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A qualitative evaluation of the hot debrief/follow-up initiative: Implications of readily identifying positive outcomes in an Australian emergency department

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Abstract

Aim: To gain insight into how emergency department nurses and doctors perceive the experience of being offered the opportunity to request a patient follow-up as part of a structured debrief initiative.

Background: An increased prevalence of burnout and compassion fatigue amongst emergency clinicians is being recognized globally. A wellbeing initiative has been implemented within a large public hospital emergency department to combat these phenomena.

Method: A qualitative research approach using semi-structured interviews was carried out to explore the participants' views relating to the debrief/follow-up initiative.

Results: A total of 17 face-to-face semi-structured interviews were conducted. This research highlighted a number of common themes including the participants understanding and perception of the follow up initiative, the barriers and enablers of effective implementation, and the perceived benefits of following up on patient outcomes in the emergency setting. This research identified unanimous support for the initiative. No negative implications relating to the initiative were identified.

Conclusions: This study indicates the positive impacts of employing a deliberate and formalized approach to enabling staff to access follow-up information about the patients for whom they provide life-giving care.

Implications for Nursing Management: Nurse Unit Managers should consider the findings of this research and understand the crucial role that nursing leadership can play in fostering the design and implementation of similar initiatives.

KEYWORDS
debrief, emergency department, nurse manager, positive psychology, wellbeing

1 | BACKGROUND

Within the health care industry, burnout is being increasingly recognized as contributing to less productive workplace culture and negative patient outcomes (Basu et al., 2017). Burnout is a state of physical, mental and emotional exhaustion and disengagement. While burnout is prevalent across all jurisdictions within the health care continuum, it is evident that clinicians who work in critical care environments (such as the ED) are particularly vulnerable (Martins Pereira et al., 2016; Mikkelsen et al., 2019). Often faced with the day-to-day challenge of balancing competing clinical priorities within a setting designed to handle the most critical of health care emergencies, clinicians working within these areas are at high risk for experiencing moral distress and decision fatigue (Rozo et al., 2017; Tawfik et al., 2017).

Health care organizations can be critically impacted by a proclivity of negativity in the workplace. Negativity bias describes a tendency for leaders to bias towards identifying and highlighting negative outcomes (Haizlip et al., 2012), which further contribute towards staff dissatisfaction. While it is accepted that identifying opportunities for improvement is of crucial importance to quality and safety practices in health care, Haizlip et al. (2012) argue that the presence of the negativity bias within some sections of the industry has inadvertently created an unforgiving workplace culture that contributes to high rates of burnout, depression and suicide amongst the workforce. Lee (2021) claims that the negativity bias within the ED can affect professional relationships, can lead to poor workplace culture and can contribute to burnout. Lee (2021) argues that humans are hard-wired to be more influenced by the negative events that take place in day-to-day life and this bias affects how we conduct our practice in the ED domain and can cause us to judge ourselves harshly (Lee, 2021).

Compassion fatigue is also common in the ED setting and more so in younger and less experienced nurses (Kawar et al., 2019; Wei et al., 2017). It describes the physical and emotional exhaustion that can occur from helping others, particularly through traumatic or stressful experiences resulting in an inability to empathize with patients. Components of compassion fatigue include the presence of burnout and secondary traumatic stress. Secondary traumatic stress is specific work-related stress that occurs from secondary exposure to extremely traumatic events. The negative feelings associated with burnout, compassion fatigue and secondary traumatic stress usually have a gradual onset and can stem from the feeling that one's efforts make no difference. They can be associated with a very high workload and/or a non-supportive work environment.

In contrast to compassion fatigue, compassion satisfaction occurs when a caregiver derives satisfaction from their work, encompassing the pleasure of fulfilment and purpose associated with their profession (Kelly & Lefton, 2017). A large body of literature from the area of positive psychology and leadership has demonstrated the benefits of strategies that promote resilience and improve workplace culture. The importance of nursing leadership in supporting such strategies to influence culture at a local level is highlighted (Kawar et al., 2019; Simpson & Knott, 2017). Workplace initiatives that improve professional satisfaction, encourage mindfulness and reward the formulation of an empathetic disposition are found to contribute to the development of cultural resilience and promote compassion satisfaction in these high-pressure environments (Salvarani et al., 2019).

Lewis (2011) argues that where organizations succeed in fostering affirmative bias and encouraging virtuous practices, they are generally more successful in building social capital reserves. Social capital is a term that refers to the quality of relationships and interactions within teams and is said to profoundly impact workforce cohesiveness and capability. The presence of social capital not only helps to produce exceptional performance but also contributes to the development of greater levels of resilience amongst teams. Where teams are supported in building social capital, they are also more likely to bounce back from setbacks (Lewis, 2011).

A structured debrief/follow-up initiative was implemented within a large Hospital ED in Queensland, Australia. A structured debriefing is a facilitated interaction between members of the interdisciplinary team that enables collective reflection after a potentially traumatic clinical event with a focus on improving both system and team performance (Rose & Cheng, 2018). The structured debrief/follow-up tool (Appendix S1) was developed by a small team of ED clinicians with an interest in staff wellbeing and self-care following consultation with neighbouring EDs. A debriefing tool that followed the 'INFO' model (Immediate, Not for personal assessment, Fast/Feedback/Facilitated, Opportunity to ask questions) was adopted (Rose & Cheng, 2018). The debriefing tool was then adapted to meet the specific needs of the department (i.e., indication for a debriefing session was adjusted according to demographic and acuity of common presentations) and to include the opportunity for participants to request follow-up of patient outcomes after they had been transferred out of the department.

Anecdotal evidence suggests that, often, clinicians would be excited to hear about the positive effects of their care; however, it is likely that positive patient outcomes are often under-communicated. The follow-up aspect of the initiative allowed participants of the debriefing to indicate if they would like to receive follow-up information about the longer-term outcome of the patient. A senior staff member would then review these requests, perform a follow-up about the outcome of the patient and relay this information back to the staff who requested it in written format. The addition of the follow-up initiative incorporated positive psychology concepts with an intention to identify positive patient outcomes and communicate these instances back to staff. The structured debrief/follow-up initiative was designed to positively impact on the psychological safety within the department, reduce uncertainty, highlight positive outcomes and provide closure to staff following stressful situations at work.

Prior to the implementation of the structured debrief/follow-up initiative, debriefing and follow-up would happen on an ad-hoc basis and would require individuals to independently identify moments that would benefit from debriefing and/or follow-up, and subsequently take initiative to organize the event/process. With limited structure and no agreed indication criteria, practices surrounding debriefing and follow-up were inconsistent and person dependant. There was no

formal opportunity for staff who were involved in these often-traumatic events, to request a follow-up on the outcomes of patients.

The concept of a structured debriefing session following acute resuscitation events is not novel. The evidence supporting the application of clinical event debriefing is well established; however, the formalized process for allowing clinicians to request a follow-up about the outcomes of the patients for whom they have provided care is less common.

This research was conducted to examine how a workplace initiative that highlights positive patient outcomes to staff working in critical care areas was perceived by ED nurses and doctors. The results will be used to inform ways that nurses in leadership roles can drive wellbeing related quality improvement initiatives while working to uplift cultural resilience and social capital within the workforce.

2 | AIMS

The aim of this research project was to gain insight into how ED nurses and doctors perceive the experience of being offered the opportunity to request a patient follow-up as part of a structured debrief initiative.

3 | METHODS

3.1 | Design

This qualitative research used semi-structured interviews to explore the participants' views on the debrief/follow-up initiative.

3.2 | Setting

The research was conducted at a large public health ED in Queensland, Australia. At the time of the study, the department employed approximately 300 nurses and 120 doctors. The Hospital is the major health centre for one of the fastest-growing regions in the state of Queensland and provides a range of specialty services for children and adults. The ED is one of the busiest in the state and sees more than 88,000 presentations each year.

3.3 | Recruitment and data collection

Participation in the study was voluntary. Staff who held part-time or full-time employment in the target ED who had volunteered to participate in the research and had participated in a debriefing event within the department were eligible to take part. Staff who were employed on casual contracts, agency staff, staff who had not taken part in a debrief procedure and staff who declined to take part were not eligible to participate.

TABLE 1 An overview of the characteristics of participants recruited to the study

Group 1—Registered nurses (RNs)	• ED registered nurses who are in resus training (NG5) • ED registered nurses who have less than 2 years of resus experience (NG5)
Group 2—Experienced registered nurses and nurse leaders	• ED registered nurses who have over 2 years of resus experience (NG5) • ED clinical nurses (CN) (NG6) • ED clinical nurse consultants (CNC) (NG7)
Group 3—Medical officers	• ED consultants

Due to the unpredictable nature of the ED and the challenges associated with shift work, a number of recruitment strategies were used including purposeful and convenience sampling. Understanding the views of both experienced and inexperienced staff was important in addition to representative views from nurses and medical doctors. A minimum of four participants from each clinician group were recruited as per Table 1. A mixture of face-to-face interviews and virtual interviews were conducted.

Advertising material was used to raise awareness about the research project amongst staff within the department. An option was added to existing debrief paper work to give staff the opportunity to indicate their willingness to take part in the research. Appropriate days for conducting interviews were determined in liaison with the Nurse Manager of the ED and the local debrief team CNC. Once interview days were decided, the principal investigator contacted potential participants who had identified their willingness to take part and who were rostered to work in the department on that day. Interviews were conducted during work hours and Interview times were negotiated in liaison with the shift manager and the participant.

The primary investigator, a registered nurse who was involved in the design and implementation of the quality improvement initiative, conducted all interviews. The primary investigator is a certified Mental Health First Aider and has worked as a critical care registered nurse for several years. A semi-structured questionnaire with prompts was developed to ensure that a consistent and focussed approach was taken during interviews (Appendix S2).

3.4 | Data analysis

All audio recordings were transcribed verbatim. Transcripts were analysed according to the six-phase approach described by Braun and Clarke (2006): (a) Familiarizing with the data, (b) Generating initial codes, (c) interrogating for themes, (d) reviewing themes, (e) defining and naming themes and (f) producing the report. Members of the

research team met on multiple occasions and were given access to the transcripts to review. Members then independently identified several emerging themes and subthemes. Findings were discussed and a shared understanding was developed and reviewed.

4 | ETHICAL CONSIDERATIONS

The study was reviewed and approved by the Metro South Health Service District Human Research Ethics Committee (HREC/2020/QMS/65976).

5 | RESULTS

5.1 | Participant demographics

A total of 17 interviews were conducted. Interviews ranged between nine and 24 min in duration. Thirteen registered nurses with various levels of clinical experience and four ED doctors agreed to participate (Table 1). The participants of the study were mostly female. Of the 13 nursing participants, only three were male. However only one of the doctors interviewed was female.

5.2 | Themes

A total of 52 codes were generated during the thematic analysis of the interview transcripts (Figure 1). These codes were then discussed and collated in to 11 subthemes and three overarching themes that highlight the perceptions about the structured debrief/follow-up initiative that emerged during the interviews (Figure 1).

5.2.1 | Theme 1: Understanding and perception of the follow-up initiative

All participants in this study had previously participated in the debriefing procedure. However, the option to request a follow-up is discretionary and it was found that follow-ups are only requested in relatively rare cases. Additionally, having requested a follow-up was not a prerequisite for participating in this study. Three of the nursing staff and none of the doctors who were interviewed had requested and/or received a formalized patient follow-up through the initiative.

As such, all participants were asked questions to gauge their comprehension of the follow-up initiative. Most participants had a sound knowledge of the initiative, with one or two requiring some clarification about the process. Where clarification was required, participants were given a brief overview, which allowed them to consider the hypothetical implications of the initiative.

Formal versus informal follow-ups

One of the sub-themes identified was the comparison between the status quo (informal follow-ups) and the formalized follow-up process. Participants identified a difference between their experience of gaining informal follow-up through word of mouth versus the potential to gain formal follow-up information about the outcomes of their patients. All the doctors who were interviewed agreed that following up on patient outcomes was a pre-existing aspect of their clinical practice. However, many of the nursing staff felt that there were several factors that influenced their ability, or inability to request follow-up information about their patients prior to the formalized follow-up initiative being implemented. *One nurse said '… previous to this being implemented (people) didn't feel empowered to be able to find answers … it was very frustrating that we didn't know what had actually happened to the patient' (G2—CNC1).*

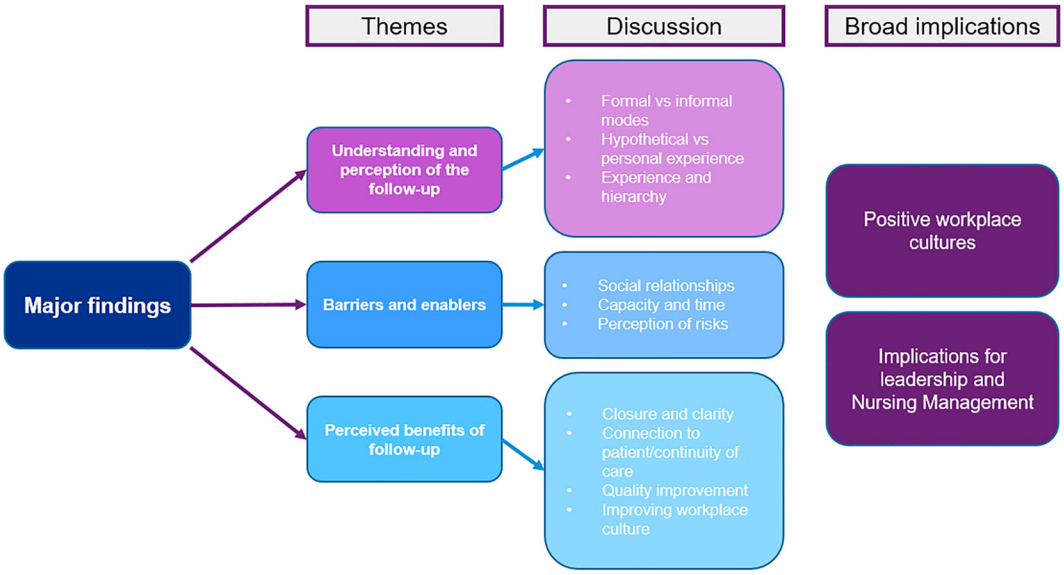

FIGURE 1 A representation of major findings following the thematic analysis process

Many participants in groups one and two referred to occasions when they had received an informal follow-up, usually by means of a brief hallway conversation with a more senior staff member or colleague. Unanimously, the perception was that these encounters did not add any clarity or give any sense of closure. Conversely, all participants who had received formalized follow-up through the debrief/follow-up initiative, believed that the initiative was conducted appropriately and added to their clinical understanding while offering a sense of closure. Many nurses discussed experiences of walking away from a resus situation without knowing what the outcome for the patient was. Many participants identified that this can lead to rumination.

Hypothetical versus personal experience

All participants who had experienced a follow-up first-hand were highly supportive of the initiative.

> … It was really good because in Emergency, people come in with a variety of critical illnesses and a lot going on. In the nursing profession, we're focused on tasks and doing things to stabilise the patient. Often, we don't really get time to understand the full picture … the debrief (and) the follow-up email have been really great for not only looking at the outcome and seeing that they had a positive outcome, but also understanding what was actually going on underneath all of the superficial symptoms. (CNC—1).

All participants in the study stated that they would like to receive follow-up information about the outcomes of patients for whom they have provided care. All participants viewed the potential to request formalized follow-up as a beneficial initiative and all saw the process as an opportunity for education. This was illustrated by a doctor in group three who despite not having received a formal follow-up was able to see the hypothetical benefit.

> … I think this is a great failure of emergency medicine across the board in that we see enormous numbers of patients, we make a lot of decisions, and we never know what happens. With the pressure of the four-hour rule, we make the same decision, we get more confident in the decision we make, and we never actually find out if it was a good decision or not. (G3—DR2)

Experience and hierarchy

It was found that generally, junior nurses were highly supportive of the process because it was perceived as helping deliver a learning experience while increasing psychological safety and providing closure following traumatic experiences. One junior nurse said *'… I noticed how helpful it was … once I'd had the resus experience where we didn't debrief' (G1—RN3).* The nurse spoke about a missed opportunity to debrief and subsequently a missed opportunity to request follow-up about the patient's outcome following a highly stressful event.

The perspective of the more experienced nursing participants in group two was similar. Many of these participants identified ways that the initiative had impacted on them personally. One senior nurse said that it has afforded her greater job satisfaction and provides closure.

Further to this, participants in group two often spoke about the initiative as a tool that could be used for education and leadership purposes. Many of the senior nursing participants argued that the initiative is more beneficial to junior staff—identifying the added potential to provide education by highlighting patient outcomes and linking it back to clinical practice for staff with limited experience.

Senior nurses also seemed to draw on past experience and reflect on how this initiative may have benefited them as younger ED nurses. This was in slight contrast to many of the younger cohort of nursing participants who were more often considering hypothetical scenarios which may arise in the future. One senior nurse explained that she had developed a resilient and stoic mindset after working in ED for many years. She argued that she does not feel the need to follow up on many of her patients because ultimately the long-term outcome for the patient is unlikely to alter her practice.

However, when asked if she would have appreciated having easier access to follow-up information about her patients as a less experienced nurse she said *'… Yeah, I think I looked for it more then, because I didn't have as many coping mechanisms or resilience or ways to process what I do'. (G2—CN3).*

Many of the senior doctors also shared a similar perspective, often considering the initiative as a leadership tool as opposed to offering a direct benefit to them personally. One of the doctors in group three spoke about the motivation behind the debrief and follow-up initiative.

> I suppose it is for education purposes, but the motivation really is to make sure that people go home without unanswered questions. Because there's nothing worse than going home thinking could we have done this? What if we did that? (G3—DR2).

5.2.2 | Theme 2: Barriers and enablers of effective implementation

Social relationships

It was identified by participants in all interviews that social relationships within the department were a key factor in obtaining informal follow-up about the outcomes of patients prior to the formalized procedure being implemented. Nursing staff who felt that they had strong relationships with senior doctors felt empowered to seek out informal follow-up information, whereas staff who were yet to develop strong social connections with senior clinicians identified more barriers to informal follow-up. It was highlighted that the formalized follow-up process provided more consistency and equity of access to this information.

Capacity and time

A few barriers and risks to formalized follow-up were highlighted. Issues such as available resourcing to carry out the work and timeliness of information transfer were discussed.

The formal follow-up process requires senior staff capacity and time. Finding the workforce capacity to ensure that debriefings and subsequent follow-ups are conducted at an appropriate time and in an appropriate manner is an ongoing challenge for the department. Without a dedicated resource, the process to finalize a follow-up can take several weeks and even months.

Perception of risks

When asked about whether there was any negative potential associated with the initiative, one participant from group two identified the potential for the follow-up to allow traumatic memories to resurface.

> … if they (the person requesting follow-up) had worked through it (psychologically worked through the experience), processed it and then moved on from it, maybe getting the feedback a month or two months down the track might just bring up a bit more … (G2—CN2).

All participants in the study were asked whether they would like to know about the outcomes of their patients regardless of whether the outcome was positive or otherwise. Overwhelmingly, all participants responded that they would like to know about the outcome either way.

> … I personally can't see how having information of a follow up could be viewed as a negative thing. Definitely those that I've spoken to also agree that they like knowing what has happened to the patient. (G2—CNC1).

5.2.3 | Theme 3: Perceived benefits of follow-up of patient outcomes in an emergency setting

A recurring theme throughout the interviews was that staff perceived a variety of benefits relating to the follow-up initiative.

Closure and clarity

Many participants in group one suggested that the initiative provides a sense of closure or resolution.

> *… I absolutely 100 per cent think that the follow-up is really, really beneficial and a really nice closure of whatever the event is that's taken place … I think on a personal note, if you really invest that time in the emotional cause, then that is where so many of us get burnt out and fatigued because we have that emotional burden … we're giving so much of ourselves every day. (G1—RN6).*

Many nursing participants across both groups identified the fact that uncertainty can contribute to emotional fatigue. *One nurse said '… the alternative is you just get left wondering and I wonder if that's why we do get that emotional fatigue because we just have so much "what if" or "what happened?"' (G2—CN2).*

A common perspective amongst the senior doctor's related to their perceptions around personal performance or decision making. It was identified that ambiguity around the outcomes of the patient has the potential to lead to rumination and cogitation. It was suggested that providing closure can help to effectively reduce performance anxiety and increase psychological safety. When asked about whether the follow-up is useful or not, one doctor suggested that the initiative has the potential to improve psychological safety within the workforce.

> … It's invaluable … we like to pretend that medicine is complicated but it's not, it's complex. We bury things in work instructions and flowcharts, but in reality, nothing is black and white. Everything I do is a shade of grey. If I am in a non-psychologically safe situation, and I think this goes for everybody, I defend my practice. (G3—Dr3).

Connection to patient/continuity of care

Considerations about the ED environment and how workflows within the ED can negatively impact one's ability to feel a connection to the patient's journey were raised amongst the less experienced nurses in particular.

> … when you're working in ED, you always look after patients when they're really unwell. But you never know if they've gotten better because they go to the ward or they get transferred somewhere else or they get discharged … You never know if they've fully recovered. So … you've always got that unknown … (G1—RN1).

Quality improvement

Participants with more years of clinical work experience were more likely to highlight the opportunity for quality improvement as a benefit of following up on the outcomes of patients. Encouraging practices of reflection and evaluation were identified as some potential benefits of increasing awareness of patient outcomes.

> It would promote more of a culture of self-reflection and evaluation of practices and planning how we could improve… (G3—DR3).

A nurse in group two highlighted the potential to use the initiative to promote recognition of positive work practices and outcomes. When discussing how the follow-up is communicated to staff, she said *'it's not what we didn't do wrong, it's what we did well and what we could do better so it works great, I think' (G2—CN1).*

Improving workplace culture

Most participants reflected the perception that the debrief/follow-up initiative has made a positive impact on the culture within the wider workplace. Participants in groups one and two shared a perception that the initiative builds cultural resilience and helps to create a psychologically safe environment. *One nurse explained that '… in the past, most of the culture (in the department was that) you either toughen up or you leave' (G1—RN7).*

When discussing how the initiative has had an impact on the culture in the department, one participant said *'It allows you to express those things and actually deal with them and then move on…' (G1—RN7).* This was a similar perspective to a senior nurse who said that she felt that staff are now more culturally empowered to be interested in the outcomes of their patients. *They said '… I think it's had a positive effect because previous to this being implemented, people didn't feel empowered to be able to find answers. I think it creates a more psychologically safe department' (G2—CNC1).*

Another nurse from group two suggested that the initiative has had an impact on staff morale.

> … it definitely improves our staff morale because it's something that everyone talks about and thinks about. People are more self-aware of their own fatigue and burnout and wellbeing and so forth. (G2—CN2).

Participants from group three identified the perception that the initiative was helping to improve multidisciplinary communication practices, especially with regards to strengthening communication channels between senior medical staff and junior nursing staff.

> It strengthens the team building and hopefully encourages more engagement too, particularly between the senior medical officers and the junior nursing staff who don't necessarily interact all that much. (G3—DR1).

6 | DISCUSSION

This research identified unanimous support for the initiative amongst participants and highlighted several positive impacts on workplace culture and staff wellbeing. No negative implications relating to the initiative were identified. The follow-up aspect of the debrief/follow-up initiative was implemented to highlight positive patient outcomes and in turn, potentially impact on levels of staff burnout within a busy ED although this was not measured in the study. The follow-up initiative was developed using principles of positive organizational scholarship and on the back of anecdotal evidence. The implications for the nursing workforce are particularly evident in the findings.

6.1 | The perceptions of participants

The level of experience of participants, along with the hierarchal structure of the workplace was observed to have some bearing over the participants perceptions around the benefits of the initiative. Amongst the less experienced participants, there was a general acknowledgement that work in critical care environments can be highly stressful and traumatic and that this initiative has the potential to protect their own psychological wellbeing in situations that may occur in the future.

While the younger and less experienced cohort of participants perceived the benefits of the initiative at the individual level (i.e., benefits to self), participants with more experience were often more likely to identify how the initiative could benefit others. There were also more stoic attitudes amongst the more experienced participants, with some senior nurses and doctors suggesting that they do not benefit directly from the formal follow-up. However, when asked to consider the benefit for others, all participants could identify the potential benefit for the younger generation of clinicians.

Furthermore, it was observed that staff who were yet to develop strong social connections with senior clinicians identified more potential benefit from the standardization of the follow-up process. The importance of this finding is the perception that the formalized follow-up process allows for more consistency and equity of access to information regarding patient outcomes. It was recognized that the standardized process for offering follow-up, means that all staff are now given an opportunity to request the information and therefore do not need to rely on their relationships with senior staff members to do so. This is particularly important for the younger and less experienced clinicians within the department who have not had the time to develop strong relationships with senor clinicians. With the commonly held perception that this cohort is more likely to receive individual benefit from the initiative, the enabling of more equitable access to follow-up information is a significant finding.

6.2 | Risks

The risks identified by participants were in relation to the potential delay in receiving information as a direct result of limited workforce capacity to conduct the follow-up process. It is an ongoing challenge for leadership within the department to ensure that the follow-up process is conducted in a consistent and timely manner.

This also raises a question as to whether participants would in fact prefer not to know about the outcomes of their patients after they have left their care. However, all participants stated ultimately that they would like to know about the outcomes of their patients, whether positive or otherwise.

6.3 | Positive workplace cultures

There is a great deal of ambiguity and uncertainty regarding the longer-term outcomes of patients in the ED setting. This is

confounded by the role that the ED plays in the triage and stabilization of critically unwell patients. Most commonly, patients who present to the ED in a critical condition are rapidly stabilized and transferred to another area within the hospital or a different hospital facility with more specialized clinical expertise. As a result, ED staff often see the patient when they are in their most critical condition. Once the patient is transferred to another care environment (typically the Intensive Care Unit) a handover of care is conducted, resulting in a transfer of responsibility for the patient's ongoing care. Commonly, this transfer can happen before the patient's condition is fully differentiated.

The degree by which the follow-up initiative has reduced uncertainty experienced by ED clinicians would require further research. However, the reported perception of increased job satisfaction and improved psychological safety is a significant finding. In health care, psychological safety amongst teams can positively impact on team performance. A psychologically safe environment can support patient safety by empowering staff to report issues and more actively engage in quality improvement initiatives (O'Donovan & McAuliffe, 2020). In environments that are considered to be psychologically safe, there is less incidence of burnout and higher levels of staff retention (Vévoda et al., 2016).

Furthermore, the initiative appears to have impacted the levels of social capital amongst the medical and nursing workforce. Direct comments were made by participants about the benefit of improving communication and engagement between members of the multidisciplinary team. With setbacks being plentiful in emergency medicine, the potential to impact levels of social capital in this context should not be overlooked.

Furthermore, the potential implications of the negativity bias in health care should also be considered within the context of the findings of this study. Negative experiences have a greater impact on our behaviour and their effects last longer in our memories (Hambley, 2019). Due to the intense nature of the environment, the negativity bias is a natural occurrence in the ED setting (Lee, 2021). We instinctively bias towards reflecting upon negative experiences to protect us from making the same mistakes twice (Hambley, 2019). It's possible that the follow-up initiative may be helping to shift the focus slightly away from the negative and broadening awareness to include positive outcomes that may have otherwise gone unnoticed. However, more research is needed to evaluate the impact of similar quality improvement initiatives on the prevalence of a negativity bias in the ED.

The findings of this study suggest that the debrief/follow-up process has allowed nursing staff to seek a sense of closure and to gain clarity in situations that are normally rife with uncertainty and to feel safe in doing so. Junior nurses now feel a sense of security going into stressful situations, knowing that the opportunity to request follow-up information about the patient is available. Furthermore, senior clinicians appeared supportive of the utility of the initiative in providing answers in medically complex situations and allowing for better quality improvement practices. Communication links between the multidisciplinary team have reportedly improved which may have resulted in increased social capital within the department. The language used by participants in many of the interviews is indicative of a flourishing organization.

6.4 | Study limitations

The level of work experience within this sample is a limitation. The recruitment of a diversity of senior and junior nurses as well as senior and junior doctors potentially would have enriched the findings. However, due to the unforeseeable impacts of COVID-19 and subsequent difficulties in recruiting participants, the junior doctor cohort was not represented. Further, only four senior doctors were interviewed which resulted in limited diversity of perspectives from the medical cohort.

7 | CONCLUSION

This study indicates the positive impacts of employing a deliberate and formalized approach to enabling staff to access follow-up information about the patients for whom they provide life-giving care in the ED. The follow-up initiative provides a new experience for nursing staff in this setting. Nurses now feel empowered to be curious about the outcomes of their patients. The benefits to the younger and less experienced cohorts within the workforce are particularly evident. Health care organizations should consider trialling similar initiatives that improve connectivity, highlight positive results and offer a sense of closure. Further evaluation on staff satisfaction and organizational culture would be beneficial.

The reported impacts on psychological safety and job satisfaction as a result of this initiative would undoubtedly be having an impact on team dynamics within the department. However, accurately identifying safety and quality improvements would require further evaluation. The findings of this qualitative study highlight opportunities for furthered investment in the development and leadership of social capital building initiatives on a broader scale.

Developing standardized practices to communicate patient outcomes back to clinicians who work in the ED setting following stressful situations at work may be an effective strategy in building cultural resilience, improving quality improvement practices and reducing burnout amongst staff who work in these areas. However, the example considered in this study is one initiative and should not be viewed as a standalone solution. To holistically address burnout amongst ED clinicians, it is recognized that a comprehensive and multifaceted management strategy is required (Wei et al., 2017).

8 | IMPLICATIONS FOR NURSING MANAGEMENT

Leadership from Nurse Unit Managers (NUMs) is a critical factor in enabling a cohesive workplace culture and ensuring the success of quality improvement initiatives in health care (Sfantou et al., 2017).

The implementation of the structured debrief and formalized follow-up initiative was a significant quality improvement undertaking and required considerable buy-in from both medical and nursing leadership within the department. Support from the NUM was particularly important in ensuring the successful implementation of the initiative and helped to create agency amongst staff. Furthermore, the leadership offered by the NUM along with other nursing and medical leaders was crucial in ensuring integration of the practice into the culture of the department and in encouraging rigorous evaluation.

It is of great importance that NUMs create supportive environments for staff to work towards improvements that may impact on the wellbeing of the workforce. It is crucial that leaders in health care organizations encourage an investment in wellness-related quality improvement initiatives (Sfantou et al., 2017). The role of Nursing leaders in positively impacting the well-being of the workforce is crucial (Pappas, 2021). NUMs should consider the findings of this research and understand the crucial role that nursing leadership can play in fostering the design and implementation of similar initiatives.

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CONFLICT OF INTEREST

All authors declare that there are no conflicts of interest with regard to this study.

ETHICAL STATEMENT

The study was reviewed and approved by the Metro South Health Service District Human Research Ethics Committee (HREC/2020/QMS/65976).

AUTHOR CONTRIBUTIONS

JP was responsible for data collection and writing the manuscript. All authors contributed to the thematic analysis of the interview transcripts, provided feedback on the draft manuscripts and approved the final version.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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