

Failure to debrief after critical events in anesthesia is associated with failures in communication during the event.

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Arriaga AF, Sweeney RE, Clapp JT, et al. Failure to Debrief after Critical Events in Anesthesia Is Associated with Failures in Communication during the Event. *Anesthesiology*. 2019;130(6):1039-1048. doi:10.1097/ALN.0000000000002649.

<https://psnet.ahrq.gov/issue/failure-debrief-after-critical-events-anesthesia-associated-failures-communication-during>

[Debriefing](#) after a critical event is a strategy drawn from [high reliability industries](#) to learn from failures and improve performance. This retrospective study of critical events in inpatient [anesthesiology practice](#) found that debriefing occurred in 49% of the incidents. Debriefs were less likely to occur when critical [communication breakdowns](#) were involved, and more than half of crisis events included at least one such breakdown. Interviews with care teams revealed that communication breakdowns present in some incidents impeded the subsequent debriefing process. The authors call for more consistent implementation of debriefing as a recommended patient safety process. A previous [WebM&M commentary](#) discussed an incident involving miscommunication between a surgeon and an anesthesiologist.