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

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. 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. In the context of information-giving following a CS, debriefing explains the events surrounding the CS and future implications. 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.

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. 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.

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). Although a ‘difficult birth experience’ comprises more than CSs (i.e., 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.
**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’). 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). 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; 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. 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 UI-MB’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. 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. 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 UI-MB.

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. 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

<table>
<thead>
<tr>
<th>Number</th>
<th>Aim</th>
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<tbody>
<tr>
<td>1</td>
<td>To assess the extent to which the trust guidelines (which are also based on national NICE guidelines) are being complied with</td>
</tr>
<tr>
<td>1a</td>
<td>If compliant – whether the pro forma has been appropriately completed</td>
</tr>
<tr>
<td>1b</td>
<td>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)</td>
</tr>
<tr>
<td>2</td>
<td>To assess whether compliance is associated with whether the CS is emergency or elective</td>
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<tr>
<td>3</td>
<td>To assess whether any mention of oral debriefing has been documented in the patient’s postnatal notes</td>
</tr>
<tr>
<td>4</td>
<td>To suggest (and if possible, implement) ideas for improvement and assess where further research is required to strengthen basis for guidelines and audit</td>
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</tbody>
</table>

*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:

**UHMB guidelines**

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 briefing letter is present
- If present, whether the briefing pro forma has been fully completed (i.e., with no missing sections)
- If present, whether it has been recorded that, as per the guidelines, a copy of the briefing 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 had had a debrief.

**Data analysis and evaluation**

**Results**

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

**Figure 1** RLI results

20 patients selected from RLI
Elective Caesarean sections: 7
Emergency Caesarean sections: 13

Evidence of debriefing found: 1
No evidence of debriefing found: 19

Pro forma used and filled out completely: 0
Evidence of oral debriefing found in notes: 1
Evidence of copy being sent to GP: N/A
Evidence of copy being sent to patient: N/A

**Figure 2** FGH results

20 patients selected from FGH
Elective Caesarean sections: 14
Emergency Caesarean sections: 6

Evidence of debriefing found: 7
No evidence of debriefing found: 13

Pro forma used and filled out completely: 6 used, of which 2 filled out completely and 4 not fully filled out
Evidence of oral debriefing found in notes: 1 (did not use pro forma)
Evidence of copy being sent to GP: N/A
Evidence of copy being sent to patient: N/A

**Analysis of results**

The results show that both sites have poor compliance. RLI has 0% compliance with using the pro forms, 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. 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.

<table>
<thead>
<tr>
<th>Number</th>
<th>Action plan</th>
<th>How it is expected to improve pro forma compliance</th>
<th>How it will be executed</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>To ensure that all women who undergo a CS have a debriefing letter completed. It would be useful to have the debriefing letter pro forma on Lorenzo.</td>
<td>This will enable all doctors to easily access and type into the pro forma whilst also completing other paperwork necessary for the patient, making it easy for them to remember to complete the pro forma (which they can then print out and take with them to the patient's bedside for a face-to-face debriefing).</td>
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<td>• More difficult to miss as Lorenzo will be used for discharge summaries; therefore there will be a regular reminder with each patient.</td>
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<td></td>
<td>• 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.</td>
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<td></td>
<td></td>
<td>• 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.</td>
<td>With the assistance of the trust's IT department, a pro forma template will be set up on Lorenzo.</td>
</tr>
<tr>
<td>2</td>
<td>Add a reminder note about using the debriefing pro forma to labour ward and maternity ward offices.</td>
<td>Having a reminder notice on the noticeboards may increase likelihood of surgeons ensuring and midwives reminding that the pro forma ought to be completed.</td>
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<td></td>
<td></td>
<td>• Will particularly help locum staff</td>
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<td>• Regular reminders</td>
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<td>• Other notices on wards also present, therefore possibly a strategy used by the staff which may have been working in the past.</td>
<td>A printed reminder notice to be placed where the important ward notices and messages are, such that everyone will be able to read it.</td>
</tr>
<tr>
<td>3</td>
<td>Send a reminder email to the doctors, midwives and nurses in the two departments to ensure the debriefing pro forma is filled out appropriately.</td>
<td>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 pro forma ought to be appropriately completed.</td>
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<tr>
<td></td>
<td></td>
<td>• Reminder/awareness</td>
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<td>• Detailed information they can refer back to if needed (and also to look at the guidelines as needed)</td>
<td>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 pro forma ought to be used and to whom the copies ought to be sent will be noted.</td>
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</table>

*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 UI IMB. 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 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, 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

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
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