The nature and benefits of team-based reflection on a patient death by healthcare professionals: A scoping review

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Anderson, ES, Sanders, J, Kinnair, DJ.

Abstract

This scoping literature review was completed to understand the nature and benefits of team-based reflection on a patient death by healthcare professionals. The review was limited to publications in English between 2006 and 2016 that were identified in the Medline, CINAHL, PsycINFO, EMBASE and Web of Science databases. We identified 1450 articles and 19 studies were relevant for inclusion in this review. The published literature is mainly descriptive with no comparative studies. The process of team-based reflection on a patient death by healthcare professionals, using a variety of techniques, can lead to improved emotional wellbeing and learning for quality improvement. However, there is little evidence for the impact on the care of the family and for future patient care. The need for a structured process for the reflection, with facilitation in a supportive healthcare context, appears to be essential for effective team-based reflection. Further research needs to be performed to ensure that team-based reflection on a patient death by healthcare professionals, meets the needs of practitioners and enhances their emotional wellbeing, supports learning from practice and leads to improved patient outcomes.

Key words: Team-based reflection, scoping review, patient-death, interprofessional-working

Introduction

The death of a patient can have major consequences for the psychological well-being of and future care provided by healthcare professionals involved in the death, especially where the death of the patient is unexpected (Bowers, *et al*., 2006; Hamric & Blackhall, 2007; Harris, 2013; Cartoon & Hupcey 2014). Practitioners working in the area of oncology are most likely to face the emotional challenges of working with patients facing life threatening illnesses (Turner, Kelly & Girgis, 2011). Patient deaths may induce post-traumatic stress symptoms, post-traumatic stress disorder (PTSD), anxiety and depression in healthcare professionals, with the consequence that future care can be impaired through the associated behaviour changes and the increased rates of professionals leaving their jobs (de Boer, et al , 2011). An important consideration for future care is also whether the death was inevitable or as a result of poor quality care, which may continue within the healthcare system (Care Quality Commission, 2016).

Review articles indicate that reflection with colleagues on a patient death may be helpful for improving psychological wellness and staff retention (Hildebrandt, 2012; Medland, Howard-Riben & Whitaker, 2004), although the mechanism of this effect is unclear (Macpherson, 2008). A recent systematic review of bereavement education literature relating to medical and clergy professionals that was commissioned by NHS Education for Scotland in 2014 highlighted the need for further research to understand the process and benefits of reflection on a patient death by healthcare professionals, especially for all of the team that have worked with the patient and family (Hesselgreaves, 2015). The importance of team-based reflection after a patient death to improve quality of care has been increasingly recognised in policy statements (World Health Organization 2004, Berwick, 2013), and this highlights the importance of modern team-based practice in healthcare (Salas, Shuffler,

Thayer, Bedwell & Lazzara, 2015; Anderson, Gray & Kim, 2016). In addition, team-based reflection is an essential component of the work of interprofessional teams (Carkhuff, 1996). A recent policy report in the United Kingdom (UK) has clearly emphasised the importance of interprofessional teamwork and collaboration reflecting on patient deaths and the importance of engaging with the patient voice through bereaved families and carer networks (NHS England, 2017).

We present the findings of a scoping literature review that was commissioned by NHS Education for Scotland that had a focus on understanding the process and benefits of team-based reflection on a patient death by healthcare professionals, with the intention to inform evidence-based recommendations for policy and practice, and to identify priority areas for future research.

Methods

A scoping review methodology was selected since it provides a "map" of the breadth of literature within a particular field to inform policy makers and practitioners of the extent, range and types of research available on a given topic (Arksey & O' Malley, 2005; Levac, Colquhoun, & O' Brien, 2010; Thomas, Lubarsky, Durning & Young, 2017). In contrast to systematic reviews, scoping reviews utilize a flexible and integrative approach to the synthesis of different types of studies (descriptive and experimental) with a focus on summarising the key findings from research and to identify important gaps in the current literature (Thomas et al, 2017). Scoping reviews have become increasingly employed by healthcare policy makers to guide pragmatic decision-making about a topic in which there have been no rigorous intervention studies (Bell, 2010).

Our review followed the five stage process outlined in the Arksey and O'Malley's (2005) scoping review framework: identifying, i) the research question, ii) identifying relevant research, iii) selecting the studies to be included in the review; iv) clarifying the data and, v) collating and summarizing reporting the results. The review adhered also to Levac and colleagues (2010) recommendations for ensuring the quality of scoping reviews, with a team of researchers, a transparent and replicable process with regular team meetings, review of full articles for inclusion, and a descriptive summary of the evidence. The use of detailed protocols to guide a scoping review is contested and a pragmatic, but clearly described approach is appropriate (Thomas et al, 2017). The team of researchers for this scoping review had expertise in interprofessional education (LA); medical education, palliative medicine and counseling (JS); psychological wellbeing (DK); health services research (RH); and performing literature reviews in healthcare (KN).

Stage 1: Identifying the research question

The scoping review was guided by the following research question: "What is the process and benefits of team-based reflection on a patient-death by healthcare professionals"? Our sub-questions sought to identify:

- Who are the professionals involved in the team-based reflection and do they include family?
- When and where do practitioners come together for the team-based reflection?
- What is the context and process of the team-based reflection?
- How is team-based reflection structured and organized, including the use of a

facilitator?

- Does team-based reflection benefit participants concerning emotional and personal well-being?
- Does team-based reflection benefit practitioner knowledge and feedback to improve practice?
- Are there any cost-benefit analyses of team-based reflection?

A variety of terms have been used to describe this process of reflection, including debriefing and reflective practice, but there appears to be significant overlap in the use of these terms (Silberman, 2007). In this review we considered that reflection was a process of "greater understanding of both the self and the situation so that future actions can be informed by this understanding" (Sandars, 2009) and this broad definition encapsulates the variety of terms that have been used to describe a similar process (Atkins & Murphy, 1993).

Stage 2: Identifying relevant research

In adopting a comprehensive approach to our search we were constrained by time factors. We therefore limited our search to English language, peer reviewed published work between 2006 and 2016 - to exclude opinion papers.

To create the search criteria the research team debated and created a variety of scenarios in which "team-based reflection on a patient-death by health professionals" would be expected. This approach helped to identify the wide range of search terms related to each of the four key concepts in the research questions and sub-questions namely; patient death; team members; team meetings; reflection (Table 1). Of particular concern was the use of

the term reflection, because of the lack of conceptual clarity which leads to significant overlap in the use of these terms (Atkins & Murphy, 1993; Silberman, 2007). Health and social care practitioners are trained to use reflection as a learning process for the maintenance of competence (Schön, 1984). Reflection is both an individual activity and a team activity with team reflexivity, emerging as essential for interprofessional working (Schmutz, Walter & Eppich, 2017). An interprofessional practitioner is expected to reflect from their own professional stance and that of other professions; this process is referred to as second order reflection (Wackerhausen, 2009). The concept of debriefing has been widely applied to a variety of different situations, including post-event discussions in which performance is compared with a standard (Tannernbaum & Cerasoli, 2013) and psychological debriefing after a traumatic event with the intention of maintaining mental well-being (Devilly, Gist & Cotton, 2006). Similarly, the concept of reflection has been widely applied to include reflective practice with the intention of improving healthcare professional practice (Tashiro, Shimpuku, Naruse, Matsutani & Matsutani, 2013).

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The search strategy was agreed with a senior librarian experienced in reviews of healthcare interventions. We searched the electronic databases Medline, EMBASE, PsycINFO, CINAHL and Web of Science (including Science Citation Index and Social Science Citation Index) in March 2016. Searchers, were performed in each database using a combination of all the search terms related to each of the key concepts, Table 1.

Stage 3: Selecting the studies to be included in the review

Screening and initial data extraction was completed using a shared online management tool, (RefsWorks) for electronic sorting of studies. The initial screening of titles and abstracts was completed in pairs and several studies with only titles had to be requested in full. All titles and abstracts of the retrieved studies were read and judged against our broad inclusion/exclusion criteria to sort into include, exclude or uncertain. Final clarification for IN studies was agreed following independent reading by pairs of reviewers. We identified 1450 articles and 25 potentially relevant studies were analysed. Six papers were later rejected and are shared in the discussion, leaving 19 IN papers (Figure 1). Our synthesis of these 19 IN papers included the collection of data on i) how is the team-based reflection described, ii) the team participants iii) the setting for the reflection, iv) the duration of the reflection session, v) who is the leader of the session, vi) the structure for the meeting, vii) the use of a theoretical framework for the reflection, viii) the purpose for the reflection, and finally ix) outcome measures.

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Stage 4: Charting the data

The selected studies were organized into a chart. Through consensus discussion by the research team, we agreed to also consider three other studies which the search had identified but did not *directly* relate to healthcare teams. Of these one related to the armed forces, one to fire-crews and another to police officers and contained detailed analysis of reflections held with teams on deaths with useful teaching tools. In addition, two studies involved pre-registration professional students taking part in team-based reflection for

learning where it was unclear if they were interprofessional. Also we identified one commentary which explored the process of debriefing drawing upon the authors' previous research (Huggard, 2013). We considered that these studies could be useful to inform the aim of our review and are referred to in the discussion. This flexible and iterative approach is typical of scoping reviews and is recommended to allow the reviewers to obtain a wider picture to inform the review (Thomas et al., 2017).

Stage 5: Summarising the findings

Themes relating to each of the research sub-questions were identified using thematic analysis (Joffe & Yardley, 2004). This was performed by the clinical reviewers working in pairs and then subsequently through discussion to achieve consensus. Typically, evaluation of the quality of each study is not performed in a scoping review (Arksey & O'Mally, 2005; Thomas et al., 2017).

Results

Overview of included studies

Most studies were from the United States (n=9), with several from the UK (n=5), Europe (n=2), Australasia (n=2), and Israel (n=1). All the studies were descriptive, with identification of the views of participants using surveys, analysis of case reviews or interviews with participating members in reflection sessions. One study used action research to explore and evaluate the development of a reflective tool for use by teams working in older persons care homes (Hockley, 2014). The teams of healthcare professionals included those from a range of settings, from acute health care, such as paediatric emergency units, to community care

settings, such as primary care and care homes, with wider team members such as clergy, managers and administrators (Table 2).

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Key review themes

We present the identified themes in response to the scoping review sub-research questions. A complete set of references for all included studies is presented in Appendix 1 (online supplementary file).

Who are the professionals involved in team based reflection and do they include family? In most studies, all relevant team members for the area of practice, including health, social care and clergy, were involved in the team-based reflection. In some hospital settings, clinical meetings were dominated by medical professionals, whereas in community care homes, team reflections were mainly by nurses. We did not identify any studies where the family were involved, although in one paper family were consulted prior to the team meeting (King et al., 2005).

When and where do practitioners come together for team-based reflection? The timings of the team meetings were often missing from the studies, as were the details of where exactly they met and the environment for the meeting. Meetings for team based reflections, when stated, varied from almost immediately (Healy & Tyrell, 2013) within days, (Bateman, Dixon, Trozzi, 2012) to one week following a patient's death (Ireland, Gilchrist &

Maconochie, 2008) or several months (Rosenberg, Vinker, Yaphe & Nakar, 2006). One group met within minutes of a critical incident by forming a huddle in a corridor (Mullan, Wustner, Kerr, Chrispopher & Patel, 2013), but the majority were stated to be held in a "clinical context", implying possible use of a nearby staff room. Morbidity and Mortality (M&M) meetings, significant event analysis (SEA) meetings (McKay, Bradley, Lough & Bowie, 2009) and sudden unexplained infant deaths (SUID) inquiries were invariably held sometime after the event, often months later (Rankin, Bush, Bell, Creswell & Renwick, 2006).

What is the context and process of team based reflection? Two main themes were identified from the synthesis of the studies, with team based reflections during the meetings having a distinct focus and associated process. First, the majority of team meetings had a specific focus to provide 'emotional support' of individuals and the team, with this type of meeting mainly for health and social care staff working in challenging areas such as oncology, especially paediatric oncology, psychiatry or end of life care involving nursing and social practitioners particularly in older peoples care homes (Keene, Hutton, Hall & Rushton, 2010; Hockley, 2014). Many of these meetings used tools which draw upon theoretical understandings from Critical Incident Stress Debriefing (CISD), which was developed primarily for those working in areas of extreme trauma (Mitchell, 1983; Everly & Mitchell, 2000). Examples of papers which described the tools are in Table 3. These meetings provided an opportunity to reflect on 'emotional' reactions to death, allowing emotional catharsis within a supportive environment.

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Second, there were team meetings that had a focus on 'quality improvement', such as M&M meetings, SEA meetings and SUID inquiries. Examples of some of these papers which articulate how they structure their meetings can be found in Table 4. Most had a specific focus on the death of a patient, but SEA included other events. All of these meetings involved a highly structured approach for quality improvement and in two cases the meeting used a root cause analysis tool (Schwarz *et al*., 2011; Baker, Darin & Lateef, 2010). One study used the TEAMSTEPPS tool, as a structured reflection tool, to focus on communication quality improvement after resuscitation (Berg *et al*., 2014) and another described a tool to help reflection on the effectiveness of teamwork in paediatric resuscitation (Debriefing in Situ Conversation after Emergency Resuscitation - DISCERN) (Mullan *et al*., 2013).

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How is team based reflection structured and organised (including use of facilitator)? The majority of meetings were led by a designated leader. In meetings where the focus was on quality improvement, the lead was always a clinician, possibly in a lead management role. In team reflection meetings held for emotional support, the leader varied but was often described as a trained facilitator. In meetings using CISD these leads were often psychologists or psychiatrists. However, there was one exception that involved a trained nurse whose work focused on bereavement.

Is team based reflection benefitting participants concerning emotional and personal well-being? In meetings with a focus on "emotional support", participants self-reported high satisfaction and help from the meetings and that in some situations team spirit could be developed (Healy & Tyrell, 2013), leading to time away from the clinical environment, to identify fresh insights to inform practice and to explore beliefs and feeling about death (Cleries, Majo, Nunez, Segarra & Inzitari, 2014).

Is team-based reflection benefitting practitioner knowledge and feedback to improve practice? In meetings with a focus on 'quality improvement', a highly structured approach for quality improvement was used and in two cases the meeting used a root cause analysis tool (Schwarz *et al*., 2011; Baker *et al*., 2010). The meetings were considered as a means to help individual practitioners to reflect on their practice and keep up to date with clinical knowledge; however, outcome measures were self-reported with no specific evidence of advances in practice. It was unclear how the M&M meetings impacted on changes within systems, although there were aspirations for change. Many studies claimed the importance of being interprofessional for advancing clinical thinking through reflection and one study highlighted reflection as a powerful tool for improving practitioner knowledge and for driving change (Rankin et al., 2006). Despite claims of poor team working, the issues raised were mainly related to poor communication, and these meetings did not consider emotional aspects of care or team processes and none of the studies considered the different value-bases of the professions (King, Shaw, Orchard & Miller, 2010). A common concern in these meetings was working to avoid public culpability of staff since practitioners discussed

personal failings in outlining their diagnostic rationales and treatment plans (Goldman, Demasa & Kemler, 2009).

Are there any cost benefit analysis of team based reflection? We identified no studies with a cost benefit analysis. However, one study involving members of Primary Healthcare Teams who met to review deaths from suicide, estimated the cost of primary care staff time and facilitator set up (King et al., 2005).

Discussion

Our scoping review on the process and benefits of team-based reflection on patient deaths by healthcare professionals noted that all of the studies were only in an early descriptive phase, and this is similar for previous studies on individual reflection in health professions education (Mann et al., 2009). This review also highlights the complexity of the nature, including the purpose and processes and the benefits of team based reflection on patient deaths by healthcare professionals. Our findings resonate with similar systematic reviews on both reflection (Mann, Gordon, MacLeod, 2009) and psychological debriefing (Devilly et al., 2006) in the work place and after disasters. In particular the wide range of approaches and outcome measures, especially the reliance on self-reporting satisfaction and perceived helpfulness that complicated any understanding of the nature and benefits of the process (Devilly et al., 2006).

CISD in particular has been subject to considerable controversy over the last decade, with studies indicating that psychological debriefing was ineffective and had the potential to do

harm (Regel, 2007). However, Regel (2007) noted that there were "considerable methodological shortcomings" (pg 415), especially the lack of appropriate training for those facilitating the debriefing process. There are also suggestions that CISD should be offered as part of a comprehensive programme of critical incident stress management that is integrated and sensitive to the individual responses to the event and the organisational context, especially the extent of supportive team members (Pack, 2013). The measurement of outcomes of reflection and debriefing for subsequent care of the family and future patient care, as well as the wellbeing of the practitioner, is difficult to measure. It has been suggested that that future trials of debriefing should employ a wider range of outcome measures that assess social and occupational function and substance misuse, as well as psychological distress (Deahl, Srinivasan, Jones, Neblett, & Jolly, 2001). However, some insights can be obtained from the literature on "therapeutic nursing", in which the nurse-patient relationship is considered to be an important outcome measure, with the nurturing of hope and the support of the patient's physical, emotional, and spiritual needs, as well as improved wellbeing of the practitioner (Freshwater, 2002).

Several studies described teams with members who had worked together for a considerable time and could be described as being part of stable teams (McKay et al., 2009), such as those working together in care homes or those working in primary care (Hockley, 2014). Others, especially those in acute hospitals, were from transient teams who could have worked together for some time, such as ward-based teams, but were more likely to work together for a limited time (Mullan et al., 2013). This especially applied to teams who worked around resuscitation events (Ireland et al., 2008). The importance of transient teams in healthcare has become increasingly recognised (Bleakley, 2013) and has

implications for taking time out from clinical care for reflection. Only one study thought about feasibility and adopted a quick huddle debrief approach taking a matter of minutes. Many studies did not consider time although those focusing on emotional support stated that the sessions were approximately one hour.

There were no studies that considered the involvement of family members in the reflection, although many consider that the perspective of the family is essential for improving care (e.g. Moons & Norekvål, 2008). Recent UK policy states that bereaved family should have the "opportunity to raise questions or share concerns in relation to the quality of care received by their loved one" (NHS England 2017, p5).

The management of the interprofessional nature of the reflection on participants was rarely considered. There was no study that considered a set of ground rules to acknowledge concerns of hierarchy, status, identity and language (Pietroni, 1992; Smith et al., 2015).

The importance of a trained facilitator was noted in most studies and resonates with previous research that suggests team-led facilitated debrief intervention results in superior team processes (Eddy, Tannenbaum & Mathieu, 2013) and is an important component for effective reflection (Sandars 2009). However, little is known about what it means to help another professional reflect from a different professional stance and engage in secondary reflection (Wackerhausen, 2009). Often doctors were missing in the teams where emotional issues were discussed and several studies discussed the impact on how individuals were viewed by colleagues. Where staff came together to share feelings and

emotions concerning death then little thought was apparently given to the range of beliefs, values and attitudes of different team members concerning death, although, there is increasing recognition of the importance of diversity across individuals for effective team working (Mitchell, Parker, Giles, 2012).

The legal and ethical ramifications relating to responsibility for safe patient care and for management of these sessions was rarely considered and remains a challenging interprofessional issue where errors relate to team-based care (Ries, 2017).

We debated several papers which fell outside of the remit of this scoping review but offer a steer on the way forward. A paper by Huggard (2013) offers a debriefing model designed by nurses in New Zealand. The model includes: How to create a safe environment; process issues such as setting time frames, confidentiality, turn taking for speaking up and; a structure starting with facts and moving onto thoughts and feelings before identifying coping strategies. The model also outlines on-going support using local structures. Of the papers linked to armed services and other public agencies dealing with extreme traumatic events three papers offered a clear outline of how to use critical event debriefing both for learning and emotional support (Sattler, Boyd & Kirsch 2014; Smith, & Brady, 2006; Miller, 2006). In addition, we identified two studies related to reflections with an education focus involving students participating in 'death rounds' with helpful structures and clear benefits, where the interprofessional is implied but not stated (Hough, Hudson, Salud, Lahey & Curtis, 2005; Kitzes, Kalishman, Kingsley, Mines & Lawrence 2009).

Our review confirms that team based reflection following a patient death remains aspirational and complex. The complexity arises in several ways:

- *Agreeing the purpose*. For example, is the purpose for team bonding and cultural change, for learning and quality improvement, for staff well-being and emotional support or for working with families to improve the patient experience and family support?
- *Variability of teams in health and social care*. In some clinical areas teams are long-standing and established teams whereas in some acute clinical areas pseudo - teams come together for brief moments?
- *Understanding more about family engagement*. At a time when patients are seen as partners in care delivery alignment with professionals whose distress pales into insignificance when compared to a families loss raises ethical issues about involvement
- *An agreed process*. These meetings require a competent facilitator using an agreed structure and reporting mechanism which is valued by attendees
- *Time pressures*. Clinically stretched areas may struggle to release staff for long periods and struggle to get the right people together at the same time.
- *The lack of any cost benefit analysis*. The evidence base is lacking concerning outcomes for individuals, teams and for patient care?

There are many unanswered questions with implications for future practice, policy and research.

Whilst we have conducted this review thoroughly this work has several limitations. We constrained our searches to recent literature within a ten year window from the main web-

based databases. Because of time limits we were unable to hand search and look wider into the grey literature. In setting a narrow criteria for health and social care teams we may have missed peripheral members such as spiritual leaders. Reflection as a term is complex and we may have missed new words where reflection is implied such as the recent growth in Schwartz rounds (Reed, Cullen, Gannon, Knight, Todd, 2015). Similarly in looking only at interprofessional groups we ignored a vast literature on predominately medically led teams, often from different branches of medicine, focussing on clinical outcomes for patient safety (Higginson, Walter & Fulop, 2012). We were unable to evaluate the identified studies using established quality criteria because of their descriptive nature. Our thematic outcomes are subjective but arose from discussions between all of the members of the review team.

Concluding comments

In this scoping review, which to our best knowledge is the first, we have highlighted the complex processes and benefits of team-based reflection on a patient death by interprofessional teams of healthcare professionals. From our findings, we recommend that a priority for practice is to use a structured process for team-based reflection on a patient death by healthcare professionals, and that this process should be facilitated within a supportive healthcare context. This has implications for training and the provision of dedicated time. Further research needs to be performed to ensure that team-based reflection on a patient death by healthcare professionals meets the needs of practitioners and leads to the intended potential joint outcomes of emotional wellbeing for staff and improved practice and care. In particular, from our review, we recommend that as a priority for future research the involvement of the bereaved family and carers to obtain a wider perspective of the issues surrounding the death of the patient. It is essential to develop

measures of appropriate outcomes of team-based reflection on patient death, both for the impact on emotional wellbeing and quality improvement. At the same time, it is also important to understand the contribution of facilitation and organisational constraints on the effectiveness of team based reflection, with deeper awareness of the values-based differences within interprofessional team members.

Declaration of Interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

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Figure 1: Flow Chart to show the Literature search results

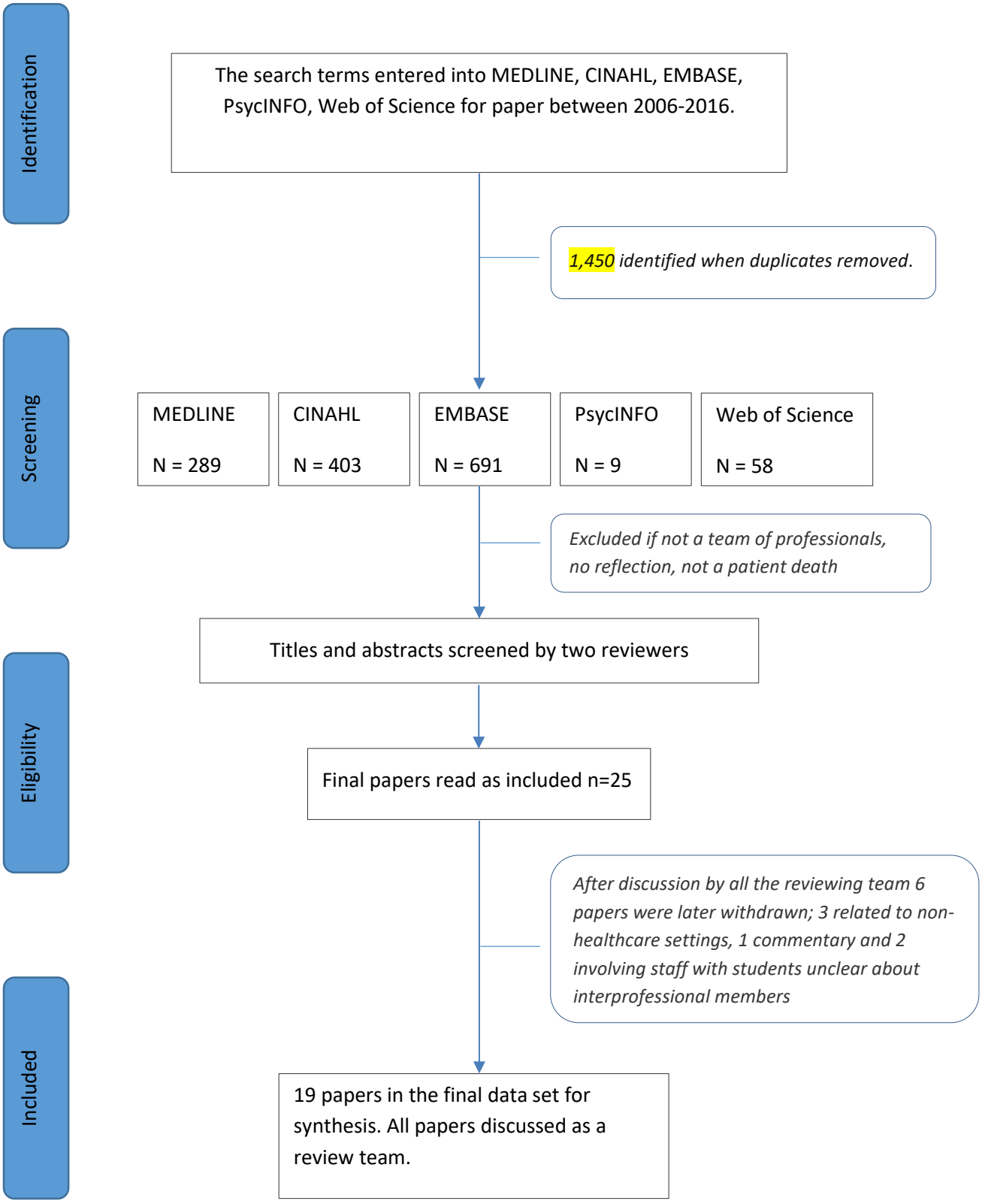

Table 1: Search terms

Terms related to patient death	Terms related to team members	Terms related to group meetings	Terms related to reflection
bereavement morbidity/mortality, death, loss, sudden infant death (SID's), stillbirth, neonatal death, peri-natal death, accident, sudden and unexpected death (SUD's), post-resuscitation.	**Doctors**, General Practitioner, family doctors, obstetricians, paediatricians, palliative care, cancer care, surgeons, physicians, physicians assistants, acute care physicians, emergency doctors **Nurses**, midwives, health-visitors, ward sisters, staff-nurses, consultant nurses, school nurses **Therapists**, occupational therapist, physiotherapist, dieticians, **Pharmacy** **Police** **Clergy/religious leaders/hospice chaplains etc** **Family/carer** **Clinical psychologists** **Counsellors, bereavement counsellors** **Students, trainers, learners**	**Teams**, multi-disciplinary team, interprofessional team, team-meeting, group meeting, Balint group, after death analysis groups, significant event audit/analysis, critical incident, mortality meeting, perinatal mortality meetings, neo-natal mortality meetings, death rounds, glossography, quality circles, audit reviews, reviews	reflection, reflective practice, post-brief, de-briefing, case-based discussion, case-review, case analysis, post-event meetings, root cause analysis, serious incident, serious untoward incidents (SUI) meetings, significant event analysis, values, individual reflection

Example: Web of Science Search Terms

TS=(accident* OR bereav* OR death OR grief OR grieve* OR grieving OR loss OR mortality OR postdeath OR "post resuscitation" OR postresuscitation OR stillbirth* OR "still birth*" OR SUDS OR SIDS OR Perinatal)
AND
TS=(doctor* OR "general practitioner*" OR gp OR gps OR obstetrician* OR paediatrician* OR pediatrician* OR "palliative care" OR "cancer care" OR surgeon* OR physician* OR nurse OR nurses OR midwife OR midwives OR "health visitor*" OR healthvisitor* OR "ward sister*" OR therapist* OR OT OR OTS OR physiotherapist* OR dietician* OR pharmacist* OR police* OR clergy OR "religious leader*" OR rabbi OR rabbis OR imam OR imams OR priest* OR pastor OR pastors OR minister OR ministers OR "faith leader*" OR chaplain* OR family* OR carer* OR "clinical psychologist*" OR counsellor* OR counselor* OR vicar* OR monk OR monks OR nun OR nuns OR police* OR paramedic* OR ambulance*)
AND
TS=("multidisciplinary team*" OR "multi disciplinary team*" or MDT* OR "patient care team*" OR "interprofessional team*" OR "inter professional team*" OR ((team or group or mortality) NEAR/1 meeting*) OR teammeeting* OR "balint group*" OR "after death analysis group*" OR ("significant event" NEAR/1 (audit* or analys*)) OR "critical incident*" OR "death round*" OR loss*OR "quality circle*" OR (meeting* NEAR/2 review*))
AND
TS=(reflection* OR "reflective practice" OR "post brief" OR postbrief OR debrief* OR "de brief*" OR "case based discussion*" OR "case review*" OR "case analysis*" OR (("post event" or postevent) NEAR/1 meeting*) OR "root cause analysis*" OR "serious incident*" OR sui OR "serious untoward incident*" OR "significant event analysis*"OR values)

Table 2 Overview of the accepted papers

Study Settings	Study Aims	Participants	Methods	Samples	Study Outcomes
• Paediatric Emergency Centre x2 • Primary Health Care Teams x3 • Paediatric Confidential Enquiry • Paediatric Intensive Care x2 • Palliative Care Hospital - Children • Rural Hospitals • Emergency Trauma Departments x3 • Palliative Care Hospital • Children's Hospital • Care Homes - frail older people • Hospital cancer care • Hospital setting x2	• To examine perceived need for an intervention on team-based reflection on practice outcomes • To examine perceived need for an intervention on team-based reflection on staff wellbeing (emotions) • To examine an intervention on team-based reflection on staff • To examine an intervention on team-based reflection on improving practice • To assess a tool for team-based reflection • To assess the benefits on a range of stakeholders of a particular method of team-based reflection • To consider recommendations for use of these team-based interventions and or best practice guidelines • To better describe a tool for team-based reflection	• Qualified professionals all papers • Mainly doctors, nurses n all papers • Social workers x1 • Stated frequently all members of particular teams e.g. paediatric, care home staff • Midwives and obstetricians x1 • Chaplains x1 • Nutrition and dieticians • Specialist e.g. language • Non-technical x1 • Accountants managers x2 • Administrativex2 • Paediatricians • Pharmacists • Psychologists • Physical therapist • Technicians • Librarian • Language interpreters	• Mixed method- surveys scored and open questions, pre and post studies • Qualitative methods - surveys of staff - interviews - focus groups - review of cases • Content analysis of reports • Action Research • Case studies	• Hospital departments- single and multiple • Individual team members • Several teams • Large numbers of reports • Time frames from one session to a year • Response rates from 58%-75% • Cyclical data or the development of tools	• Confirmation of need • Benefits for staff, emotional wellbeing • Benefits for staff learning needs • Benefits for team processes • Benefits for understandings systems • Recommendations for how to structure sessions • Findings on the next steps for practice and so what • Illuminating the need for further research • Timeliness for when to offer sessions • Research required on structure and processes how to do reflective sessions well •

Table 3: Paper Examples: Debriefing tools for emotional support

Paper	Structure of reflective discussions What and Where	Reflection outcomes
From: USA **Keene *et al*., 2010**	**Critical Incident Stress Debriefing (CISD)** • Welcome and introductions *Purpose of the meeting outlined* • Factual information *Share how you were involved* • Case review *What was it like taking care of this patient? …etc* • Grief responses *What have you experienced since the death?* • Emotional *What will you remember?...etc* • Strategies for coping with grief *How are you taking care of yourself…?* • Lessons learned *What lessons did we learn for caring for this patient/family* • Conclusion *Acknowledge care provided.*	**Evaluation Study: Pre and post staff survey** Debriefing sessions were requested for professional distress and the most distressing aspects related to how long the professionals had developed relationships with the patient and family. • 98.4% found the sessions helpful • 97.8% Informative • 97.8% Meaningful "Many evaluations stated it as helpful to hear how other disciplines viewed what happened from their perspective" p187 Staff who attended scored higher on their ability to manage stress.
From: UK (Scotland) **Hockley, 2013**	**Reflective Debriefing Groups (RdBGs) TOOL designed** **Nursing home led by experienced nurse specialist** • Resume of the case • What happened? • Description of action • Different times, shift experiences • How did the participants feel? • Exploration of personal and interpersonal feelings • Anticipation of unexpected expressions • What was good?… what was bad? • What does it mean? • What can we learn… how does practice need changing?	**Questionnaire survey** • Opportunistic learning • Staff could leave distressing incidents in the group discussions • Clarify personal and cultural beliefs • Learning about handovers • Using reflection to increase knowledge

Table 4: Examples: Structure of clinical meetings to reflect on improving care

Paper	Structure of reflective discussions	What and Where	Reflection outcomes
From UK (Scotland) **McKay et al., 2009**	**Framework using case reports** • What Happened? • Why did it happen? • What has been learned? • What has been changed?	**Significant Events Analysis** In Primary Care	Goal: "a team-based approach to enhancing patient safety through reflective learning".
From: UK (England) **Rankin et al., 2006**	**Case detailed examination** (details not available)	**Confidential Enquiry Panels** Community setting	Goal: To make recommendations based on enquiry findings.
From USA **Mullan et al., 2013**	**Debriefing Tool** • Patient details • Debriefing data • What went well…? • What could have gone better…? • Was the physician the team leader? • Was anyone confused? • Timings • State if anyone needed counselling	**In situ post-Resuscitation** Acute paediatric Emergency	Goal: To improve clinical performance.
From Nepal **Schwarz, *et al*., 2011**	**Case selection** • Clinical operations • Supply chains • Equipment • Personnel • Outreach • Societal • Structural	**Mortality/Morbidity conference with a Quality Improvement focus using Root Cause Analysis** Remote District General Hospital	Goal: Address systems orientated issues for Quality Improvement.
From UK **King *et al.,* 2005**	**Critical Incident review Questionnaire** Completed prior to the meeting consists of 27 questions - material sought prior to meeting from next of kin.	**Critical Incident reviews** Primary care teams	Goal: To consider feasibility of reviews after patient suicides and if they might change practice.
From USA **Goldman et al., 2009**	**Case selection** • Concise case summary • Focus behind the interventions on actions taken • Questioning - Why? • Underlying reasoning	**Mortality/Morbidity meeting** Child and adolescent Psychiatry	Goal: "To examine practice while looking for opportunities to improve care".
From Israel **Rosenberg *et al*., 2006**	**Clinical Death Register**. • Gender distribution • Age • Cause of death • Place of death • Residence and dependence before death • Involvement of family physician in terminal care	**Mortality Case review** Family Physicians; meetings held twice yearly.	Goal: "…identifying poor-suicidal patients, when to hospitalize the sick elderly, dealing with the anger of bereaved families, and ensuring proper home care for terminal patients".

From USA **Szekendi *et al*., 2010**	**Case selected for the past 2-3 months** • Topic • Questions • Implemented changes	**Mortality/Morbidity meeting** Primary Care teaching clinics	Goal: "To inform frontline providers about adverse events that occur at the hospital and to engage their input in root cause analysis".
From USA **Baker et al, 2010**	**Case discussion using root cause analysis** • Errors and challenging cases	**Morbidity and Mortality conferences** Intensive Care Unit	Goal: "…discuss complications and errors, attempt to modify behaviour and judgment, and aim to prevent repetition of errors".

Appendix: Papers included in the synthesis for the review

Paper ID	Paper Details
1	**Theophilos**, Y., Magyar, J. & Babl, FE. (2009). Debriefing critical incidents in the paediatric emergency department: Current practice and perceived needs in Australia and New Zealand. *Emergency medicine Australasia,* 21 (6), 479-483.
2	**McKay**, J., Bradley, N., Lough, M. & Bowie, P. (2009). A review of significant events analysed in general practice: implications for the quality and safety of patient care. *BMC Family Practice,* 10, 61, 1-11. Doi:10.1186/1471-2296-10-61
3	**Rankin,** J., Bush, J., Bell, R., Cresswell, P. & Renwick, M. (2006). Impacts of participating in confidential enquiry panels: a qualitative study. *British Journal of Obstetrics and Gynaecology.* 113 (4), 387- 392.
4	**Mullan, PC**., Wuestner, E., Kerr, TD., Christopher, DP. & Patel, B. (2013). Implementation of an in situ qualitative debriefing tool for resuscitations. *Resuscitation,* 84 (7), 946-951
5	**Keene, EA**., Hutton, N., Hall, B. & Rushton, C. (2010). Bereavement debriefing sessions: An intervention to support health care professionals in managing their grief after the death of a patient. *Paediatric Nursing,* 36(4), 185-190.
6	**Schwarz, D.,** Schwarz, R., Gauchan, B., Andrews, J., Sharma, R., Karelas, G.et al. (2011). Implementing a systems-oriented morbidity and mortality conference in remote rural Nepal for quality improvement. *BMJ Quality and Safety*, 20 (12), 1082-1088.
7	**King, E**., Kendall, K., Wiles, R., Rosenvinge, H., Gould, C. & Kendrick, A. (2005). General practice critical incident reviews of patient suicides: benefits, barriers, costs, and family participation. *Quality and Safety in Health Care.* 14 (1), 18-25.
8.	**Clevinger, R.** & McDaniel Hohenhaus, S. (2010). When your pediatric patient becomes a crime scene. *Journal of Emergency Nursing*-,36(1), 53-54.
9	**Cleries, X.,** Majo, J., Nunez, M., Segarra T. & Inzitari, M. (2014). Reflection and Learning in a Palliative Care Unit. *Palliative Medicine*. 28(6), 843–844.
10	**Goldman, S.,** Demaso, D.R. & Kemler, B. (2009). Psychiatry morbidity and mortality rounds: Implementation and impact. *Academic Psychiatry,* 33 (5), 383-388.
11	**Hockley, J**. (2014). Learning, support and communication for staff in care homes: outcomes of reflective debriefing groups in two care homes to enhance end-of-life care. *International Journal of Older People Nursing*, 9 (2), 118-130.
12	**Healy, S.** & Tyrell, M. (2013). Importance of debriefing following critical incidents. *Emergency Nurse* 20(10), 32-37.
13	**Ireland, S.** Gilchrist, J. & Maconochie, I. (2008). Debriefing after failed paediatric resuscitation: a survey of current UK practice. *Emergency Medicine Journal,* 25, 328-330.
14.	**Rosenberg, R.,** Vinker, S., Yaphe, J. & Nakar, S. (2006). The role of the periodic Mortality Case Review Sessions in a Primary Care Teaching Clinic. *Israel Medical Association journal,* Vol 8 , 373-377.
15	**Bateman, S.** & Dixon, R., Trozzi, M. (2012). The Wrap-Up: A Unique Forum To Support Pediatric Residents When Faced with the Death of a Child. *Journal of palliative medicine*, 15(12)1329-1334.
16	**Berg,** G., Hervey, A., Basham-Saif, A,. Parsons, D., Acuna, D. & Lippoldt, D. (2014). Acceptability and Implementation of Debriefings After Trauma Resuscitation. *Journal of Trauma Nursing,* 21(5)201-208.
17.	**Seagull, D.** (2015). Supporting optimal cancer patient care with integrated staff care. *Psycho-oncology* 24, 138-139.
18	**Szekendi, MK**., Barnard, C., Creamer, J. & Noskin, G.A. (2010). Using patient safety morbidity and mortality conferences to promote transparency and a culture of safety. *The Joint Commission Journal on Quality and Patient Safety*, 36(1), 3-9.
19	**Baker, S.,** Darin, M., & Lateef, O. (2010). Multidisciplinary morbidity and mortality conferences: improving patient safety by modifying a medical tradition. *Joint Commission Perspectives on Patient Safety, 10*(2), 8-10.