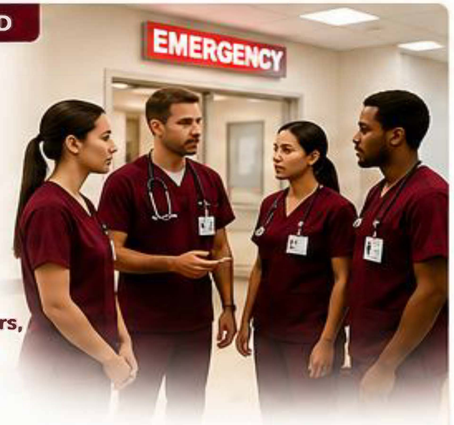
Iowa Specialty Hospitals & Clinics

PAUSE. DEBRIEF. IMPROVE.

Using Hot & Cold Debriefs to Strengthen Patient & Staff Safety

BACKGROUND: WHY WE STARTED



Critical clinical events place significant emotional and cognitive demands on healthcare teams. Without structured reflection, valuable lessons, latent safety threats, and opportunities for improvement may be lost.

At Iowa Specialty Hospitals & Clinics, we implemented standardized Hot and Cold Debriefs to support caregivers, promote organizational learning, and strengthen a culture of safety.

OUR OBJECTIVE

HOT DEBRIEF
- IMMEDIATE
- IN THE MOMENT

COLD DEBRIEF
- REFLECT
- LEARN
- IMPROVE

SAFER PATIENTS | **SAFER STAFF** | **STRONGER TOGETHER**

WHY DEBRIEFING MATTERS: EVIDENCE THAT DRIVES SAFER CARE

COMMUNICATION

Communication failures are a leading contributing factor in approximately 70% of serious adverse events.[1]

TEAM PERFORMANCE

Structured briefings and debriefings improve teamwork and are associated with better surgical outcomes, including reduced mortality and morbidity.[2,3]

CONTINUOUS LEARNING

Debriefing transforms individual events into system-wide improvements through structured reflection and action.[4]

SELECTED REFERENCES:
1. The Joint Commission (2021). Sentinel Event Data: Root Causes by Event Type 2004–2020.
2. West, C. P., et al. (2014). Association of implementation of a medical team training program with surgical mortality. *JAMA*, 312(11), 1087–1096.
3. Sharafeldin, T., et al. (2015). Changes in burnout and satisfaction with work-life integration in physicians and the general US working population. Mayo Clinic Proceedings, 90(12), 1600–1613.
4. TeamSTEPPS® 2.0 (2017). Team Strategies & Tools to Enhance Performance & Patient Safety.

OUR JOURNEY: FROM CONCEPT TO PRACTICE

PHASE 1 — RESEARCH & EVIDENCE REVIEW
Reviewed best practices and national models.

PHASE 2 — PROGRAM DEVELOPMENT
Created standardized Hot & Cold Debrief tools and defined roles.

PHASE 3 — STAKEHOLDER ENGAGEMENT
Engaged multidisciplinary teams across the organization.

PHASE 4 — PILOT & REFINEMENT
Piloted in key areas, gathered feedback, and refined process.

PHASE 5 — EDUCATION & ROLL OUT
Trained staff and implemented across all departments.

PHASE 6 — PROGRAM MONITORING & CONTINUOUS IMPROVEMENT
Monitor debrief completion and participation. Review trends and identify opportunities for improvement. Refine the process through ongoing education and staff feedback.

THE ISH DEBRIEF PROCESS

ANALYZE WHAT HAPPENED
Gather facts and understand the event.

IDENTIFY IMPROVEMENTS
Discuss what went well, what could be better, and why.

DRIVE LASTING CHANGE
Implement action items and update processes.

BETTER CARE FOR EVERY PATIENT
Safer today. Stronger tomorrow.

EARLY IMPLEMENTATION (TO DATE)

- **2** Hot Debrief & Completed
- **2** Cold Debriefs Completed
- **9** Improvement Opportunities Identified
- **5** System Improvements Implemented
- **95%** Multidisciplinary Participation

MULTIDISCIPLINARY ENGAGEMENT

95% Participation Across Roles

RN | TECH/CNA | Provider | EMS | CRNA | Leadership | Quality | Safety | Lab

PRACTICE CHANGES RESULTING FROM DEBRIEFS

OB SAFETY
Seizure pads for OB beds

EMERGENCY READINESS
Keeping O_2 supplies stored in an O_2 cupboard in the patient room for immediate needs.

CLINICAL PRACTICE
Post intubated sedation guidelines developed

CROSS-FACILITY COMMUNICATION
Enhanced communication/collaboration when critical/emergent patients are arriving

SIMULATION & EDUCATION
Implementation of Hot Debriefing tool use during mock Code Blue drills to build staff familiarity and comfort with the process.

SUPPORTING OUR CAREGIVERS

CRITICAL INCIDENT STRESS MANAGEMENT (CISM)
Led by mental health professionals trained in critical incident stress management who are available to participate in Hot and Cold Debriefs, providing emotional support and strengthening team resilience following difficult events.

STAFF VOICE

> *"Debriefing has been a way for our team to engage together and help me feel supported as a new nurse. The process feels safe and my ideas have felt valued."*

FUTURE DIRECTIONS

- Continue organization-wide implementation and staff engagement.
- Monitor debrief completion, trends, and improvement opportunities.
- Evaluate long-term impact on caregiver well-being and psychological safety.
- Measure patient safety, process improvements, and organizational learning over time.
- Expand interdisciplinary collaboration and share lessons learned across the organization.

Every Debrief Makes the Next Patient Safer.