Introducing debriefing post-cardiac arrest at University Hospitals Dorset NHS Foundation Trust: a QI project

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Table 1. Debrief lead and themes discussed

Patient	Who lead the Debrief	Themes discussed					
		Communication	Teamwork	ALS Protocol	Safety	Areas of Improvement	Other
1	CCOT/Resus	Y	Y	Y	Y	Y	None
2	N/A						
3	CCOT/Resus	Y	Y	Y	Y	Y	None
4	N/A						
5	Intensive Care Registrar	Y	Y	N	Y	Y	None
6	Medical Registrar	Y	Y	Y	Y	N	None
7	N/A						
8	N/A						
9	Senior Nurse	Y	Y	Y	Y	Y	None
10	Senior Nurse	Y	Y	N	Y	Y	None
11	CCOT/Resus	Y	Y	Y	Y	N	None
12	N/A						
13	CCOT/Resus	Y	Y	N	Y	N	None
14	CCOT/Resus	Y	N	Y	Y	N	None
15	N/A						
16	N/A						
17	N/A						

Introduction

Resuscitation Council UK guidelines advise team debriefing post-cardiac arrest in order to allow team members to process and reflect on their experiences of the events, thereby identifying opportunities for improvement in future. However, debriefing rarely took place at University Hospitals Dorset. We aimed to promote the council's guidelines and to understand how we can improve the junior doctor experience around in-hospital cardiac arrests.

Materials and methods

This quality improvement project (QIP) was conducted at University Hospitals Dorset NHS Foundation Trust, which combines both Poole Hospital and Royal Bournemouth Hospital after the merger in 2020. Both are district general hospitals in the South of England.

Initially, a 10-question online survey was disseminated to junior doctors at University Hospitals Dorset. A total of 62 responses were obtained. The main findings included 54% of responders stating they often do not have time to process how they feel about what happened at a cardiac arrest call; 79% had attended cardiac arrest calls where they felt resuscitation was inappropriate; delay in discussion about resuscitation with the patient/family was deemed the most likely reason for inappropriate resuscitation (63%); and 68% of responders chose debriefing post-cardiac arrest as an area for improvement.

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After review of current evidence-based models for debriefing, our proposed change was to add a debrief section to the existing online 'Medical Emergency Team (MET) form' on the electronic patient record (EPR) system that is completed after every cardiac arrest. This would prompt clinicians to have a debrief. We planned to start implementation and data collection at Poole Hospital first because of their use of the electronic MET form, which Royal Bournemouth Hospital does not use yet.

Implementation of changes and data collection began from 1 February 2021 at Poole Hospital. The first round of data collection was until May 2021 and is still ongoing.

Results and discussion

Documented debriefs were analysed for a debrief lead and common themes discussed (Table 1). 9/17 (53%) cardiac arrests during this period had a documented debrief, which is a major improvement considering prior to this QIP almost zero debriefs occurred.

Currently, data is still being collected at Poole Hospital, and we have yet to implement the changes at Royal Bournemouth Hospital. Another online survey is due to be disseminated to junior doctors again at the trust to obtain their views on the new changes. However, we require a longer data collection and testing period (at least 1 year) before doing so.

The main challenges encountered were as a result of the coronavirus pandemic, which slowed data collection as there were overall fewer hospital attendances and admissions for non-COVID related conditions. Clinicians also recognised the importance of addressing resuscitation earlier with patients, reducing the number of inappropriate attempts.

Conclusion

The new post-cardiac arrest debriefing form was successful in increasing the number of debriefs occurring at Poole Hospital between February and May 2021. The next steps involve implementing the changes at Royal Bournemouth Hospital and auditing its success there. ■