UC San Diego Health

Implementation of the STOP 5 Debrief in the Emergency Department

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Introduction

- The Emergency Department (ED) is often a place of high-stress or difficult cases, with very little time to process these events before returning to other duties in the department.
- “Hot debriefs” occurring right after a difficult case have been shown to decrease burnout, reduce stress, and lead to key process improvements relevant to future codes (ex. Take STOCK, BONE break, TIM tool).
- Previous studies have compared hot vs cold debriefs, or examined standardized debrief implementation in the prehospital or ICU setting.
- The aim of this project was to implement the STOP 5 debrief tool, improve confidence in leading debriefs, and address barriers to hot debriefs.

Methods

- Nursing staff and residents were educated on the STOP 5 debrief during shift change and during educational conferences.
- Laminated posters were placed in the resuscitation rooms and in the MD work area “doc box”.
- Standardized surveys were distributed to attendings and residents before implementation of the standardized tool and again 6 months later.
- Continuous variables were calculated with independent samples T-test, ordinal responses were calculated with Mann-Whitney U test, and binary responses were calculated with Fischer's exact test.

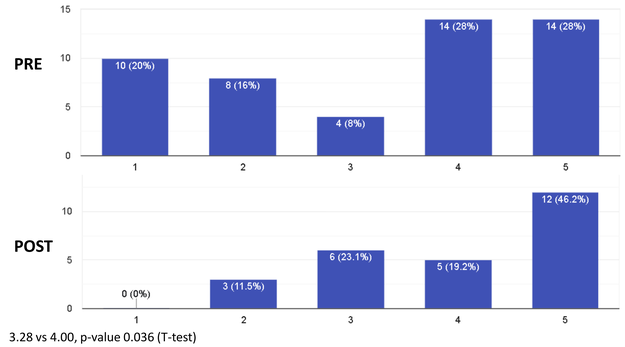
Sample Survey

1. What is your role/title?
2. In debriefs within the Hillcrest ED, who has participated in the debrie
3. In the Hillcrest ED, how many debriefs have your participated in?
   a. 1-5, 5-10, 10+
4. How confident do you feel INITIATING a debrief
   a. Scale 1-5
5. What has contributed to you NOT INITIATING a debrief?
6. In the Hillcrest ED, how many debriefs have you led?
   a. 1-5, 5-10, 10+
7. How confident do you feel LEADING a debrief?
   a. Scale 1-5
8. What has contributed to your NOT LEADING a debrief?
9. How confident do you feel PARTICIPATING in a debrief?
   a. Scale 1-5
10. How knowledgeable are you in the components of an effective debrief?
    a. Scale 1-5
11. If asked to, would you be able to LEAD a debrief following a difficult resuscitation, clinical case, or death?
    a. Yes/No
12. In the Hillcrest ED, how satisfied are you with current debrief practices and the debriefs that you have participated in?
    a. Scale 1-5
13. How could debriefs be improved in the Hillcrest ED?

Results

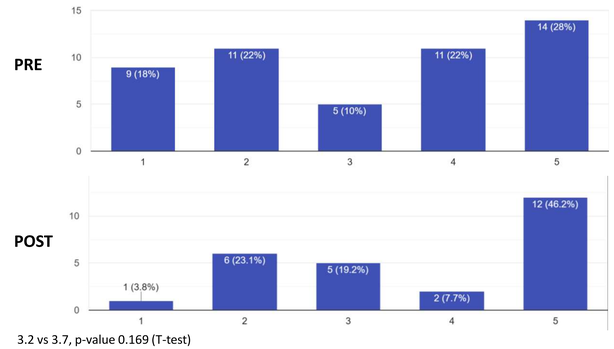
- 50 participants completed pre-intervention surveys, and 26 participants completed post-intervention surveys.
- There was a significant increase in the number of physicians who felt comfortable initiating a debrief (3.28 vs 4.00, p-value = 0.036).
- There was no significant change in the level of confidence with regards to leading a successful debrief (3.2 vs 3.7, p-value = 0.169).
- Commonly cited reasons for not having a debrief include lack of time (84%), lack of experience (30%), and “not my role” (15%), however, participants almost universally wanted more debriefs.

How confident do you feel INITIATING a debrief?



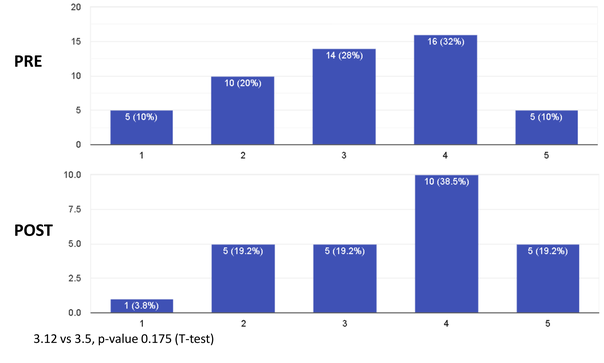
3.28 vs 4.00, p-value 0.036 (T-test)

How confident do you feel LEADING a debrief?



3.2 vs 3.7, p-value 0.169 (T-test)

How satisfied are you with current debrief practices?

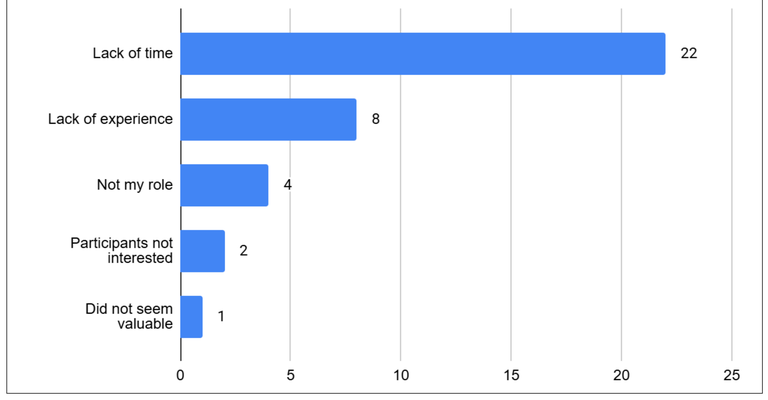


3.12 vs 3.5, p-value 0.175 (T-test)

How many debriefs have you led?

Mann-Whitney U, p-value 0.230

What has contributed to you NOT INITIATING debriefs



Conclusion

- The implementation of the STOP 5 hot debrief led to an improvement in how comfortable physicians felt initiating debriefs.
- There remains significant barriers to universal debriefs after appropriate cases, most notably physicians perceived lack of time and lack of experience in leading these debriefs.
- Further work is needed to build a culture where hot debriefs are expected and encouraged, while further training is also needed to help ED staff feel more comfortable initiating or leading these debriefs.

References

1. Walker CA, McGregor L, Taylor C, Robinson S. STOP5: a hot debrief model for resuscitation cases in the emergency department. Clin Exp Emerg Med. 2020 Dec;7(4):259-266. doi: 10.15441/ceem.19.086. Epub 2020 Dec 31. PMID: 33440103; PMCID: PMC7808839.
2. Herman JW, Cox-Henley M, Brown H, Brown K, Joshua T, Lemons C. Clinical Debriefing Impact Related to Intent to Leave and Job Satisfaction. Air Medical Journal. 2024 Jul;43(4):365-366. doi: 10.1016/j.amj.2024.05.018.
3. Sugarman M, Graham B, Langston S, et al Implementation of the ‘TAKE STOCK’ Hot Debrief Tool in the ED: a quality improvement project. Emergency Medicine Journal. 2021;38:579-584.
4. Amberly Hess, Tasha Flicek, Alexandra T. Watral, Meshach Phillips, Kelly Derby, Sara Ayres, Jason Carney, Anthony Voll, Renaldo Blocker. BONE Break: A Hot Debrief Tool to Reduce Second Victim Syndrome for Nurses. The Joint Commission Journal on Quality and Patient Safety. 2024;50(9):673-677. doi: 10.1016/j.jcjq.2024.05.005.
5. Edmondson M, Guscoth L, Highfield J, Kelly FE. Team Immediate Meet tool to help intensive care staff: Staff perception of an updated version and preliminary feedback following implementation. J Intensive Care Soc. 2023 Feb;24(1):117-120. doi: 10.1177/17511437221113239. Epub 2022 Jul 5. PMID: 36874285; PMCID: PMC9975809.
6. Sweberg T, Sen AI, Mullan PC, Cheng A, Knight L, del Castillo J, Ikeyama T, Seshadri R, Hazinski MF, Raymond T, Niles DE, Nadkarni V, Wolfe H. Description of hot debriefings after in-hospital cardiac arrests in an international pediatric quality improvement collaborative. Resuscitation. 2018 Jul;128:181-187. doi: 10.1016/j.resuscitation.2018.05.015.
7. Gilmartin S, Martin L, Kenny S, Callanan I, Salter N. Promoting hot debriefing in an emergency department. BMJ Open Quality. 2020;9:e000913. doi: 10.1136/bmjoq-2020-000913.
8. Twigg S. Clinical event debriefing: a review of approaches and objectives. Current Opinion in Pediatrics. 2020 Jun;32(3):p 337-342. doi: 10.1097/MOP.0000000000000890.