From the Medical School ...

Debriefing following a Caesarean section: an audit to compare current practices with local trust guidelines

Vineela Nallapuneni; Alison Sambrook, MRCOG

Morecambe Bay cannot escape the media spotlight, so we should perhaps ask: 'What can we do to shine within our own right?'

Collecting and utilising information from staff, patients and families should drive forward quality improvement. The audit included in this issue considers our current practice of debriefing post-caesarean section. Whilst it is common for verbal information to be given, finding evidence that this has been performed is challenging, confirming the adage 'If it's not written, it's not done'. An excited, sleep-deprived new mother may not remember information important for her health and future pregnancies.

Good Medical Practice states: 'You must give patients the information they want or need to know in a way they can understand.' Debriefings originated in the military to receive information from a soldier after a mission and enable assessment of the individual to return them to regular duties as soon as possible. Doctors also have a duty to discuss and explain the implications of the care they have provided and help patients return to their normal lives as soon as practicable.

We should not be disappointed by the results of this audit, but see it as an opportunity to take things forward. What is the best way to provide this information? Look out for instalment two surveying both our patients and staff for what and how they would like their information. Will we stay with paper or move into the electronic age?

Alison Sambrook

Vineela is a fifth-year student at Lancaster Medical School.

Aims

According to NICE and University Hospitals of Morecambe Bay Trust (UHMB) guidelines, women who have undergone a Caesarean section ought to be formally debriefed by a surgeon following the operation, using the provided debriefing *pro forma*, to discuss the events that occurred and plans for management of future pregnancies. This aspect of clinical practice has been highlighted by the staff at the Women's and Children's Service department at UMBH as being poorly complied with. Therefore, this audit aims to look at the compliance rate of debriefing following a Caesarean section across two hospitals in UHMB.

INTRODUCTION

Caesarean sections (CSs) and debriefing

In England, 24% of births are delivered by CS annually, and 9.2% of them are known to develop negative outcomes.^(1,2,3) CS, being a surgical procedure, must be effectively communicated about prior to and following its execution, to ensure that the patient is completely aware of the events. Debriefing is one such communication method.

Debriefing provides an opportunity for victims of a traumatic experience to talk through the events and plan for the future with a professional, with the original intention of preventing post-traumatic stress disorder.⁽⁴⁾ In the context of information-giving following a CS, debriefing explains the events surrounding the CS and future implications.⁽⁵⁾ This is noted in the NICE (2011) guidelines, that recommend ensuring both verbal and paper-based information sources are available for the patient post-CS.⁽⁶⁾

Debriefing is an important aspect of delivering thorough, professional care, as it enables patients to have a specifically documented, demarcated contact time with professionals, for explanation and expression of any medical and psychological concerns surrounding the operation, thereby empowering their education and future delivery decisions. Debriefing also lies in accordance with guidelines for professional behaviour as noted by key regulatory bodies.

The World Health Organisation Surgical Safety Checklist notes that, post-operatively, the professionals involved (surgeon, anaesthetist, nurse) review any recovery concerns and patient management; this must be clearly communicated to the patient, as the patient has a right to be aware of the surgery and its consequences.⁽⁷⁾ This is further emphasised through Good Medical Practice and Good Surgical Practice, both noting that patients must be appropriately informed in a comprehensible format, and promoting inter-disciplinary communication with transfers in patients' care.^(8,9)

Debriefing post-CS in the UK: current practices

City University London's 2006 survey noted a range of UK-based service provisions available for women with a difficult birth experience (see table 1).⁽¹⁰⁾ Although a 'difficult birth experience' comprises more than CSs (ie, including instrumental deliveries), this provides an indication of the debriefing culture.

Despite systems for debriefing being available, little research has been conducted into their use and effectiveness. This report aims to assess compliance with one-off debriefing by a surgeon following CSs, as this is what local trust guidelines stipulate and is the basis for the audit.

Percentage of UK hospitals offering formal or informal services for women who have had a difficult birth experience	94% (CI 86% - 98%)
Percentage of postnatal services offering debriefing services	75% (CI 67% - 86%)
Who is providing these services? Midwives, midwife-counsellors, doctors Birth Afterthought programme	65% (CI 53% - 76%) 13%
Involvement of psychotherapists (ie, counsellors or clinical psychologists)	23% (CI 14% - 34%)
Who is funding these services? Midwifery department	87%
Table 1 Postnatal debriefing in the UK (Source: adapted from ⁽¹⁰⁾)	

LITERATURE REVIEW

Little research has been conducted regarding the effectiveness of a one-off debriefing event conducted in hospital immediately following a CS.

A Melbourne-based study in 2000, assessing the impact of midwife-led postnatal debriefing on reducing maternal depression, although showing inconclusive evidence regarding its effectiveness, noted positive feedback from women about debriefing (only 6% rated the debriefing as 'unhelpful', while 43% felt it was 'very helpful' and 51% responded 'helpful').⁽¹¹⁾ However, this study looked at operative childbirth (which also includes forceps and vacuum extraction (VE)), therefore, results are not as applicable for this audit. However, the sample size for CSs in this study was quite high (n=624), therefore, this study shows a good indication. The particular features of Australian healthcare must also be taken into consideration when drawing conclusions.

One study in 2005 (looking at community debriefing by midwives at ten days or ten weeks post-delivery in 319 cases from an English district general hospital) showed how the differences in scores between the debriefing and non-debriefing groups were statistically insignificant (although the debriefing group in general had lower fear of childbirth scores, used to understand whether debriefing was successful).⁽¹²⁾ However, validity to this audit may be difficult as there were two debriefing sessions instead of one, which were conducted by midwives and looked at all operative deliveries (not just CS).

Another randomised trial, in two large hospitals in Perth, also highlighted no positive effects of one-off, standardised debriefing;⁽¹³⁾ however, this difference was not noted to be statistically significant, and this study cannot be extrapolated to understand the effects of debriefing post-CS, as it looks at all deliveries. However, this study also noted that most women found the debriefing helpful.

Similarly, another 2005 study showed that women found debriefing useful, and noted that the intervention group had fewer adverse mental health effects.⁽¹⁴⁾ However, the participants also included women who had forceps, VE and spontaneous deliveries too, and the intervention involved face-to-face counselling followed by a phone call six weeks afterwards, which is slightly different to the debriefing proposed in UHMB's guidelines, therefore it is difficult to extrapolate these results to the current study.

Giving individualised information to women following a CS has been noted to improve likelihood of future vaginal births.⁽¹⁵⁾ This shows the positive impact of engaging with patients, and providing clear explanations, highlighting the significance of debriefing. This is also exemplified by the authors of a 2009 study, who note the importance of providing structured information for women considering delivery options following a previous CS.⁽¹⁶⁾ This shows the importance of using a structured *pro forma* like the trust highlights, and the positive influence clear debriefing can have on patient education and decision-making.

The literature review shows that it is difficult for one debriefing session to affect the mental health of women who have had a CS, particularly as there are predisposing risk factors to take into consideration with regards to their mental health, which may impact their health following delivery. Additionally, the results from previous studies may have been inconclusive because of the quality and content of the debriefing *pro formas*, and do not take into consideration any prior mental health problems, making it difficult to reach conclusions regarding the significance of debriefing.

Therefore, despite lack of positive evidence that debriefing has had an impact on women's health, the fact that the majority of the women found it helpful shows the importance of debriefing for good professional practice and ethical reasons. However, the authors have described no adverse effects following debriefing, which is encouraging in ensuring debriefing continues, as it is also morally important for the woman to know the procedures conducted on her body.

STAGE 1: PREPARATION

We have identified that the process is poorly conducted across UHMB.

This practice is important to audit because written material enables better synthesis of information (particularly as verbal explanations may not be fully understood in the busy surroundings following an operation and childbirth), and gives the women a useful reference point for consideration of delivery methods for future pregnancies.⁽¹⁷⁾ It is also important for clinical communication, because written briefings are useful for communication between obstetricians, general practitioners (GPs) and patients (particularly as the *pro forma* used by

Number	Aim
I	To assess the extent to which the trust guidelines (which are also based on national NICE guidelines) are being complied with
Ia	If compliant – whether the <i>pro forma</i> has been appropriately completed
Ib	Whether a copy has been documented as being sent to the patient and their GP (on top of a copy being noted in the patient's medical records)
2	To assess whether compliance is associated with whether the CS is emergency or elective
3	To assess whether any mention of oral debriefing has been documented in the patient's postnatal notes
4	To suggest (and if possible, implement) ideas for improvement and assess where further research is required to strengthen basis for guidelines and audit
Table 2 Aims of the audit	

UHMB is simple to understand for patients). Having a set document will ensure this briefing is conducted to the same consistent level of detail across the two hospitals and, if the system is set up appropriately, will also ensure the briefing is conducted for all patients.

STAGE 2: CRITERIA SELECTION

The criteria and standards were selected based on the local trust guidelines (UHMB (2013)) for how debriefing ought to be documented (which were adapted from NICE guidelines), as shown below.^(5,6)

UHMB guidelines⁽⁵⁾

Caesarean section guideline 3 ed. (date ratified: 12.10.13)

Guideline section 4.8 Postoperative care – Debrief

Women should be debriefed prior to discharge about the reason for performing a Caesarean Section and any complications. Implications for future pregnancies should be discussed and a pro forma completed to allow a follow-up letter containing these details to be sent out (copy to be sent to the patient, her GP and one to be retained in the hospital notes).

Criteria

All women undergoing CSs should have a debriefing letter (using the *pro forma*) completed, copied and filed for hospital use, GP records and patient records.

Standard

100% compliance

STAGE 3: MEASURING LEVEL OF PERFORMANCE

Methods

Inclusion criteria

Women who have undergone a CS – elective or emergency during (and inclusive of) the dates 31 January to 1 April 2014, at either Royal Lancaster Infirmary (RLI) or Furness General Hospital (FGH).

Data collection

Twenty patients who fit the inclusion criteria were identified and selected for each site. Their files were then read for evidence of having completed the official debriefing letter (using the *pro forma*) for their CS, and data (shown below) was recorded (see Appendix for data collection *pro forma*).

Data collected for audit

- RTX of mother and baby's date of birth
- Site of patient's CS (hospital)
- Whether the surgery was emergency or elective, and grade of surgery
- Whether a debriefing letter is present
- If present, whether the debriefing *pro forma* has been fully completed (ie, with no missing sections)
- If present, whether it has been recorded that, as per the guidelines, a copy of the debriefing letter has been sent to the patient's GP and the patient
- Whether any evidence of oral debriefing (not medical review) was found in the patient's notes

NB This is specifically not to look at regular postoperative medical reviews, but at whether it has been expressly written that the patient has had a debrief.

Data analysis and evaluation

Results

Figures 1 and 2 below show the audit results for RLI and FGH.

Analysis of results

The results show that both sites have poor compliance: RLI has 0% compliance with using the *pro formas*, and FGH has 30%. Only 33% of FGH's cases (with *pro forma* compliance) were filled out completely, the remaining 66%, despite being filled with the patient's sticker, were not completed. Additionally, only one case (per site) had evidence of an oral debriefing.

At RLI, no differences with compliance were seen based on the operation being elective or emergency. At FGH, all the cases with the *pro forma* were elective. This may be because, with

elective surgery, there is greater scope for planning and arranging for debriefing, which may not be logistically feasible in emergency settings where the patient's medical care becomes prioritised. However, having said that, it is difficult to assess this as the positive results for debriefing compliance were too few to differentiate between the two categories of CS.

Similarly, too few *pro formas* were used to understand fully whether there being no evidence of copies being sent to the patient or patient's GP was because of poor medical record keeping (ie, they may have been sent but not noted so), or because they were not sent out.

The poor compliance with the debriefing *pro formas* highlights the importance of staff awareness and providing accessible systems to ensure the *pro formas* are used.

The surgeons may feel they do not have enough time to fill in the *pro forma*, particularly if they are unsure as to whether the *pro forma* is compulsory or not. This is exacerbated by the guidelines not being easily accessible on both sites, and the *pro formas* being on a shelf at the RLI site (and both the doctors

and midwives may not know this), with no reminders about using the *pro formas* found in the labour or maternity wards at RLI. This may mean that the surgeons forget about the *pro forma*.

The current guidelines on CS do not include the *pro forma* in the appendix, which provides further barriers to acknowledging that a *pro forma* is available for use.⁽⁵⁾ Furthermore, the non-permanent (eg, GPST trainees) and locum staff may not be aware of the local trust guidelines, with poor communication pathways regarding this because the staff keeps changing on a semi-regular basis.

STAGE 4: MAKING IMPROVEMENTS

Table 3 shows the key action points for stage 4 of the audit: implementing reminders for the department staff and setting up a page on Lorenzo (the electronic clinical records system) to make the *pro forma* more accessible to improve *pro forma* compliance.

Number	Action plan	How it is expected to improve <i>pro forma</i> compliance	How it will be executed
1	To ensure that all women who undergo a CS have a debriefing letter completed. It would be useful to have the debriefing letter <i>pro forma</i> on Lorenzo.	This will enable all doctors to easily access and type into the <i>pro forma</i> whilst also completing other paperwork necessary for the patient, making it easy for them to remember to complete the <i>pro forma</i> (which they can then print out and take with them to the patient's bedside for a face-to-face debriefing). <ul style="list-style-type: none"> • More difficult to miss as Lorenzo will be used for discharge summaries, therefore there will be a regular reminder with each patient • Having a fixed system in place will mean that all the doctors across the two sites will be reminded about it uniformly, which will hopefully result in changing practice throughout the whole team, rather than just seeing changes in one or two consultants • After initially possibly being reminded by Lorenzo, it can trigger the healthcare team to come up with a system of their own whereby the debriefing is done along with the rest of clinical assessment 	With the assistance of the trust's IT department, a <i>pro forma</i> template will be set up on Lorenzo.
2	Add a reminder note about using the debriefing <i>pro forma</i> to labour ward and maternity ward offices.	Having a reminder notice on the noticeboards may increase likelihood of surgeons ensuring (and midwives reminding) that the <i>pro forma</i> ought to be completed. <ul style="list-style-type: none"> • Will particularly help locum staff • Regular reminders • Other notices on wards also present, therefore possibly a strategy used by the staff which may have been working in the past 	A printed reminder notice to be placed where the important ward notices and messages are, such that everyone will be able to read it.
3	Send a reminder email to the doctors, midwives and nurses in the two departments to ensure the debriefing <i>pro forma</i> is filled out appropriately.	By using an email, it will serve as an access point for the healthcare professionals to re-read it at their convenience to ensure their full understanding of how the <i>pro forma</i> ought to be appropriately completed. <ul style="list-style-type: none"> • Reminder/awareness • Detailed information they can refer back to if needed (and also to look at the guidelines as needed) 	With the help of IT department or the department's secretaries, an email with complete information on the guidelines, when a patient should be debriefed following a CS and by whom, which <i>pro forma</i> ought to be used and to whom the copies ought to be sent will be noted.

Table 3 Action plan

STAGE 5: MAINTAINING IMPROVEMENTS

A re-audit is recommended to be conducted a further month following implementation of the suggestion for improvement.

ANALYSIS

This audit has shown important findings: clinical practice towards debriefing has poor compliance, with little variation in results between the two sites highlighting the extent of this across the trust, which therefore has significant scope for improvement which can positively impact patient care.

One strength of this audit is that this is the first time debriefing practices were reviewed within UHMB. The audit was carried out methodically, and auditing both sites ensured that all CSs conducted within the trust were included.

The key limitations to this audit are that the sample size (40) for a time period of two months may be too small, and an inaccurate representation of the practices conducted. However, with 80% of the cases showing no evidence of any debriefing, a larger sample size may not have made a difference to the audit. This is the first half of the audit, and if the actions implemented show an improvement in compliance rates, there may be a stronger indication of reasons behind poor compliance rate.

Future research recommendations include assessing doctors' awareness and attitudes towards the *pro forma*, to understand the poor compliance. Researching patients' views on whether any oral debriefing was conducted, and their assessment of it, would be useful, as well as assessing whether the debriefing *pro forma* was used to go over the CS with them, and whether this was deemed sufficient for their understanding and benefit.

CONCLUSION

The key conclusion from this audit is that debriefing is, generally, very poorly done in the trust, with extremely few events where the debriefing *pro forma* has been used (and only in FGH), and even less evidence of an oral debriefing having been conducted. The key reasons for poor compliance are likely to be due to poor awareness of the availability of a *pro forma* and of the importance of debriefing as noted in the guidelines. To this effect, the implementations suggested before doing a re-audit include making the *pro forma* more accessible by having it on Lorenzo, and sending out email reminders and placing reminders on the wards for it to be completed.

With regards to the oral debriefing, if the postoperative medical review was written to mean that the women had a debriefing, it will change the light of issues to be improved as it will mean that better awareness of appropriate paperwork completion is required, rather than improved awareness of debriefing requirements.

Furthermore, even with the two occasions where evidence of oral debriefing was found, it is difficult to assess whether the debriefing was conducted thoroughly, as no further information was given.

The audit has been executed fairly well, with its key strengths being that it is the first of its kind to be executed in the trust, and its key weakness being that the sample size may be too small.

It remains to be seen whether a re-audit in a month's time will show any impact. However, meanwhile, further research into doctors' and patients' experiences with debriefing is needed to see how best the compliance with debriefing *pro formas* can be used. [See editorial comment.]

REFERENCES

1. NHS Institute for Innovation and Improvement. Focus on: caesarean section. (Accessed 13 April 2014) Available at: http://www.institute.nhs.uk/quality_and_value/high_volume_care/focus_on%3A_caesarean_section.html
2. Bragg F, Cromwell DA, Edozien LC, et al. Variation in rates of caesarean section among English NHS trusts after accounting for maternal and clinical risk: cross sectional study. *Br Med J* 2010;341:c5065
3. American College of Obstetricians and Gynecologists (College); Society for Maternal-Fetal Medicine, Caughey AB, Cahill AG, Guise JM, Rouse DJ. Safe prevention of the primary cesarean delivery. *Am J Obstet Gynecol* 2014;210(3):179-93
4. Mitchell JT. When disaster strikes . . . the critical incident stress debriefing process. *JEMS* 1983;8(1):36-9
5. Kitson S. Caesarean Section. University Hospitals of Morecambe Bay NHS Foundation Trust. Version 3.0, October 2013
6. National Institute for Health and Care Excellence. Caesarean section (2011). (Accessed 13 April 2014) Available at: <http://www.nice.org.uk/nicemedia/live/13620/57162/57162.pdf>
7. World Health Organisation. Surgical Safety Checklist (1st edition). (Accessed 13 April 2014) Available at: http://www.who.int/patientsafety/safesurgery/tools_resources/SSSL_Checklist_finalJun08.pdf?ua=1 (accessed 13 April 2014)
8. General Medical Council. Good Medical Practice: Duties of a doctor. (Accessed 13 April 2014) Available at: http://www.gmc-uk.org/guidance/good_medical_practice/duties_of_a_doctor.asp
9. Royal College of Surgeons. Good Surgical Practice 2014: A Draft for Consultation. (Accessed 13 April 2014) Available at: <http://www.rcseng.ac.uk/surgeons/surgical-standards/docs/good-surgical-practice-2014-draft>
10. Ayers S, Claypool J, Eagle A. What happens after a difficult birth? Postnatal debriefing services. *Br Med J* 2006;14(3):157-61
11. Small R, Lumley J, Donohue L, Potter A, Waldenström U. Randomised controlled trial of midwife led debriefing to reduce maternal depression after operative childbirth. *Br Med J* 2000;321(7268):1043-7
12. Kershaw K, Jolly J, Bhabra K, Ford J. Randomised controlled trial of community debriefing following operative delivery. *BJOG* 2005;112(11):1504-9
13. Priest SR, Henderson J, Evans SF, Hagan R. Stress debriefing after childbirth: a randomised controlled trial. *Med J Aust* 2003;178(11):542-5
14. Gamble J, Creedy D, Moyle W, Webster J, McAllister M, Dickson P. Effectiveness of a counseling intervention after a traumatic childbirth: a randomized controlled trial. *Birth* 2005;32(1):11-9
15. Catling-Paull C, Johnston R, Ryan C, Foureur MJ, Homer CS. Non-clinical interventions that increase the uptake and success of vaginal birth after caesarean section: a systematic review. *J Adv Nurs* 2011;67(8):1662-76
16. Frost J, Shaw A, Montgomery A, Murphy DJ. Women's views on the use of decision aids for decision making about the method of delivery following a previous caesarean section: qualitative interview study. *BJOG* 2009;116(7):896-905
17. Johnson A, Sandford J. Written and verbal information versus verbal information only for patients being discharged from acute hospital settings to home: systematic review. *Health Educ Res* 2005;20(4):423-9

APPENDIX
Debriefing *pro forma* to be used by surgeons

University Hospitals of Morecambe Bay NHS Foundation Trust

APPENDIX 4

**PROFORMA TO BE COMPLETED BY SURGEON
AFTER EVERY CS**

Original to patient
Copy into labour section of main notes
APPENDIX Copy to GP

Date:

Dear

You had a caesarean section on ...

At.....Gestation

The main reason for this was ...

Findings/complications of the operation were....

The incision on your womb was....

My recommendations for future pregnancies and birth are.....

Any other relevant/ongoing problems

If you are planning to have another baby and are suitable for a vaginal birth you may like to consider leaving a gap of 2 years before conceiving again. This will increase your chance of delivering vaginally next time.

Signed