EST. There is no standing commitment, come as you are when you need support.

Introspective Spaces - is a mission driven organization building reflective communities for women in healthcare with an emphasis on trauma informed care through creative self expression.

Operation Happy Nurse -helps nurses struggling with stress, anxiety and/or depression by offering a community focused on improving overall mental health and physical wellbeing.

PeerRxMed - is a free peer-to-peer program for physicians and other healthcare professionals offering support, connection, encouragement, resources and skill building for optimal well-being.

Physician Support Line - helps physicians and medical students navigate personal and professional challenges through a volunteer network of psychiatrists (to share with colleagues).

Rekindled Nurse - is specific to the Pennsylvania region and works to empower, support & encourage nurses through resources and events. If you are local, learn more about their in person nurse led peer group.

Safe Call Now - includes trained peer advocates who can provide assistance, resources and support for any public safety or medical personnel and their families.

Appendix A: Additional Resources for Emotional Support

Therapy Resources (virtual and in-person)

American Academy of Experts in Traumatic Stress - offers online support groups for emergency responders and health care professionals.

Debriefing the Front Lines - resources and support for any public safety or medical personnel and their families.

Emotional PPE - offers free therapy for nurses and healthcare workers.

Psychology Today - includes detailed listings by state of mental health professionals and support groups.

Talkspace - offers several virtual packages with varying pricing options based on your needs, including an asynchronous chat option. They accept most major insurances.

Therapy Aid Coalition - offers free and low-cost therapy sessions to healthcare workers and first responders.

Anxiety Relief & Medication

Daily Communication Initiative - sign up for a complimentary 1 year subscription from Debriefing the Front Lines and receive a daily affirmation Monday - Friday. This unique offering allows you to respond in real time and speak directly with a debriefing facilitator should you need extra support.

Insight Timer - the free version has +65,000 Meditations, music and courses.

Sobriety Support

The Light Ahead - offers a compassionate, stigma free pathway for sober or sober curious nurses. Whether you are curious about sobriety from alcohol and drugs (this includes opiates, benzos and over the counter sleep aids), already sober or wish to explore sobriety without rules or labels - all are welcome.

Nurses in Recovery - is a robust resource page highlighting support groups, treatment centers, articles, and books for nurses struggling with addiction.

Advocacy

Dr. Lorna Breen Heros Foundation - works to reduce burnout among healthcare professionals and safeguard their well-being and job satisfaction.

Appendix B: Identifying Qualities of a Skilled Debriefing Facilitator

Assess Interest and Engagement:

- Shows enthusiasm for continuous learning and improvement
- Naturally creates a safe space for others and known for this on the unit
- Actively participates in meetings and discussions about quality and safety

Evaluate Experience and Knowledge

- Prior experience in debriefing or related practices
- Clinical expertise or training in communication and teamwork.

Observe Leadership Qualities

Identify individuals who naturally take on leadership roles within the team. Look for a few of the following traits:

- Contemplative
- Empathetic
- Curious
- Creative
- Visualizes space for change
- Proactive and initiates discussion, not afraid to go first

A Debriefing Facilitator should be someone you would describe as a:

- Problem-solver
- Collaborator
- Effective, clear communicator
- Connector
- Active Listener
- Life-long learner
- Self-regulated
- Role models asking for help

Encourage Peer Recommendations:

- Seek input from colleagues about who you believe would excel in this role.
- Create a culture where team members can nominate peers who demonstrate potential.

Consider Availability and Commitment:

- Ensure the interested candidate has the time and willingness to dedicate to learning and facilitating debriefing sessions
- Assess their current workload to avoid overburdening them.

Evaluate Communication Skills:

- Look for individuals who communicate effectively and can facilitate discussions among diverse team members.
- Ability to provide constructive feedback and foster an open dialogue