Surgical Debriefs

Mallory Kremer, MD

Debrief is a dedicated session in which participants review and reflect on team performance or a clinical outcome. Surgical debriefs are multi-disciplinary, involving surgeons, anesthesia, nursing and allied healthcare staff. These sessions are structured with a designated moderator utilizing a checklist to guide the discussion. Surgical debriefs are typically implemented across a healthcare system as part of a comprehensive quality package. The World Healthcare Organization first published a surgical safety checklist in 2009 to guide organizations implementing structured surgical debriefs[1]. Surgical checklists have been shown to decrease morbidity and mortality in patients across a diverse global patient population in a variety of economic settings, as well as improve team performance and communication[2,3].

In the operating room, formal checklists or "time-outs" are utilized as a type of debrief *before, during, and after* procedures. Prior to starting a procedure, a structured debrief is an opportunity for closed loop communication within the multi-disciplinary team to confirm key elements such as the procedure plan and surgical site, fire safety, anesthetic considerations, and equipment availability. A pre-incisional debrief again confirms team members names and roles, administration of antibiotics, and anticipated critical steps and case length. Post-surgical debriefs are crucial to facilitating safe handoffs to post-anesthesia nursing care, but their importance goes beyond the status of foley catheters and incisional dressings. A thorough post-surgical debrief integrates lessons learned, identifies performance gaps, and reflects on team performance. These huddles discuss what the team did well during the surgery and identify systems-based issues to address.

Barriers to a robust post-surgical debrief include time constraints such as the divided attention of team members during emergence from anesthesia, and pressure on surgical providers to address other patient care. A strong institutional culture of safety can increase buy-in and adherence to debriefing protocols in operative settings.

Example: On GYN overnight call, an urgent D&C for bleeding in the setting of suspicious molar pregnancy was performed. The surgical team included a traveler circulator nurse, and an orthopedic surgical technician at 0200. During the post-procedure debrief with the attending physician, the team realized that the specimen (uterine contents) was not retrieved from the sock in the suction canister. This narrowly averted disposing of the specimen: creating an irretrievable specimen event with potential serious implications for the patient's continued care.

Reference Materials

1. WHO guidelines for safe surgery. Safe surgery saves lives. © World Health Organization, 2009. https://www.who.int/publications/i/item/9789241598552, accessed March 17 2024.
2. Haynes AB, Weiser TG, Berry WR, et al. A surgical safety checklist to reduce morbidity and mortality in a global population. *N Engl J Med*. 2009;360(5):491-499. doi:10.1056/NEJMsa0810119
3. Brindle ME, Henrich N, Foster A, Marks S, Rose M, Welsh R, Berry W. Implementation of surgical debriefing programs in large health systems: an exploratory qualitative analysis. BMC Health Serv Res. 2018 Mar 27;18(1):210. doi: 10.1186/s12913-018-3003-3. PMID: 29580254; PMCID: PMC5870386.