BMJ Open Quality

Impact of a debrief tool in acute child and adolescent mental health inpatient units: a centre's experience

William Billal Shepherd ,[1] Kyna Patterson,[2] Jessica Blake,[3] Danielle Ward,[2] Ashlee Clarke,[3] Cristina Diaz-Navarro,[4] Farah Abdulsatar [5]

To cite: Shepherd WB, Patterson K, Blake J, *et al*. Impact of a debrief tool in acute child and adolescent mental health inpatient units: a centre's experience. *BMJ Open Quality* 2024;**13**:e002704. doi:10.1136/bmjoq-2023-002704

Received 1 December 2023
Accepted 15 May 2024

[1]Schulich School of Medicine & Dentistry, University of Western Ontario, London, Ontario, Canada
[2]London Health Sciences Centre, London, Ontario, Canada
[3]Department of Child and Adolescent Psychiatry, London Health Sciences Centre, London, Ontario, Canada
[4]Cardiff and Vale University Health Board, Cardiff, UK
[5]Department of Paediatrics, Western University, London, Ontario, Canada

Correspondence to
Dr Farah Abdulsatar; fabduls@uwo.ca

ABSTRACT

This manuscript presents the pioneering use of a post-event staff debriefing tool, TALK, in Acute Child and Adolescent Mental Health Units (CAMHU). While unsuccessful in reducing the rate and severity of patient behavioural events, our centre observed promising psychological benefits for CAMHU staff as a result of debriefing, with the tool promoting emotional resiliency and providing a platform for open conversations. Debriefing also served as a venue for patient concerns with care to be raised by staff, addressed and reflected in updated care plans. This initiative demonstrates the utility of debriefing to foster a culture of learning, improve staff wellness and enhance patient safety in CAMHU settings.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Staff debriefing has evidence to show that it improves outcomes and bolsters staff mental health following critical events in acute settings, such as the paediatric intensive care unit and the emergency room. However, despite child and adolescent mental health units being the site of frequent and harmful patient behavioural events, debriefing has largely been unstudied in this environment.

WHAT THIS STUDY ADDS

⇒ While our study failed to demonstrate a reduction in either rate or severity of patient behavioural events following implementation of debriefing, feedback from staff suggests positive psychological benefits and highlights debriefing as an opportunity to iteratively improve patient care.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ This study highlights the positive impact debriefing can have in the child and adolescent mental health unit in terms of supporting staff and enhancing patient care. Further studies should aim to quantify any potential benefits and should explore the possibility of involving patients in debriefs to decrease the rate and severity of patient behavioural events.

INTRODUCTION

Acute Mental Health Inpatient Units in Children's Hospitals represent the location of the most frequent and severe patient behavioural events (PBE).[1] PBEs have a detrimental impact on patients, leading to increased lengths of stay and poor discharge prognoses, but also have deleterious effects on staff, driving burnout and increasing turnover rates.[2 3] These effects were already well documented prior to the COVID-19 pandemic, but demand on paediatric mental health services has increased significantly since then, both in Canada and abroad.[4–6] Given this, calls have been made for immediate action to defend paediatric mental health workers from intolerable levels of professional stress and burnout.[3]

One effective tool for improving patient safety and supporting healthcare workers in stressful environments is post-event staff debriefing, which offers potential advantages with respect to accessibility, adaptability and cost-effectiveness.[7] Debriefing has been studied in various healthcare settings such as the emergency room setting as well as in teams involved in cardiac arrest resuscitations (code blues), with up to 90% of respondents in certain publications highlighting psychological benefits and improved emotional resiliency as a result of implementation.[8 9] Improvements in patient outcomes with debriefing have also been noted, with studies showing increased survival rates following cardiac arrest resuscitation in paediatric intensive care units.[10] Considering the similarities between PBEs and other acute deteriorations in patient health, we explored the utility of post-PBE debriefing among staff in Child and Adolescent Mental Health Units (CAMHU) in order to reduce the rate and severity of PBEs and help promote staff well-being.

PURPOSE

The purpose of this initiative was to implement post-PBE staff debriefing using the TALK tool and assess its impact on rate and

Impact of a Debrief Tool in Acute Child and Adolescent Mental Health Inpatient Units, A Centre's Experience

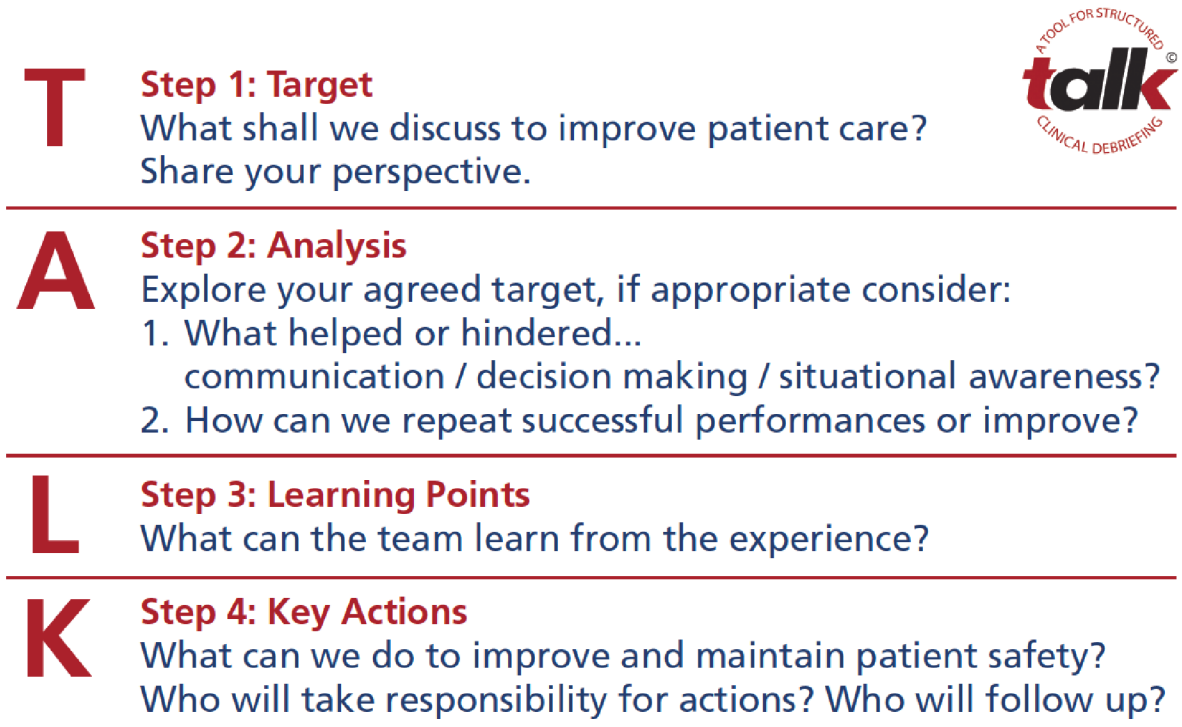

Figure 1 The TALK tool, as found in Diaz-Navarro *et al*.[11]

severity of PBEs, as well as its impact (if any) on staff well-being.

METHODOLOGY

Exemption from the institutional research ethics board was obtained prior to implementation given the quality improvement (QI) nature of this project.

Implementation and training of staff in debriefing were facilitated by the unit's child and youth counsellors, clinical manager and QI champions. The tool was reviewed during orientation sessions with all staff. Debriefing was formally implemented in July 2022. Debriefs were initiated at the request of staff to ensure that they were supportive and not burdensome.

Debriefing was conducted using the TALK tool (figure 1), a standardised clinical tool designed to facilitate team self-debriefs and promote a culture of learning and patient safety.[11] Under this framework, debriefing first begins with selection of a target for discussion, which in our case is centred on a preagreed trigger: the PBE. The second step involves analysis of the care provided for the PBE in terms of what went well and what could be improved. Third, the results of analysis are distilled into learning points to be carried forward by the team. Finally, key actions which serve to maintain or improve patient safety are identified, and responsibility is delegated among members of the team to ensure appropriate follow-up.

Both the monthly rate and severity of PBEs (defined as the proportion of events either bringing harm or nearly bringing harm to patients or staff) were tracked as primary measures. As a secondary measure, verbal feedback on debriefing was collected from CAMHU members, comprising registered nurses, by QI champions through informal conversation.

Patients were not involved in the design, or conduct, or reporting, or dissemination plans of our research.

FINDINGS

In terms of our primary outcomes, there was no significant decrease in the rate of PBEs (figure 2) or their severity (figure 3) following the implementation of debriefing.

With regard to staff perception of debriefing, our secondary measure, verbal feedback given to QI champions showed that while some CAMHU staff were not familiar with the tool as they had not had the chance to use it, they were aware of its exitance:

- 'I've heard of it but haven't used it before'.

Some CAMHU staff were not sure it was still being implemented:

- 'didn't know we were still using it'

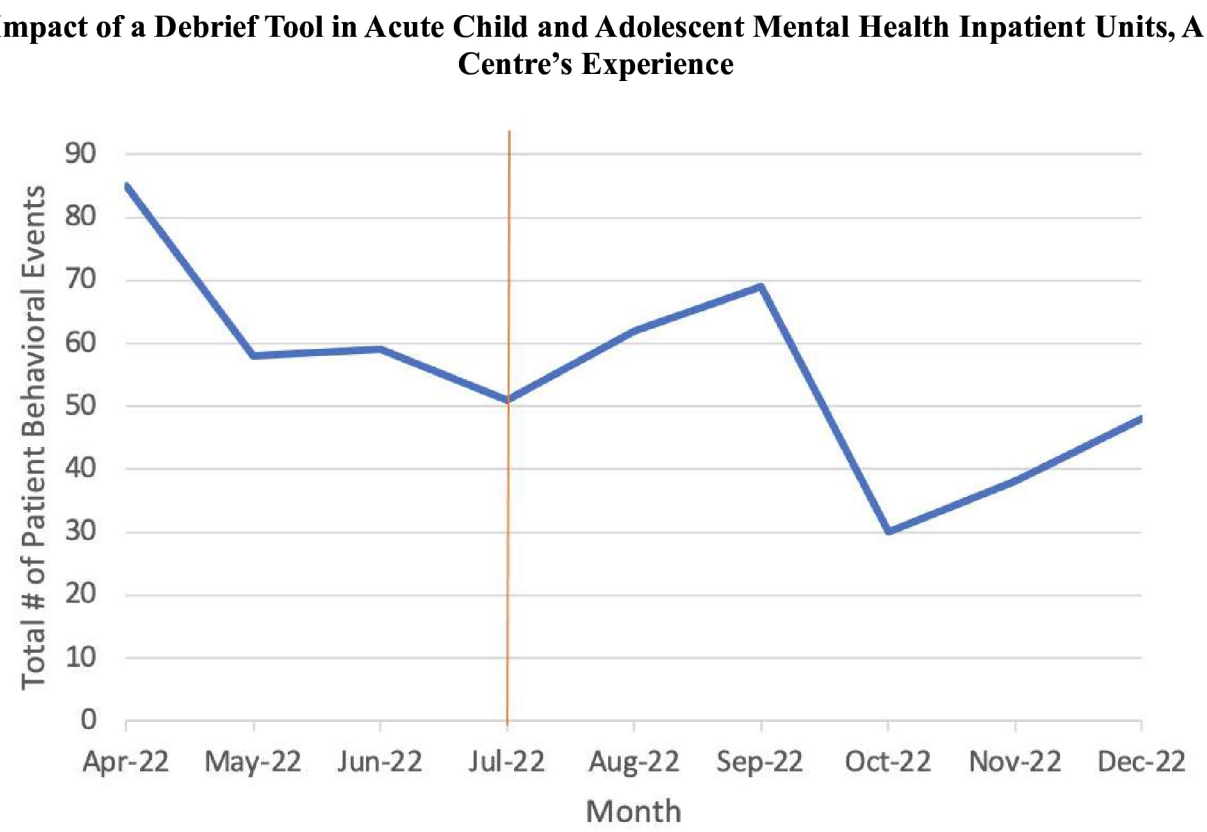

Figure 2 Total number of patient behavioural events by month. Vertical line marked for July 22 represents when the debrief tool was implemented.

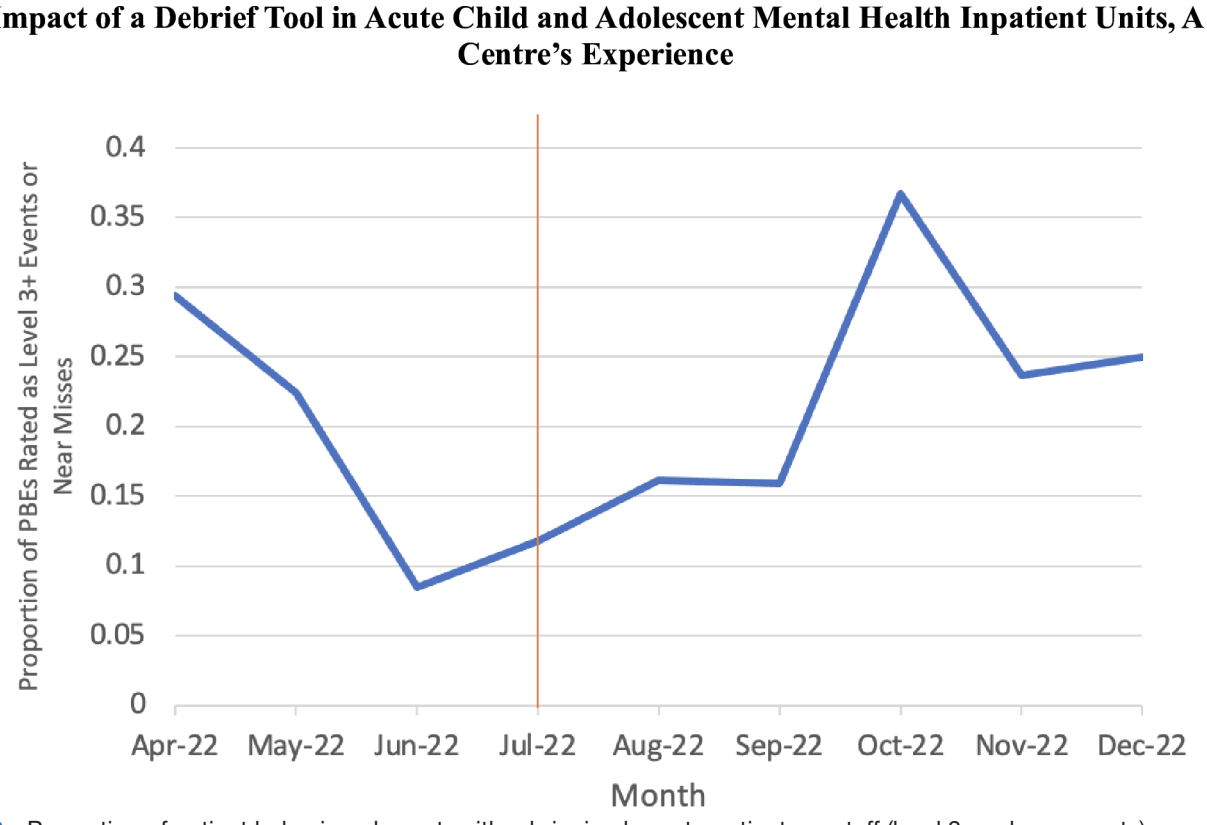

Figure 3 Proportion of patient behavioural events either bringing harm to patients or staff (level 3 or above events) or nearly bringing harm to patients or staff.

However, there were CAMHU staff who had previously used the TALK debrief tool that gave positive feedback on it:

- 'It is a good tool to get the conversation going.'
- 'It was helpful to open the conversation and teach staff about vicarious trauma.'
- 'It has been helpful to emotionally debrief with staff but would also like to see more staff debrief the areas for improvement/actions during the incident (ie, patient privacy, least restrictive measures)'

Staff have highlighted that debriefing has contributed to an overall positive team dynamic, including all disciplines.

From a patient perspective, staff have noted that debriefing allows for a deeper understanding of the perspectives of all stakeholders in adverse events. It has helped delineate the rationale behind decisions that have contributed to critical incidents such as restraints. Furthermore, debriefing has provided a venue for patient concerns regarding care plans to be raised by staff, addressed and reflected in updated care plans.

Verbal feedback suggests promising psychological benefits for staff, as well as indirect benefits for patients, but further research is needed to quantify the impact of debriefing on both staff burnout and patient satisfaction.

The findings of this project were presented at multiple venues, including the Solutions for Patient Safety Regional meeting, the Association of Faculties of Medicine of Canada Continuing Professional Development conference and the London Health Sciences Center Child Health Research Day conference. Since then, this project has gone on to receive widespread attention. Representatives from various inpatient units (adult mental health unit and general paediatric medicine unit) at our centre have expressed interest in implementing this tool. On a national level, this project received attention from various children's hospitals who are exploring implementation of this tool locally. Furthermore, this project has also been accepted as a Leading Practice for patient safety by the Health Standards Organization.[12]

LIMITATIONS

Several limitations within our project were identified, which future work should aim to address. While our project does show promise in terms of psychological benefit for staff, our results are qualitative. It is also important to note that our results are limited to our local feedback provided from a small number of CAMHU staff, and that feedback was collected in an informal, non-standardised manner, partially limiting the strength of this data. To address this limitation, our centre is currently pursuing a strategy of longitudinally administering the Oldenburg Burnout Inventory, a well-being survey validated internationally for healthcare workers.[13] This approach would allow us to quantifiably assess staff burnout before and after implementation of debriefing and determine if debriefing has a measurable impact. Should other centres embark on using debriefing, similar quantitative approaches can be considered early on in order to provide more accurate and robust data on the true impact of this tool.

Additionally, initial data have failed to demonstrate a link between debriefing at our centre and improvement in either PBE rate or severity. There are many potential reasons behind this, but a review of available research is notable in that interventions which do successfully reduce PBE rates (such as dialectical behavioural therapy or the positive behavioural interventions and supports system) are all heavily based on patient engagement.[14 15] This suggests that debriefings which involve patients following PBEs in child and adolescent inpatient units may yield better outcomes, but further research is needed to isolate the effects of patient-centred debriefing from other components of multimodal interventions.[16] Exploring this direction in future studies will provide valuable insight.

The final limitation of our debriefing approach lies in one of its strengths, its staff-driven nature. Debriefing sessions are initiated at the request of unit members following a PBE, allowing staff to have flexibility and freedom in accessing support. However, during periods of inpatient surges, it has been observed that fewer debriefing sessions occur due to demanding workloads and limited access to support. To address this challenge, our centre has introduced QI champions to promote sustainability and remind staff of the availability of debriefing even during busy periods. Future research should explore strategies to ensure consistent access to debriefing support, regardless of workload, to maximise its effectiveness as a tool for staff well-being. By addressing these limitations and considering future research directions, we can further enhance our understanding of the impact of post-PBE debriefing on reducing burnout and improving the well-being of staff in acute CAMHUs.

CONCLUSIONS

Postevent debriefing using the TALK tool shows promise in enhancing staff well-being in CAMHU and has been recognised as a Leading Practice by the Health Standards Organization. While qualitative evidence supports its efficacy, future research should focus on quantifying the impact of debriefing on staff burnout. Additionally, exploring patient-centred debriefing interventions and strategies to reduce the occurrence and severity of PBEs can further improve patient outcomes. Implementing standardised debriefing tools can help healthcare institutions foster a culture of learning, support staff and enhance patient safety in CAMHUs.

POTENTIAL IMPACT AND IMPLICATIONS FOR PRACTICE

The potential impact and implications of postevent debriefing for practice are significant, particularly in addressing the rising levels of burnout among healthcare workers, as highlighted by the Mental Health Commission of Canada in response to the COVID-19 pandemic.[17] This is especially true of staff members on CAMHU,

where they regularly encounter emotionally challenging and traumatic events involving a vulnerable patient population.

Implementing postevent debriefing provides an innovative approach to mitigate the effects of patient behavioural events on staff well-being. The described debriefing method offers a practical solution that can be easily adapted and implemented in other healthcare centres. Moreover, the debriefing tool itself is freely accessible online, making it a cost-effective resource for organisations seeking to provide support for their staff.

By incorporating postevent debriefing into their practices, healthcare centres can proactively address the psychological impact of patient events on staff, enhance well-being and potentially reduce burnout among their healthcare professionals. This approach not only supports the mental health of staff members but also contributes to the overall quality of care provided to child and adolescent patients.

Contributors JB, AC, DW and KP designed the intervention, implemented it, and edited and reviewed the manuscript. WS conceptualised, developed and wrote the manuscript. FA supervised and guided the creation of the manuscript and reviewed and edited it.FA is the guarantor who accepts full responsibility for the work and/or the conduct of the study and controlled the decision to publish. JB, AC, DW and KP have access to the data. CD-N helped write, review and edit the paper.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available upon reasonable request. Not applicable.

ORCID iDs
William Billal Shepherd http://orcid.org/0000-0003-4575-6912
Farah Abdulsatar http://orcid.org/0000-0003-2426-0723

REFERENCES

1 Dean AJ, Gibbon P, McDermott BM, *et al*. Exposure to aggression and the impact on staff in a child and adolescent inpatient unit. *Arch Psychiatr Nurs* 2010;24:15–26.
2 Baeza I, Correll CU, Saito E, *et al*. Frequency, characteristics and management of adolescent inpatient aggression. *J Child Adolesc Psychopharmacol* 2013;23:271–81.
3 McNicholas F, Adamis D, Minihan E, *et al*. Occupational stress in clinical and non-clinical staff in child and adolescent mental health services (CAMHS): a cross-sectional study. *Ir J Psychol Med* 2024;41:54–60.
4 Khan JR, Hu N, Lin P-I, *et al*. COVID-19 and pediatric mental health hospitalizations. *Pediatrics* 2023;151:e2022058948.
5 Vyver E, Han AX, Dimitropoulos G, *et al*. The COVID-19 pandemic and Canadian pediatric tertiary care hospitalizations for anorexia Nervosa. *J Adolesc Health* 2023;72:344–51.
6 Deren B, Matheson K, Cloutier P. Rate of adolescent inpatient admission for psychosis during the COVID-19 pandemic: A retrospective chart review. *Early Interv Psychiatry* 2023;17:115–7.
7 Evans TR, Burns C, Essex R, *et al*. A systematic Scoping review on the evidence behind Debriefing practices for the wellbeing/emotional outcomes of Healthcare workers. *Front Psychiatry* 2023;14:1078797.
8 Gilmartin S, Martin L, Kenny S, *et al*. Promoting hot Debriefing in an emergency Department. *BMJ Open Qual* 2020;9:e000913.
9 Gauthier S, Richardson L. A code blue Debriefing session to foster resiliency. *Med Educ* 2016;50:566–7.
10 Wolfe H, Zebuhr C, Topjian AA, *et al*. Interdisciplinary ICU cardiac arrest Debriefing improves survival outcomes. *Crit Care Med* 2014;42:1688–95.
11 Diaz-Navarro C, Leon-Castelao E, Hadfield A, *et al*. Clinical Debriefing: TALK© to learn and improve together in Healthcare environments. *Trends in Anaesthesia and Critical Care* 2021;40:4–8.
12 Muto S. CONGRATULATIONS leading practice submission decision letter: TALK Debrief tool following patient behavioural events. 2023.
13 Halbesleben JRB, Demerouti E. The construct validity of an alternative measure of burnout: investigating the English translation of the Oldenburg burnout inventory. *Work & Stress* 2005;19:208–20.
14 Katz LY, Cox BJ, Gunasekara S, *et al*. Feasibility of dialectical behavior therapy for suicidal adolescent Inpatients. *J Am Acad Child Adolesc Psychiatry* 2004;43:276–82.
15 Reynolds EK, Grados MA, Praglowski N, *et al*. Use of modified positive behavioral interventions and supports in a psychiatric inpatient unit for high-risk youths. *Psychiatr Serv* 2016;67:570–3.
16 Eblin A. Reducing seclusion and restraints on the inpatient child and adolescent behavioral health unit: a quality improvement study. *J Child Adolesc Psychiatr Nurs* 2019;32:122–8.
17 Mental Health Commission of Canada. Situation critical: distressed health-care workers in need of psychological support. Mental Health Comission of Canada; 2022. Available: https://mentalhealthcommission.ca/news-releases/49456-situation-critical-distressed-health-care-workers-in-need-of-psychological-support/ [Accessed 15 Aug 2023].