SAFETY FIRST

Using Debriefing to Address Disruptive Behaviors and Improve Clinician Well-Being

PODCAST

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In 2008, The Joint Commission released a breakthrough sentinel event alert warning health care facilities that disruptive behavior is a substantial barrier to the provision of quality patient care.[1] In 2019, the results of an international survey of members of 134 perioperative associations in seven countries showed that 7,171 (97%) of the 7,391 respondents indicated they had personally experienced or witnessed at least one disruptive behavior during the previous year.[2] In addition, more than half of the respondents reported that they experienced or witnessed at least 10 of the 14 measured behaviors (eg, disparaging comments, offensive language, inappropriate comments about patients, insults). Disruptive behavior is a persistent, substantial problem, and results of a systematic literature review estimated that disruptive behavior appears to be caused by 6% to 18% of OR clinicians.[3] The American Medical Association defines *disruptive behavior* as speaking or acting "in ways that may negatively affect patient care."[4(p1)] The behavior can also impede the ability of a physician "to work with other members of the health care team,"[4(p1)] and vice versa.

In 2022, results of a systematic literature review showed that disruptive behavior negatively affects patient care.[5] The review highlighted several potential effects of disruptive behavior, including

- adverse events (eg, mortality, falls, hand hygiene noncompliance),
- neglect of care needs (eg, patient hygiene, repositioning),

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- poor clinical outcomes (eg, reduced diagnostic ability during patient emergencies), and
- diminished patient safety (eg, lack of adherence to safety protocols).[5]

Disruptive behavior can be detrimental to patients and their care when communication, teamwork, clinical decision making, and technical performance are undermined.[3]

Clinicians are also vulnerable to the ill-effects of such behavior and may feel that *team psychological safety*[6]—"a shared belief that the team is safe for interpersonal risk taking"[7(p354)]—is lacking. They may not feel supported to mention safety concerns, especially in the presence of a disruptive colleague, which can then negatively affect patient safety.[6] Psychological safety can benefit teamwork, and correlations show that disruptive behavior destabilizes the psychological safety and well-being of team members and increases patient care risks for harm.[8] However, tools for assessing disruptive behavior "have not been validated in health care settings,"[8(p18)] and therefore have yet to be used routinely in clinical settings. As a result, team psychological safety and its importance remain underestimated in the background[6] of perioperative environments where patient safety is the primary focus.

Clinicians who are directly involved with or witness disruptive behavior can experience negative effects on their wellness, such as

- increased anxiety levels,[9]
- fear of conflict when working with a disruptive colleague,[9]
- impaired cognitive function and performance,[10] and
- stress and compounding of an existing high cognitive load.[11]

These effects may cause the clinicians to make errors[12] that negatively affect patient safety. Over time, the clinicians may become dissatisfied with their work and decide to leave their position.[13]

Encounters involving disruptive behavior may be subtle or overt, constantly witnessed, and expressed by increasing levels of severity through recognized patterns of behavior. Disruptive behavior can involve

- incivility (eg, yelling, eye rolling, sighing),
- microaggression (eg, using slurs, stereotyping),
- bullying (eg, attacking integrity, making threats, gossiping), and
- harassment (eg, using obscenities, making insults or unwelcomed sexual advances).[14]

We believe that one reason this problem persists is that it can be normalized and unaddressed. This article reviews disruptive behaviors and use of debriefing to improve clinicians' psychological safety and well-being.

CAUSES OF DISRUPTIVE BEHAVIORS

Any member of the health care team can display and instigate disruptive behaviors. The causes are multifactorial; triggers of disruptive behaviors in perioperative areas include rotations among the health care team according to the facility's work shift system and concerns about limited infrastructure (eg, material and human resources).[15] Another factor is the sociocultural context of the OR, which is affected by the clinicians' experience, organizational roles (formally and informally defined), interpersonal relationships (eg, hierarchy), and intrapersonal characteristics.[15] Intrapersonal characteristics include "personality traits, psychological conditions, and transient physiological states that increase the probability of acting disruptively."[3(p131)] Situational work conditions involving concerns associated with supplies, performance errors, miscommunication, and procedural noncompliance can also trigger disruptive behavior.[15]

The relationship between an instigator and a target is one in which the instigator perceives the target to have less social power and uses that advantage to reward or coerce a desired behavior from the target.[3] Instigators may take a dominant approach to conflict management and have low empathy for others and limited coping skills; they also can be argumentative.

Cognitive load is an intrapersonal factor that can cause disruptive behavior. *Cognitive load theory* aims to describe "how the information processing load induced by learning tasks can affect students' ability to process new information and to construct knowledge in long-term memory."[16(p261-262)] This theory originates from educational psychology[16] but has important relevance in perioperative

settings with regard to the "amount of finite working memory resources an individual must allocate"[17(p312)] for the clinical task at hand.

Conceptually, cognitive load can be described as intrinsic, extraneous, or germane.[18] *Intrinsic cognitive load* is the mental effort directly related to the task and is influenced by mood-related elements, such as emotions, stress, and uncertainty. *Extraneous cognitive load* increases under suboptimal conditions; in the clinical setting, this is usually represented by distractions and interruptions that are unrelated to the current task.[18] *Germane cognitive load* involves working memory resources that process intrinsic cognitive load[11] and the automation and construction of mental schemas to connect information.[18]

For experienced clinicians, there can be some automation associated with clinical tasks that may lighten the intrinsic cognitive load.[18] Expert clinicians require less cognitive work than novices; however, if uncertainty (eg, an unexpected surgical complication) is introduced, the intrinsic cognitive load can increase even for the expert. When there is increased intrinsic cognitive load, an additional rise in extraneous load (eg, an interruption caused by malfunctioning equipment) can lead to *cognitive overload*—that is, when the cognitive demands become greater than the available cognitive resources.[18] Characteristics of cognitive overload in the clinical setting include decreased performance capability and decision-making ability. In the dynamic atmosphere of the perioperative environment, increases in cognitive load can quickly shift clinicians into cognitive overload, adding to the possibility of disruptive behaviors. Distractions can add to cognitive load, and one too many can result in disruptive behavior, potentially distracting others. By considering this problem with a cognitive load and overload perspective in mind, we believe that nurses are better able to improve their understanding of the problem and identify sustainable mitigation strategies.

STRATEGIES TO CONSIDER

Checklists are used to promote safe practice and team communication in surgery and can enhance patient safety.[19] Additionally, the use of safety checklists in the OR has been shown to support psychological safety[17] and positively influence cognitive load.[11] For a clinician, checklists, standardizations, and routines may help offload some of the demands and decrease their cognitive load, thereby freeing up working memory and allowing them to improve patient care.[17] Well-designed checklists can provide a clear structure with a process for communicating effectively and an accessible framework for supporting adherence to clinical requirements.[20] Shared knowledge of the checklist components promotes mutual support and psychological safety for clinicians.

Routine debriefing is another strategy that perioperative clinicians can use to improve the climate of psychological safety.[21] In perioperative areas, a *debriefing* is a "short dialogue conducted after the procedure has concluded that is designed to improve team performance and effectiveness."[22(p1109)] In addition to end-of-procedure debriefings, clinicians can initiate a debriefing during any patient care situation, and all involved clinicians should participate.

Debriefing encourages clinicians to focus and reflect on the aspects of care that went well and those that would benefit from change, as well as how to make those productive changes.[23] For clinicians who find it difficult to speak up, debriefing provides a structured platform for constructive team discussion and enables collaboration. The process of debriefing can increase clinicians' self-awareness[24] and help them to understand the effect of their actions and behaviors. Team debriefing also can contribute to improved situational awareness[25] and increased knowledge associated with mistakes and successes.[21]

In perioperative environments, however, debriefings are not widely used and can be challenging to implement and maintain because of a variety of barriers, including time pressures, lack of support or buy-in, hierarchical concerns, and limited action on previously identified issues.[21] Debriefing models are generally comprised of three to six steps,[23] and debriefing checklists can contain multiple steps.[26] One example is a practical three-phase model involving preparing, assessing and analyzing, and finalizing[23] that can be used in perioperative settings to implement a sustainable debriefing with a sequential checklist to guide the process.

The first step in developing a standardized debriefing process involves engaging an interdisciplinary team of stakeholders (eg, surgeons, anesthesia professionals, nurse managers, perioperative nurses, information technology personnel) to review the facility's policies and best practices for OR safety.[22] After reviewing the available literature, the team can use discussion sessions to garner

commitment and consensus and plan the implementation process. The team also can construct tools and documents for debriefing, such as a static sequential checklist based on the World Health Organization's Surgical Safety Checklist[27] to guide procedural debriefings based on the organization's needs.

Contingent on available facility and electronic health record software, the debriefing checklist can be embedded in the safe surgery protocols and uploaded for shared access and ease of data collection. Additional tools may include a facility-produced demonstration video to use during education sessions on debriefing. The team can develop cognitive aids for use during debriefings, such as debriefing checklist posters, whiteboards, electronic whiteboards, or computerized checklists, in each OR.[22] Finally, a debriefing tool—a paper or electronic version of the debriefing checklist—can be used by perioperative clinicians to record and report information (eg, barriers, disruptions) on the debriefing to leaders for follow-up (Figure 1). When paper tools are used, the interdisciplinary team should designate the location for disposition of the completed tools because these may contain information that can be entered into a database for analysis.

After determining the debriefing process and developing applicable tools, it may be beneficial to conduct a pilot of the new process. During this testing phase, clinicians should complete the debriefing (with applicable tools) and provide feedback. The interdisciplinary team can use the feedback to assess the clinicians' engagement and make any needed modifications before full implementation.

The interdisciplinary team also should plan communication and implement education and competency verification for all affected clinicians before full implementation.[22] The education sessions can include mock debriefings to provide clinicians with an opportunity to practice and evaluate their performance.

Operating Room
Safe Surgery Debriefing Checklist

Checklist	Yes	No	N/A	Comments
Briefing				
Count				
Specimens				*(eg, CSF for culture)*
Procedure Performed				*(eg, I&D subdural abscess)*
Wound Class				
Patient Disposition				
What Went Well				
Improvements				
Action Items (report below)				
Booking –				Supplies –
Equipment –				Teamwork –
Efficiency –				Other –
***Action item(s) status to be reported by Clinical Manager**				
Perioperative team member		Surgeon		Date and OR #

Figure 1. An example of a postprocedure debriefing checklist. N/A = not applicable; CSF = cerebrospinal fluid; I&D = incision and drainage.

TAKEAWAYS FOR PERIOPERATIVE NURSES

Debriefing provides a powerful and valuable learning opportunity for perioperative nurses[23] that can be used to improve both technical and nontechnical skills, such as communication, teamwork, and situational awareness.[21] Although the debriefing culture in the OR is still in its infancy in many organizations,[23] it is beneficial for nurses because it supports a positive and safe learning environment,[23] promotes psychological safety,[21] engages and empowers them in discussions,[23] helps to build their self-confidence, and encourages reflective learning experiences among all team members.[23]

The hierarchical culture of the OR[28] may trigger disruptive behavior, hamper communication, and prevent nurses from speaking up.[9] Perioperative nurses can use checklists to decrease cognitive load[17] and team debriefings to foster psychological safety and elevate communication beyond information transfer.[21] Because disruptive behavior can be underreported,[13] perioperative nurses should use available reporting systems to document disruptive behavior when they directly experience or witness it. Perioperative nurses should participate in team training activities,[22] which may include mock debriefings. They also should adhere to their facility's standardized debriefing process and stop all unnecessary conversations when the debriefing is initiated.[22]

TAKEAWAYS FOR PERIOPERATIVE NURSE LEADERS AND EDUCATORS

Perioperative leaders and educators should support a culture of safety and address disruptive behavior when it occurs.[22] They should recognize the effects of cognitive overload and collaborate with interdisciplinary teams to create processes to minimize overload. In addition to addressing disruptive behavior, developing and implementing checklists and standardized debriefing processes can help to foster an environment in which clinicians feel supported to address patient safety concerns and maintain or improve their well-being. Leaders and educators should strive to create an environment that promotes resilience among team members and a shared mental model to increase situational awareness and decrease disruptive behavior.[22]

Educators should be involved in the creation of checklists and debriefing processes. They should collaborate with leaders to provide education sessions on effective team communication and use applicable tools during onboarding and ongoing education activities.[22] To avoid normalization of the underreporting of disruptive behavior, they should advocate for effective reporting systems.[13]

Leaders can use data from debriefing documentation to prioritize and resolve issues and barriers for clinicians. They should address disruptive behavior and respond to reports of such behavior in a consistent and timely manner to positively affect patient care and clinician morale.[13] Coupled with addressing disruptive behavior promptly, fostering a culture of safety for patients and clinicians through implementing checklists and a standardized debriefing should promote and elevate team engagement, productivity, satisfaction, and well-being.

Earn Contact Hours

Contact hours are available for this activity. Earn the contact hours by reading this article, reviewing the outcome and objectives, and completing the Learner Evaluation at *https://aorn.us/aug24-sf-v2.*

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