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SHARE debrief tool

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The SHARE debrief tool supports health and social care teams to engage teams and staff who may be affected by the outcome (ie safety actions) of a learning response.

It can be used to:

- present findings from a learning response (such as an incident investigation, MDT review and Swarm huddle) and define and agree areas for improvement
- collaboratively develop and prioritise safety actions in response to defined areas for improvement
- corroborate thinking regarding safety actions before agreeing to implement them
- debrief after the completion of a learning response to improve the learning response process and engagement.

Refer to the **safety action development** guide for further information on how to develop areas for improvement and safety actions.

We have used the SEIPS[1] framework (see SEIPS quick reference and work system explorer) to structure the SHARE Debrief. We recognise there are other systems-based approaches and frameworks which you may use to frame a debrief, for example, the Human Factors Analysis Classification System and AcciMaps (amongst others). Furthermore, if your organisation has invested in training and education on After Action Review (AAR), you may carry out debriefs using an AAR approach.

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[1] Holden, R.J., Carayon, P., Gurses, A.P., Hoonakker, P., Schoofs Hundt, A., Ozok, A.A. and Rivera-Rodriguez, A,J. (2013) SEIPS 2.0: a human factors framework for studying and improving the work of healthcare professionals and patients. Ergonomics, 56(11), 1669-1686.

Figure 1 summarises the five steps in a SHARE debrief:

1. **S**cene
2. **H**ear
3. **A**rticulate
4. **R**esponse
5. **E**mbed.

Table 1 provides tips for facilitators on how to conduct a SHARE debrief.

Appendix A gives an example of how to organise and carry out a SHARE debrief, including an illustration of how to communicate the output using the SEIPS framework.

Figure 1: Five steps in a SHARE debrief

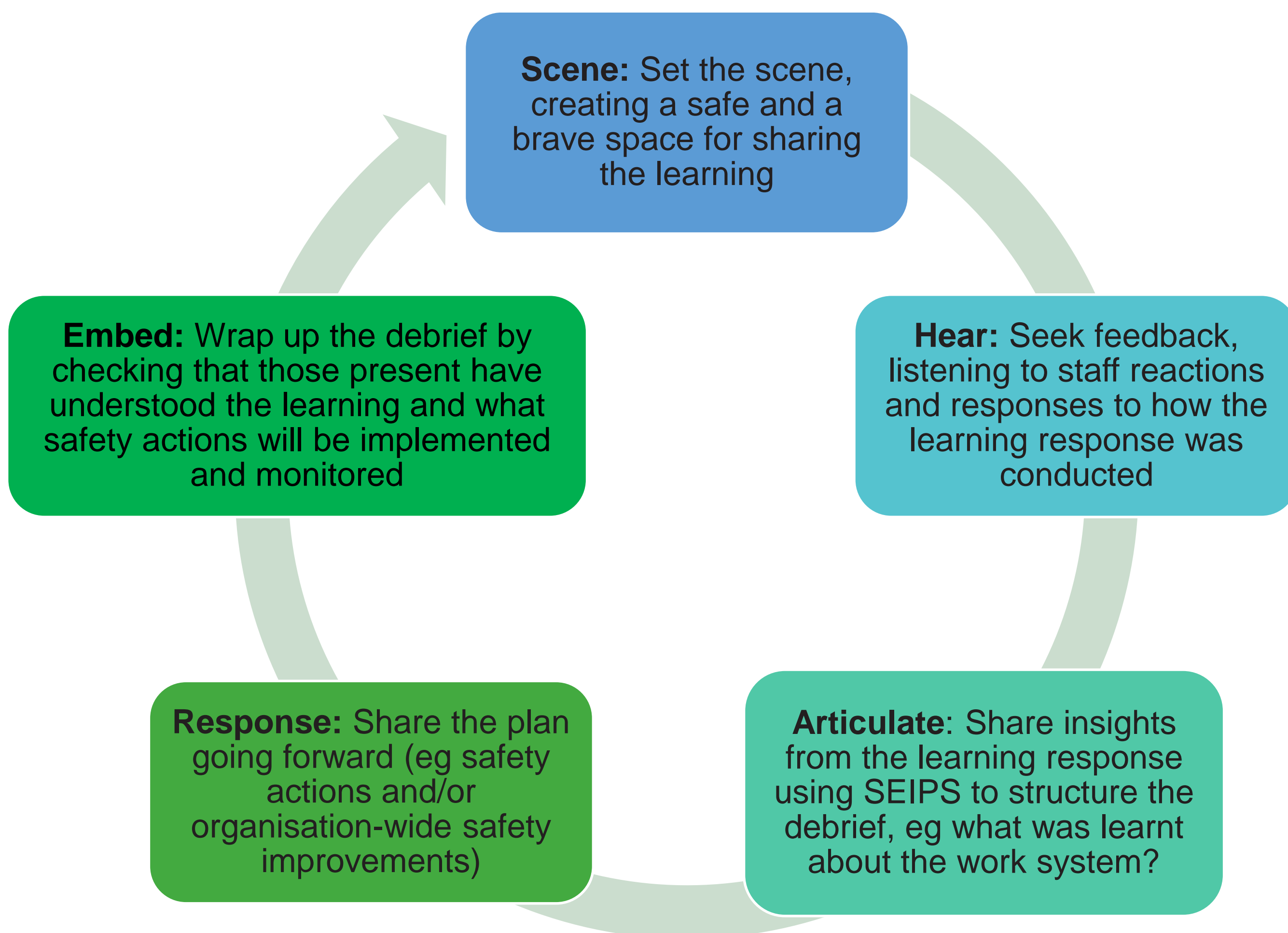

Table 1: Tips for facilitating a SHARE debrief

<table>
<tr><th colspan="2">Stage</th><th>Tips for facilitators</th></tr>
<tr><td>Scene</td><td>Set the scene, creating a safe and a brave space for sharing the learning</td><td>Organising the debrief
1. Be inclusive: identify a debrief time and venue that suits frontline health and social care teams.
2. Consider how to ensure learning is cascaded to as many staff as possible: you may need to set up several debriefs and/or work with colleagues to identify how learning will be cascaded to frontline health and social care teams after the debrief.
3. When setting up the SHARE debrief be clear that its purpose is to:
– share the findings of a learning response
– listen to staff feedback on ‘what went well’ and ‘what could be improved’ about the way the learning response was carried out to ensure continuous improvement.
At the start of the debrief
4. Be clear that everyone’s feedback and perspective on the learning response is important.
5. Be clear that there is no place for hierarchy: everyone’s voice and perspective is equally important.</td></tr>
<tr><td>Hear</td><td>Emotions and reactions to how the learning response was conducted</td><td>6. Check how staff are feeling about participating in the debrief. If they are nervous, put them at ease and reassure them.
7. Start by asking the staff present to share what went well and how the approach might be improved.
Giving staff an opportunity to share their feedback about the learning response shows that you are listening and learning too, not simply imparting information on the outcomes of an investigation, MDT review, etc. Seeking staff feedback on how the learning response was carried out supports continuous improvement when implementing the PSIRF.
Having the ‘what went well?’ and ‘how might we improve our approach?’ conversation at the start of the SHARE debrief also enables you to tune into how staff are feeling about the event, safety</td></tr>
</table>

		theme/issue or incident from the outset of the debrief.
Articulate	Share insights from the learning response using SEIPS to structure the debrief, eg what was learnt about the work system?	8. Explain what has been learnt using SEIPS to frame your insights. A storytelling approach based on the SEIPS framework has several advantages: – the focus of the feedback is on the work system, not individual staff members – you can organise feedback around the six dimensions of the SEIPS framework (technology and tools, organisation, environment, person, tasks, and external environment). 'Chunking' your storytelling in this way helps retention and learning. 9. Pause when sharing what has been learnt and invite participants to share their reflections. Structuring your feedback one dimension at a time – with a pause after each – makes the debrief a two-way conversation.
Response	Share the plan going forward (eg safety actions and/or organisation-wide safety improvements)	10. Share the safety actions identified so far (if any) and who has responsibility for ensuring the implementation of each safety action. 11. Seek input from the staff present about further safety actions or safety improvements, empowering them to come up with ideas and solutions. 12. If organisation-wide safety improvements were identified, share with the staff present how these have been escalated and/or the safety improvement plan.
Embed	Wrap up the debrief by checking with those present that they have understood the learning and what work system improvements will be implemented.	13. Use 'read-back' or 'teach-back': ask individual staff to summarise one learning point they heard during the debrief. 14. Thank everyone for listening and learning together.

Appendix: Worked example – carrying out a SHARE debrief

Safe discharge is a theme in trust A's patient safety improvement plan. An MDT review of three recent patient discharges from an older adults ward identified learning points. Learning response lead B shared these the older adults ward team in a SHARE debrief:

- Information was missing in the three patient discharge summaries; they had all been created at a time when the trust's electronic patient record system was undergoing a scheduled update.

  For this contributory factor, a safety action had been agreed with the Director of IT that will ensure scheduled updates to the electronic patient record system are not carried out in the late morning/early afternoon on weekdays (these are the peak time for discharges of all patient groups).

- Trust A was trying to improve the flow of older adult patients through its wards in response to bed pressures on its services. Staff caring for two of the patients in the MDT review had reported feeling pressured to discharge patients into the community to free up beds for other patients.

  For this contributory factor, there was trust-wide learning relating to managing the competing goals of patient flow and safe discharge. The MDT review had identified that other specialties in the organisation felt the same pressure as the older adults team, and that this needed to be fed into a wider safety improvement plan around improving organisational safety culture.

- The adult social care team in borough B had been struggling to respond to new older adult referrals and put care packages in place in a timely way because there was a shortage of home care staff across the borough. Many local council approved home care providers were struggling to take on new older adult referrals because of high levels of staff sickness and staff turnover.

  This contributory factor was external to trust A. The MDT review had concluded the older adults team needed to be aware of the systems gaps and challenges experienced by borough B's adult social care team and local home care providers. The executive director of nursing at trust A was working with community and social care colleagues through the ICS to work potential solutions, although it was recognised there was no 'quick fix.'

Scene

Learning response lead B arranged the SHARE debrief by extending the older adults MDT meeting that took place every Wednesday afternoon by 30 minutes. Learning response lead B briefed and tasked ward sisters and other consultants to explain to colleagues ahead that the purpose of the debrief was to share learning from a recent MDT review of three older adult discharges into the community. They did this at the team's daily huddles, carried out every morning and early evening.

Learning response lead B set the scene at the start of the debrief, making it clear that the team needed to set hierarchy aside, and that every colleague's perspective was equally important.

Hear

Learning response lead B then sought feedback from the staff present at the debrief about how well the learning response (MDT review) had been handled. A nurse and an HCA who had participated in the MDT review fed back that it felt different to an incident investigation and that there was a genuine focus on identifying systems learning, not individual blame. Occupational therapist C shared her team's distress about the three cases and that in future there needed to be more emphasis on staff support when setting up MDT reviews. Learning response lead B acknowledged the feedback received and took away the action to improve staff support when setting up an MDT review.

Articulate

Learning response lead B structured the 'articulate' part of the debrief by sharing the learning from the MDT review about the discharges of the three patients.

Using a one-page schematic of the SEIPS framework (see Figure 2), learning response lead B started by stating the aim of the MDT review was to explore learning around safe patient discharge of older adults. He then shared the learning relating to the 'person' dimension of SEIPS, outlining the vulnerabilities of older adults with complex needs and how they require ongoing social care and healthcare support when discharged so that they are safe at home and are not readmitted to hospital.

Learning response lead B then relayed the findings relating to the 'task' (ie safe discharge), 'technology and tools' and 'organisation' dimensions of SEIPS. For example, he explained the scheduling of updates to the electronic patient record had been identified as a contributing to omission of information in each patient's discharge summary. He then paused and invited reflections from the staff present: some expressed surprise that key patient information was not automatically translated into the discharge summary when a scheduled IT upgrade was being carried out. They were

unaware that some of the IT system's functionality did not work during scheduled updates.

Learning response lead B then explained how the organisation had drifted into making staff feel pressured to discharge patients into the community because of the need to improve patient flow. Once again, learning response lead B paused after sharing this 'chunk' of the learning and invited feedback and reflections from the staff present. This led to a conversation in which the team agreed that their priority should always be 'safe patient discharge over all other considerations'.

He finished his summary of insights by explaining the learning from the 'external influences' dimension of the SEIPS framework; notably the pressure on home care services and the older adults social care team in borough B and how this was delaying putting in place social care plans for older adults with complex needs discharged into the community.

Response

Learning response lead B shared the safety actions identified in the MDT review, including the broader organisation or healthcare system-wide learning. He encouraged the staff present to identify other safety actions they could implement locally. For each safety action, there was clear allocation of responsibilities. The deadlines for implementation were discussed. For example, the safety action agreed with the director of IT to not schedule updates to the electronic patient record system late morning/early afternoon on weekdays (the peak times for discharges of all patient groups) was to be implemented in May 2022.

Organisation-wide learning relating to the culture where staff felt pressured to discharge patients because of the focus on patient flow had been escalated to the quality and safety team.

The executive director of nursing at trust A was collaborating with community, social care and ICS colleagues to identify systems-based solutions to the staffing and sickness absence problems the home care services were experiencing. This was an ongoing problem for which there is no 'quick fix.'

Embed

Learning response lead B asked one member of staff present to start the read-back/teach-back part of the debrief by sharing one take home message from the debrief, and then for other staff to do so. Staff agreed this helped consolidate their learning.

Learning response lead B ended the debrief by thanking everyone for participating. He also committed to take away the feedback about a greater focus on staff support when an MDT review is set up.

Figure 2: The SHARE debrief summary