GRASPIT

GLOBAL RECOGNITION & ASSESSMENT OF THE SICK PATIENT & INITIAL TREATMENT

National Resuscitation Council of Kenya

GRASPIT TRAIN THE TRAINERS COURSE MANUAL

GLOBAL
RECOGNITION AND
ASSESSMENT OF THE
SICK
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INITIAL
TREATMENT

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Introduction

In order for the GRASPIT course to be sustainable and widely disseminated it is important that Kenyan medical and nursing staff become confident in taking on the delivery of this teaching. An important outcome of each GRASPIT course is to identify from amongst those attending potential future GRASPIT trainers. They can then be invited to attend a GRASPIT Train the Trainers course and help form a local faculty which can then deliver further courses. Ideally several members of staff from a hospital or clinic would be trained as instructors. Alternatively trainers from a group of hospitals or clinics may decide to form a local network and deliver courses together at a central location or rotate the delivery around the different sites. The local trainers will receive support and guidance from experienced Kenyan trainers and from the GRASPIT coordinator.

Aims of the Train the Trainers Course

The aims of the GRASPIT Train the Trainer course are to:

- reinforce the key principles of the GRASPIT course
- review the course material
- introduce the basic concepts of adult education
- provide practical advice on delivering teaching sessions

The Train the Trainers course is supported by an accompanying slide set and this manual. This material will be of particular value to those who have little or no experience in teaching, but will hopefully useful to experienced teachers as well.

The accompanying GRASPIT Course Organisers Manual provides information on organising a course and provides information on supporting resources and material.

Overview of the GRASPIT Course

The failure to recognise the deteriorating acutely ill patient is well recognised as a significant risk factor for a poor outcome. When reviewing these cases two consistent themes emerge; either the failure to take and record appropriate observations and / or a failure to recognise abnormal vital signs as a trigger for timely action. The interventions required are often relatively simple in nature (basic airway management, oxygen therapy or intravenous fluids coupled with escalation for senior clinical review), but have a profound impact on the patients chances for survival.

In the UK, in order to address the problems identified above, national courses such as ALERT (Acute Life threatening Events Recognition and Treatment) and SOS (Stabilisation of the Sick, Torbay Hospital) have been developed. Experience gained during MEAK orthopaedic missions suggested that very similar challenges regarding the recognition and management of acutely ill patients existed in Kenyan Hospitals. The GRASPIT course (Global Recognition of Acutely Sick Patient and Initial Treatment) was therefore developed through collaboration between UK and Kenyan medical staff.

The key principles promoted by the course are:

- Importance of monitoring vital signs and recognising abnormality
- Use of a systematic (ABCDE) approach to the assessment of the acutely sick patient
- Initiating treatment in order to address identified problems
- Effective communication between health professionals

These principles, which are equally applicable to adults and children, are complemented by material that helps to reinforce prior knowledge and clarify the rationale for treatment. Experience shows that the course works best when delivered to a multidisciplinary audience of medical officers, clinical officers and nurses as this represents the makeup of teams that are managing patients in the clinical environment. It is also help if there is a spectrum of experience from junior members of staff to the more senior as this helps ensure that the key principles are actually transferred from the classroom and adopted in the management of patients.

Although delivered as a course GRASPIT actually represents a systematic approach to patient care. If its principals are to be adopted and consistently applied in Kenyan hospitals then the requirements extend beyond simply providing staff with a one day training course. Other factors that need to be addressed include the availability of simple equipment, improved monitoring and recording of vital signs and effective communication between members of the health care team. Leadership and promotion of the GRASPIT principles by senior members of staff is also crucial.

TRAINING THE GRASPIT TRAINERS

1. Principles of Adult Learning

To be most effective as a teacher it is important to understand the principles of adult learning.

It is useful to start by considering some definitions:

Learning: "is a change in behaviour as the result of experience"

Teaching: "is a planned experience that causes a change in behaviour"

There are different aspects of learning that we maybe endeavouring to change

- **Knowledge** - what is the definition of different types of shock
- **Skills** - how to perform bag mask ventilation
- **Attitudes** – commitment to promoting the GRASPIT principles

Therefore at the outset of planning training or teaching session it is important to have a view of what behaviour it is you wish to encourage in the learners i.e. to use a systematic approach to the assessment of the unwell patient, correct method of sizing and inserting a guedel airway. Through careful planning and using some core principles the likelihood of a teaching experience in bringing about a change of behaviour is increased and this includes recognising that adults learn differently from children and from one another.

Adults are generally in a learning situation because they want to be. Children are in a learning situation because they have to be. This is a good start but it means that if adults do not want to be in the learning situation they will not participate. Learning must be interesting, relevant, applicable, achievable and learners must be able to say they have achieved something. Adults learners must be able to see how what they learn can be applied.

Therefore to make training successful adult learners need to:

1) Enjoy learning - they will not enjoy threats, humiliation and fear

2) Be motivated - this might be from within eg. "I want to be a GRASPIT trainer" or from external influences eg a senior saying "I want you to go on this course"

3) Understand what they are doing and why - the information been taught has to be relevant and meaningful for them (this is often aided by using examples they would experience in real life)

4) Be actively engaged and participating

5) Have defined aims and outcomes

6) Be encouraged to reflect

7) Have a positive experience - identifying that someone has done something well will create a positive experience and encourage learning. Concentrating on the negative is a much less enjoyable way to learn

There are many different ways of learning including: listening, watching, reading, talking, doing and interacting. Each person has a preferences for the way in which they like to learn and therefore teaching that provides a range of learning methods are likely to be more successful.

Barriers to effective learning can come from within the learner and could be related to factors such as having been sent to the session when they don't feel it is relevant to them or concerns around been embarrassed in front of their peers or seniors. External factors such as the teaching environment (too hot, too crowded, too noisy) can also inhibit learning. A good trainer will recognise these issues and address them. This could be through ensuring that all delegates are engaged in the training, understand the purpose behind it and through providing positive feedback.

Structure of a Teaching Session

Every planned teaching episode should incorporate the following 3 components:

1) **Beginning**

   The beginning (also known as the "set") should cover the focus of the session and what the key outcomes are. It is also the time to outline how the session will be organised and the roles of those that are involved. It is also an opportunity to agree any ground rules and prepare the environment.

2) **Middle**

   This is the main component of the teaching or "dialogue". Do not try to cover too much. It is best to limit the points covered to between 3-5 and aim to deliver 10-15 minutes chunks. Add zingers to keep attention levels up.

3) **Closure**

   At the end of the session summarise and review the main points that have been covered. Keep to time and leave time for questions.

This model applies to all teaching methods such as lectures, scenarios, skills, workshops and demonstrations.

Asking Questions

Types of Questions

Closed questions: these generate single word answers and make it difficult to get a discussion going

Open questions: allow ideas to grow and encourages discussion

Levels of Questions

Facts eg state, who, when, what, where, spell, describe

Understanding eg How would you describe? How would you compare?

Application eg Can you apply these to anything else? How would you apply this in your hospital?

These three levels test a deepening understanding of the subject.

Learner's Answers

Encourage people to answer questions and repeat the answer back to ensure that all in the group have heard it. If the answer is wrong this has to be acknowledged, but encourage another attempt.

2. Giving a Lecture

In the GRASPIT course material the lectures are already prepared for you, but to make the Train the Trainers course more useful and applicable to other teaching you may get involved in this section of the manual covers:

1) Different types of presentation and when to use them
2) Preparing a lecture
3) Giving a lecture

Different Types of Presentation

The aim of a presentation is to communicate with the audience and whether you choose to do this by giving a lecture, facilitating a discussion group, teaching a skill station or using a scenario partly depends on:

- What you are planning to teach
- Size of the audience
- Their knowledge level
- Equipment available

The advantage of a lecture is that it is suitable for a large audience and is a good way to convey a large amount of information. It is particularly useful for outlining broad concepts and principles and introducing facts and ideas. As in the GRASPIT course these may well be revisited and covered in more detail, through scenarios or group discussions. The main disadvantage of a lecture is that is difficult to know if all the audience have listened and understood what has been taught.

Preparing a Lecture

Writing the lecture takes much much longer than giving the lecture – so start preparing in plenty of time. A useful framework to use is:

Beginning:

- What is the purpose of the lecture – what do you want to achieve?
- How will you set the scene and outline the objectives?

Middle:

- Plan the dialogue around 3-5 major points - don't try and cover too much
- Add cases and stories to illustrate points, but make sure they are relevant and meaningful to the audience

End:

- Summarise at the end
- Plan in time for questions

When writing a lecture remember the acronym KISS – Keep it Short and Simple

- Short words and sentences
- Beware TLA's – three letter abbreviations
- Put aside at times and return with fresh eyes
- Powerpoint
  - o Use large text
  - o Only 4-7 points per slide
- Overheads
  - o Large clear writing
- Blackboard /whiteboard / flipchart
  - o Write clearly
  - o Allocate a scribe if you do not write well

Mini-summaries during lecture

- Say what you are going to say
- Say it
- Say what you have said

If something is said three times the audience is more likely to remember it

The GRASPIT lectures are already written and prepared, but you will need to practise in order to get familiar and confident with the material. A guide is that the practise time should be ten times the length of the lecture – so a 15 minute lecture needs 21/2 hours to practise! Time your rehearsals so that you do not run over time.

Feel free to adapt the GRASPIT material through adding different pictures or clinical examples. We do not mind if slides are changed, but please ensure you keep a master copy to refer back to and do not lose the key messages for the lecture.

Giving a Lecture

Preparation of Equipment and Environment

Be flexible and adapt to what is available. It is certainly possible to give a great lecture with little or no equipment, but it does make it more challenging.

Choose your equipment – black or whiteboard, overhead projector or laptop and projector. If using a laptop make sure the presentation is loaded up, you know where to find it and get it started. Make sure the projector is connected and working. Check that you know which controls move the slides forward or back and run through the slides if possible to make sure they are looking as you expect when projecting. Have a back up plan for accessing the presentation ie loaded on a spare datastick or CD or e-mail it to yourself (assuming that you are able to access the internet at the venue). Save Powerpoint presentations in older formats in case the computer you are given to use doesn't have the most up to date software. Have printed hard copies of the slides available in case of power failure.

Try and get to the venue early so that you can set up the room. Depending on the size of the audience, choose the layout you want and if necessary move chairs about. A U shape or even circle can encourage more communication with audience.

Ensure that everyone can see the audiovisual aid (white board, screen etc). Check the electricity supply, lighting, air-conditioning and other sources of noise.

It is very helpful to be able to see the time whilst delivering the lecture to avoid over-running. The ideal is a clock at the back of the room which avoids having to look at a watch.

Delivery of a Lecture

In the delivery of a presentation there are three parts, the beginning, middle and end.

Beginning:

Start by greeting the audience and introducing yourself. If you are giving the first or only lecture of the day this is a good time to introduce the "housekeeping" points such as location of toilets and fire exits, request mobile phones are turned off or are on silent and give an overview of the timings for the session.

State the aim and content: The actual lecture should start with the "set" outlining the aims and objectives of the talk. Inform the audience of how you would like to manage questions for example "I'm happy to take questions at any time, but there will also be time at the end of the lecture". Request that the audience tell you if they can't hear you or see the slides.

Middle – teach the material

Delivery:

- Stand to one side of the screen halfway between the screen and audience
- Face forward so that they can see your lips and mouth
- Hold your head up and throw your voice as if talking to the back of the room
- Speak at a slower pace than you would in conversation
- Try and avoid (through practise) "ums" and "ers"
- If teaching in English remember that this may not be their first language for the audience. Avoid slang, colloquial language and jokes. Use simple English.
- Maintain eye contact – essential for getting feedback from the audience and requires practice
- Try and ensure you look at both sides of the room (people naturally tend to look to one side of the audience)
- Avoid bad habits such as pen clicking or shuffling on the spot
- Do not read from the slides. Know them well enough that you can convey the message in a natural way. The slides are there to summarise key points.
- Use notes if they help you feel more confident, but try not to read out as a script (four word lines are easy to recognise and will discourage reading).
- Nerves are to be expected and are best handled by
  - practise and then more practise
  - rehearse the start particularly – once you get going it is likely to be easier
  - visualise success – imagine yourself at the end of a successful lecture

Interaction – keeping the audience engaged (and awake)

- Ask for thoughts on how they would manage a clinical problem then move to relevant slide and compare
- Reward responses with prizes (such as sweets)
- Run mini-competitions between opposite of the room
- At start of lecture (especially after lunch or if having several lectures in a row) ask the audience to stand up and shake their arms and legs
- Try and get all involved rather than allowing one or two delegates to dominate.

Asking questions

- Allows you to assess the level of knowledge
- Encourages two way communication and improves attention which means the audience will remember more of what you say
- Questions can be directed at the entire group or to individuals
- When the answer comes repeat it so that everyone hears it
- If an answer is not forthcoming from an individual get support for them by asking others to suggest relevant ideas or experience

- Be careful not to humiliate participants. Be aware of that some healthcare providers may have many years' experience, but their practise may differ from what you are used to.
- If a delegate gives an incorrect answer this needs to be addressed, but try and avoid being too negative.
- When you take questions make sure everyone has heard and if necessary repeat it
- If a question develops into a discussion avoid over-running by keeping it brief or suggesting that it continues in the break period.

End

Summarise

- You summarise what has been taught
- Alternatively ask the audience to summarise
- Good test of their understanding

Questions

- If not covered in the session

Thank audience for their attention

3. Teaching a Scenario

Using a clinical scenario is a method of teaching which aims to be as near to real life as possible. They provide the opportunity to engage delegates in small group discussions and for them to practice essential skills. These methods of learning are associated with a much higher average retention rate of knowledge and skills when compared to lectures.

Preparation:

Each scenario is supported by an information sheet which outlines the clinical information and learning points the delegates should ideally cover. Although it is important that delegates run through a complete ABCDE assessment each scenario will be focussed on the management of one or perhaps two particular clinical problems, such as management of an obstructed airway or hypotension. The trainer should ideally have had an opportunity to familiarise themselves with this information before running the scenario. Each scenario station is also supplied with a box of equipment that the delegates can utilise.

For the scenario stations the delegates are spilt into small groups. The ideal is to have roughly the same number of delegates in each group as there are stations so that as each group rotates each delegate can have the opportunity to lead. This isn't always feasible, for example there maybe groups of six rotating around four stations. Try and avoid significantly bigger groups than this as it then difficult to keep all involved. A trainer or helper should monitor the time and give each group a warning at an agreed time ie 5-10 minutes from the end so that the trainer can ensure there is time for summing up and for questions from the delegates.

If running a full GRASPIT course the delegates will have seen the faculty demonstrating the GRASPIT principles of ABCDE assessment and initial treatment using a clinical scenario. If a different programme is been run and this hasn't happened then consider starting with such a demonstration by the faculty. See below re options regarding the demonstration of a scenario.

Make the 'set' (beginning) by introducing yourself, saying what this session is about and describing

how it will be run. At the outset of the scenario establish the roles that each delegate will be expected to perform eg patient, doctor or nurse conducting assessment. At some stations the patient maybe a manikin. You may wish to brief the patient separately from the group on the clinical problem they are representing so that they can act accordingly. Ensure that delegates each have an opportunity to perform a patient assessment as they rotate from station to station. Once roles allocated provide the delegate conducing the assessment with the initial information setting the scene, point out the equipment that they may have available and reinforce the use of the ABCDE approach covered in the lectures and faculty demonstrations. Ask them to verbalise their thinking as they proceed.

Stress that, as in real life, they can ask for help from colleagues (although at times you might delay the "arrival" of this help in order to encourage them to continue leading the management of the patient.

As the delegate assesses the patient provide them with the findings at each step eg for an obstructed airway you would report (or imitate) stridor like noise when the delegate asks what they can hear. (Enthusiastic "patients" will engage with acting out their role!). It is important that as clinical problems are identified that the appropriate treatment is commenced before the assessment continues.

If the delegate doesn't do this or is struggling to remember the correct actions you can suggest that they ask their colleagues for suggestions or you can ask the group what they think in order to get them to give prompts. Be careful not humiliate the delegate performing the assessment. Reassure them that the whole point of the scenarios is to practise and learn in a safe environment. Ideally there should be time in the scenario to run through a complete ABCDE assessment and demonstrate the appropriate management of identified problems. Ideally then encourage the delegate to repeat the ABCDE assessment concentrating on the major findings. This is a good opportunity to report improvements in the patient's condition to positively reinforce their actions.

At the end ask the delegate to summarise their findings and actions and get them to outline what the next steps might be in terms of definitive treatment. One option is to do this in the form of a handover to a senior colleague suing the SBAR format.

Close the session with a summary of the main points that have been covered and ask if there are any questions. Thank the delegate who took the lead and encourage the group to do so too – good time for a round of applause.

Demonstrating a Scenario

One instructor will act as the doctor or nurse conducting the assessment and a second instructor acts as the patient. A third instructor acts as an assistant to the doctor or person in charge. A fourth instructor acts as a commentator. He or she will introduce the scenario, indicate the nature of the clinical findings and at times intervene and ask the person conducting the assessment questions. The action can be stopped at any time and a summary made of progress up to that point.

There are two alternative approaches to running this type of scenario.

The first approach is to run the scenario once only. With a commentary and discussion as you go. This is the approach we usually use in the GRASPIT course.

The second approach is to repeat the scenario four times using an instructor and a student.

This approach is favoured by educationists for teaching a skill and could be equally well applied to

teaching a student how to insert a chest drain for example. (See Box 1 page 14).

To work well these demonstration scenarios should be rehearsed in advance, perhaps with the candidate giving a deliberate wrong answer so that the instructor can bring the rest of the audience into the discussion. 'What do you think of that answer?'

It is much better to use one of the other instructors who has been rehearsed as the student. They will know what to do and will give a good demonstration.

If you pick a candidate from the audience and they perform poorly, much of the educational value of the session can be lost. The key to success is good preparation.

4. Teaching a Skill

There are two key points to remember when teaching a skill:

1) Make sure the learners have plenty of time to practise.

2) Teaching is the best way for people to learn.

After a learner has been taught the skill and had an opportunity to practise they should be observed teaching it to a colleague or be asked to talk the instructor through the procedure. This reinforces the learning and provides the opportunity for the trainer to observe and correct the leaners technique if required. It is important to prevent leaners adopting bad habits, as once they are established they are difficult to get rid of.

It can be helpful to divide the skill up into smaller steps or "chunks" and practise these first rather than attempting to teach the entire procedure in one go.

Consider the learners prior skills and experience when teaching a skill. Novice beginners will need clear direction on how to do a task. The next level is to assist or coach someone as they perform it. Those who are more competent and experienced may only require brief supervision before it can be delegated.

Know the expected leaning outcomes and that you know how to do the skill yourself. It will be obvious very quickly if you don't!

Steps in teaching a skill

Preparation

- Check in advance that you have all the required equipment and that it is working
- Clarify the leaning objectives for the session
- Outline the indications for the procedure and how it fits into the wider care of the patient

Structured skills learning

Should follow the four stage approach to teaching a skill (see Box 1 below) and ideally then get the learner to teach another.

Box 1.

Four stage approach to teaching a skill (Mackway-Jones & Walker)

Stage 1 the instructor demonstrates silently at normal speed

Stage 2 the instructor demonstrates more slowly while providing a commentary (opportunity to ask and answer any questions)

Stage 3 the instructor demonstrates while the learner provides a commentary

Stage 4 the student demonstrates and explains to the instructor

(Mackway-Jones K, Walker M, eds. The pocket guide to teaching for medical instructors. London: BMJ Books, 1999)

Where necessary chunk the procedure into manageable parts. Demonstrate each chunk, explaining what to do so learners know what they are expected to achieve by the end of the session. Ensure the learner tells you what they plan to do before they do it, so they have it clear in their mind and you are confident they know what they are doing. Supervise the learner practicing until you are sure you can afford to withdraw.

Keep your eyes on what the learners are doing. Don't leave them unsupervised until you are absolutely sure they know what they are doing.

Help get it right before they leave you if possible. If you don't, the learner will probably not attempt to move on to the next stage of skill development.

Feedback

Provide balanced feedback so learners know how they are doing.

5. Facilitating a Discussion

A discussion group facilitated by an instructor is a useful alternative to giving a lecture. It is particularly useful for small groups and when you want to seek people's opinions and come to an agreed decision eg how to implement GRASPIT training in your hospital. Those involved in developing a plan or solution are much more likely engage with it. In general a discussion is 10X more likely to change practice when compared to a lecture. It is important to be aware that it takes longer to cover a topic using a discussion group compared to a lecture. The advantage is that the course participants will remember more through taking part.

In a successful discussion group communication will occur between members of the group as well as between the leader and group members (referred to as an open discussion). This mixed communication pattern is the principle difference from a lecture where there is one way communication between the teacher and learner. A closed discussion is one where the leader is at the centre of the discussion and comments are all passed though the leader. A closed discussion allows the leader to control the direction and content of the discussion. It is recommended for more junior (or new) learners.

There three stages in a discussion group:

Set

- Clearly set out the aims of the discussion and what you hope to achieve by the end ie a plan for introducing GRASPIT to a hospital
- Link the topic to the rest of the programme
- Create a suitable environment eg chairs in horseshoe or circle, flipchart / white or blackboard to record points with a nominated person as scribe

Dialogue

- Ask open questions and encourage participation from all members
- Try not to spend too much time taking yourself
- Encourage all to participate
- Need to strike a balance between letting the group talk freely and encouraging ideas, but directing them enough to achieve the objective
- Intervene if they stray from the topic
- Avoid lecturing the group at all costs
- Provide opportunities for reflection through silence

Closure

- Allow enough time to summarise properly
- Questions are permitted, but don't allow new issues to be introduced
- Summarise the leaning points that were covered (not what you think should have been covered).

Difficult Situations

Brainstorming

- Very useful if the group is quiet and individuals reluctant to contribute ideas
- Decide a topic
- Ask each member of the group turn to contribute an idea or comment
- Make it clear that they can "pass" / "no comment"
- Record the ideas
- Continue going round group until no further ideas coming forward
- Agree which ideas to discuss further

Person is too dominant

- Take eye contact away and direct towards someone else
- Wait for them to pause for breath and then ask them to wait while you ask someone else to join the discussion

Someone does not talk

- Look towards them when asking question
- Do not force them to answer or cause embarrassment

Someone is negative

- Ask them a question to get them involved

Someone falls asleep

- Move towards them and talk in their direction
- Check that room is not too hot

Room too small

- Is larger room available or can you go outside

Too large a group

- 20 is probably a manageable maximum
- Consider splitting larger groups if you have enough trainers to facilitate

Golden Rules

a. Clarify outcomes at the start.

b. Prepare the environment.

c. No lecturing.

d. Ask good questions.

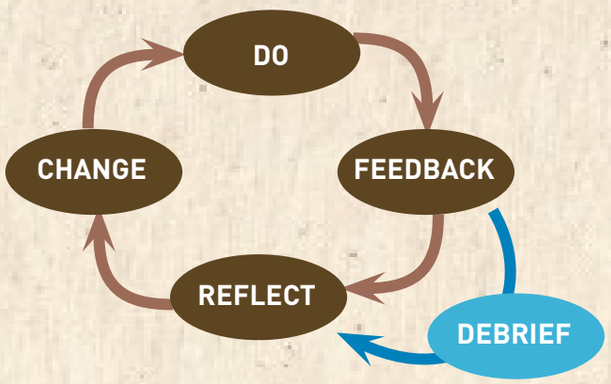
e. Help non native speakers.

f. Be quiet & listen.

g. End with learning points.

6. Proving facilitated debriefing (feedback)

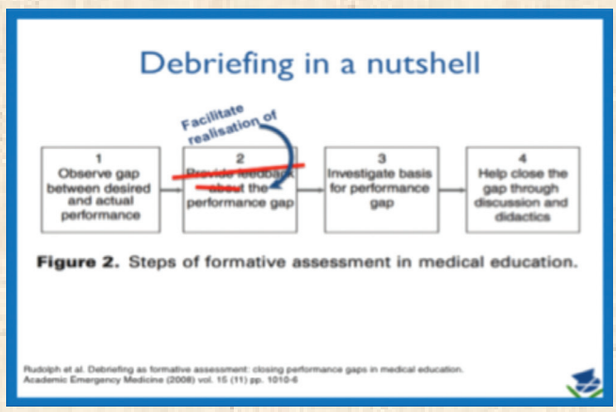
For teaching to be effective and change behaviour, there needs to be a cycle of activity. Individuals may need to go round the cycle several times in order for learning to take place.



Providing feedback is an essential part of the cycle; it draws upon experiences of both trainer and trainee and is a tremendous learning tool because it develops the ability to reflect and to develop internal mechanisms for self-regulation, autonomy and sophisticated decision making. However, it can be more of a teacher-centred activity.

DEBRIEF, is not the same as feedback, but it is a tool that enables feedback and reflection to take place between a number of people or individually, and which provides a structure for review of an event in an emotional, a cognitive and a practical way, thus addressing the psychosocial and practical elements of learning. The aim of structured and supported debriefing is to *"...standardise the instructor/student debriefing interaction to assist learners in thinking about what they did, how they did it, and how they can improve."* Facilitated debriefing is a mixture of reflecting and teaching, and is a learner centred activity. The learner who is new to a task or skill needs supported assistance to be able to process the event, understand the theory, think about how they performed and then how they will adapt or change how they undertake the skill in the future.

Structured elements to debriefing include three specific debriefing phases with related goals, actions, and time estimates. The three phases are **1) the *reactions* phase** – often where the learners can "blow off steam" about what has been most concerning to them; **2) the *analysis* phase** in which the learners, facilitated by the trainer, discuss their performance; **3) the *summary* phase** in which the learners take away lessons learned. All of the phases are as important as each other; however, the analysis phase is where the opportunity arises for the learner to identify their gaps, reflect, and potentially can identify areas in which to change.



There are 4 key phases to the analysis as seen in the diagram. The important aspect to the analysis phase is to guide the learners through their gaps to a point at which learning can take place in a safe and meaningful way.

Debriefing is a skill, therefore, that requires practice and should be done in flexible way, which is sensitive to all the learners, and assist the learners to identify areas for improvement. The learner may well have had previous negative experiences and so are nervous or wary about the interaction. Therefore, using a structure is invaluable.

There are a number of debriefing tools, and it is important to be aware of them, and their pros and cons, in order to use the most appropriate one, or combine one or more approaches within teaching intervention or as part of training trainers to teach.

Some of the commonly used modes and models of debriefing are:

1) **Positive, negative, positive:** An outdated method which is not learner focussed or a robust way to ensure learning occurs.
2) **DELTA** + : The facilitator asks the group, or the individual for "things that went well and things to improve." This method can be helpful if the learning is not able to reflect immediately or has little insight. However, it is teacher-centric and often it is difficult for the learner to know what the teacher is thinking.
3) **SHARP** – **S**et learning objectives, **H**ow did it go, **A**ddress concerns, **R**eview learning points, **P**lan ahead. This model can be good for practical skills training, or training in practise.
4) **OSAD** – **O**bjective **S**tructured **A**ssessment of **D**ebriefing. This model can be complicated initially, but has some good ways to phrase sentences, and pitfalls to avoid. The handbook also includes a section for debriefing the debriefer.
5) **iTRUST** – implementation Transition Reactions Understanding Solutions Take home message The training event and the debriefing are seen as a whole package, and each stage is worked through before progressing to the next.
6) **Debrief Diamond:** Description of the scenario or event Analysis structured around non-technical skills Application of knowledge to their own practice.

Common pitfalls:

There are a number of things to avoid when debriefing. This list is not exhaustive, but can be helpful to aid in practising how to deliver the message that you want for the learner.

Avoid saying *"that was good"* straight after a skill or scenario training – it may be that there were positive aspects, but it can be perceived as carrying out an assessment of the learner.

"How do you feel that went" – this can unsettle the learner because they are often anticipating negative feedback, or they can feel that there was an assessment of their performance.

Asking another learner to critique or provide feedback – whilst this may be meant to be supportive, it can be seen as threatening and judging.

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DEFINITIONS AND EXEMPLAR BEHAVIOURS

CATEGORY	DEFINITION
1. Approach	Manner in which the facilitator conducts the debriefing session, their level of enthusiasm and positivity when appropriate, showing interest in the learners by establishing and maintaining rapport and finishing the session on an upbeat note.
2. Establishes learning environment	Introduction of the simulation/learning session to the learner(s) by clarifying what is expected of them during the debriefing, emphasising ground rules of confidentiality and respect for others, and encouraging the learners to identify their own learning objectives.
3. Engagement of learners	Active involvement of all learners in the debriefing discussions, by asking open questions to explore their thinking and using silence to encourage their input, without the facilitator talking for most of the debriefing, to ensure that deep rather than surface learning occurs.
4. Reflection	Self-reflection of events that occurred in the simulation/learning session in a step by step factual manner, clarifying any technical clinical issues at the start, to allow ongoing reflection from all learners throughout the analysis and application phases, linking to previous experiences.
5. Reaction	Establishing how the simulation/learning session impacted emotionally on the learners.
6. Analysis	Eliciting the thought processes that drove a learner's actions, using specific examples of observable behaviours, to allow the learner to make sense of the simulation/learning session events.
7. Diagnosis	Enabling the learner to identify their performance gaps and strategies for improvement, targeting only behaviours that can be changed, and thus providing structured and objective feedback on the simulation/learning session.
8. Application	Summary of the learning points and strategies for improvement that have been identified by the learner(s) during the debrief and how these could be applied to change their future clinical practice.

EXAMPLE OF SCORE 1	EXAMPLE OF SCORE 5
"You made lots of errors in that scenario, which is poor since I assume that you must have seen that scenario before."	"Let's start the session with introductions, so we can understand each other's backgrounds and previous experiences."
"I'm not interested in what you see as the purpose of this session but I know what I want to teach you about and its very important to me."	"Please start by explaining what you hope to take away from this debriefing session. The information we discuss remains confidential."
"I'm now going to teach you about the correct way to do things and I'd like you all to keep quiet and listen to me."	"As team leader, can you describe to us what was going on at that point in the scenario? Why do you all think that happened?"
"I can tell you exactly what you did and why you were doing it in that way."	"Could you talk through what you observed, right from the start, in a step by step way, so we are all clear about the events that occurred?"
"I can't understand why you are getting upset about the events in the scenario, it's never had that impact on other people."	"That part appeared very stressful to us observing, how did you feel at the time? Do you think that it impacted upon the rest of the experience, and in what way?"
"There's no point asking you why you did that but you should know to do it differently next time."	"Why do you think that event happened at that particular moment? So what was distracting you then?"
"That was all fine I suppose but I don't think you did anything particularly well."	"So you identified that your team was not aware how concerned you were, can you suggest ways in which you could communicate your concerns more clearly next time?"
"So you'll do better next time? I think you know what you did wrong in the scenario. Let's finish there."	"Can you summarise the key points you learnt from this session? How do you think you might change the way you manage the situation if faced with it again in your clinical workplace?"

	1 (done very poorly)	2
1. Approach	Confrontational, judgmental approach	
2. Establishes learning environment	Unclear expectations of the learner(s); no rules for learner(s) engagement	
3. Engagement of learners	Purely didactic; facilitator doing all of the talking and not involving passive learner(s)	
4. Reflection	No acknowledgment of learner(s) reactions, or emotional impact of the experience	
5. Reaction	No opportunity for self- reflection; learner(s) not asked to describe what actually happened in the scenario	
6. Analysis	Reasons and consequences of actions are not explored with the learner(s)	
7. Diagnosis	No feedback on clinical or teamwork skills; does not identify performance gaps or provide positive reinforcement	
8. Application	No opportunity for learner(s) to identify strategies for future improvement or to consolidate key learning points	

3	4	5 (done very well)
Attempts to establish rapport with the learner(s) but is either over- critical or too informal in their approach		Establishes and maintains rapport throughout; uses a non- threatening but honest approach, creating a psychologically safe environment
Explains purpose of the debriefing or learning session but does not clarify learner(s) expectations		Explains purpose of debrief and clarifies expectations and objectives from the learner(s) at the start
Learner(s) participates in the discussion but mostly through closed questions; facilitator not actively inviting contributions from more passive learner(s)		Encourages participation of learner(s) through use of open-ended questions; invites learner(s) to actively contribute to discussion
Asks the learner(s) about their feelings but does not fully explore their reaction to the event		Fully explores learner(s) reaction to the event, dealing appropriately with learner(s) who are unhappy
Some description of events by facilitator, but with little self-reflection by learner(s)		Encourages learner(s) to self-reflect upon what happened using a step by step approach
Some exploration of reasons and consequences of actions by facilitator (but not learner(s)), but no opportunity to relate to previous experience		Helps learner(s) to explore reasons and consequences of actions, identifying specific examples and relating to previous experience
Feedback provided only on clinical (technical) skills; focuses on errors and not purely on behaviours that can be changed		Provides objective feedback on clinical (technical) and teamwork skills; identifies positive behaviours in addition to performance gaps, specifically targeting behaviours that can be changed
Some discussion of learning points and strategies for improvement but lack of application of this knowledge to future clinical practice		Reinforces key learning points identified by learner(s) and highlights how strategies for improvement could be applied to future clinical practice

7. Principles of Learning Further Reading

Principles of Learning

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The journal Medical Education, published by Blackwell, is a good source of further information and research.

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