The Covid-19 pandemic has exposed and exacerbated the stresses that frontline healthcare workers encounter on the job. We implemented a process called "Circle Up," which creates a regular time and place for problem-solving and connection, to promote better communication and improve the psychological well-being of care teams. Participants report greater interprofessional peer connectedness and less psychological distress. They feel encouraged to speak up more throughout the day and with colleagues they would not normally approach. Circle Up offers a proactive, rather than reactive, process of peer support that seems to work synergistically with clinical process improvements.

Introduction

The demands of Covid-19 care have exposed old and new challenges in our healthcare system. Psychological harm arises from stress and burnout, known threats to healthcare workers prior to the disruption of Covid-19. But during the Covid-19 pandemic many of the world’s hospital staff are overwhelmed—often working in newly formed teams with improvised and untested protocols in makeshift spaces to care for an overwhelming number of critically ill patients with a poorly understood disease. Inefficiencies in workflow adaptation impair patient safety, erode team cohesion and demoralize clinicians. Frequent changes in workflow and concerns regarding personal protective equipment (PPE) are the norm. We already learned in the SARS epidemic that psychological depletion and trauma, cascading into burnout, were common. The daunting challenge before us: enhancing existing patterns of team communication and coordination that promote concurrent process improvement and support clinician psychological health—all at a pace required to address the Covid-19 crisis.
A wide gap exists between the realities of Covid-19 care and the pace and structure of existing systems of process improvement and psychological support, which are poorly-suited to the hour-to-hour, shift-to-shift and day-to-day improvement requirements of a Covid-19 unit. An effective approach would rapidly capture, synthesize and integrate front-line workers’ insights into workable and testable solutions.

We offer a solution: An inexpensive, easy-to-implement, and broadly-applicable process for coordinating clinical care under the moniker “Circle Up,” meant to invoke the brief and inspirational planning or after-action conversations convened by sports coaches or platoon leaders (“Let’s Circle Up!”). This recurring process involves interprofessional on-shift team briefing and debriefing, intended to improve both psychological health and care quality. The goal is to create recurring, predictable moments of connection and problem-solving that create a “safe container” for clinicians in the midst of complex, dynamic clinical work. The approach builds on the authors’ 15 years of experience in leading, teaching, and researching organizational change efforts, and debriefing and peer support across the Harvard teaching hospitals and internationally, as well as working in and leading acute care teams.

We designed Circle Up around research and practice on high-performance healthcare teams to enable sustained, high-quality work, including efficient adaptation in the face of uncertainty. The approach is rooted in a foundational philosophy of “holding ourselves to high standards while holding each other in high regard” and is based on these guiding principles:

1. Sustained work effort requires psychological well-being, which is supported by many factors including opportunities to contribute to solutions, learn and share in teams, and support one’s colleagues.

2. Psychological safety—the perception that the environment is safe for interpersonal risk taking—promotes effective team behaviors such as asking for help, speaking up, and sharing ideas.

3. Communication that is timely, frequent, and focused on problem-solving builds mutual respect and clarifies shared goals in a way that improves coordination and clinical outcomes.

4. High quality feedback is critical to improving complex teams and their output. Healthcare cultures are not static but are iteratively created, changed, and sustained by the “normal” micro conversations and actions of organizational life.

Using Circle Up, front-line teams can build and sustain psychological safety and peer support and improve clinical processes. Circle Up activities can serve as a daily engine for sustaining or enhancing quality and safety, well-being, and lean initiatives. Briefings serve as initiating mechanisms for front-line and just-in-time quality improvement; peer check-ins reinforce colleagues’ support of each other, and debriefings provide data for process improvement. These recurrent small episodes gradually create a new culture characterized by esprit de corps, adaptability, community, innovation, curiosity, and compassion. Combining purposive emotional support and improving clinical processes strengthens cohesion, meaning, and, ideally, joy at work.
Using Circle Up, front-line teams can build and sustain psychological safety and peer support and improve clinical processes."

In one project we led, daily 10-minute debriefings facilitated sharing of frustrations and ideas that led to the creation of an intracranial pressure treatment kit. The “brain box” simplified and expedited brain-saving interventions in the neuro intensive care unit, led to a sense of accomplishment and satisfaction, and reduced staff stress when confronted with a patient whose brain was swelling.

Below we describe the elements of Circle Up and how to implement it, and we report on its impact in early use.

**The Circle Up system of briefing, peer support, and debriefing**

The team connection and tone for the shift are framed by a briefing and a debriefing and reinforced by check-ins throughout the day. Briefings coordinate care at the beginning of each shift and debriefings promote reflecting, learning, and peer support at the end (see Figure 1). Circle Up briefings and debriefings are different from traditional care team communication, both in content and participation. Unlike patient handoffs, which are usually nurse-nurse or doctor-doctor conversations, Circle Up briefings and debriefings aim to include the entire team of clinicians and staff for the shift. Unlike rounds, these are 10-15 minute (or less) conversations which are not isolated to details regarding individual patients. Instead, these conversations develop a situational overview and plan for the shift. They emphasize team communication practices and their effect on patient care and individuals on the team.
Circle Up Workflows Example

Unlike patient handoffs, which are usually nurse-nurse or doctor-doctor conversations, Circle Up briefings and debriefings aim to include the entire team of clinicians and staff for the shift."

Circle Up involves three primary activities:

1) Team briefing shortly after beginning a shift or prior to a procedure to connect and establish and optimize a work plan. In the briefing one might hear “Two respiratory therapists are out sick. We only have two therapists for 60 patients on this floor. Here’s an idea for how to manage today. Let’s talk about it.”

2) Team leader and peer check-ins to offer support or just listen. One might hear “Getting moved to a new unit with a new team is tough, how are you doing?”

3) Team debriefing before the end of a shift to reflect on successes and difficulties, and to initiate adaptations and solutions (See Figure 2). In the debriefing one might hear “Reactions to today?” [discussion] “What helped your team work well together?” [discussion] “How could our work be 1% better?” [discussion] “How did the shift affect you personally?”

Examples of information team might need:
- We have a new clinician to patient ratio; new protocols
- 20 new ventilators just arrived
- We have new PPE guidelines
- We have new guidelines for cleaning and storing reusable equipment
The leader may be any member of the team who is comfortable in the role and has facilitation skill. In the ICU, for example, the leader could be the attending physician, nurse manager or educator, or respiratory therapist. The debriefing—geared towards learning, reflection, and support—may be led by a facilitator who is not on the care team, such as a social worker or other trained debriefer. A neutral leader may make it easier to raise communication issues, and since the leader is unaware of the problems of the shift, they can explore issues among the entire team instead of being tempted to solve problems or prematurely end the discussion of a familiar issue raised before diverse perspectives are heard.

Briefing

Briefings support high quality work by clarifying and aligning roles and expectations across the team. Multi-directional communication and perspective-sharing can also promote relationships, problem-solving, and a culture of support and learning. Circle Up briefings allow the team to see who they are working with and connect, review clinical needs for the day, and anticipate and prepare for challenges. A Circle Up briefing includes:

- A greeting, introductions, and an explicit invitation by the leader to speak up
• Updates on care-related protocols and processes
• Invitation to share concerns or anticipated challenges
• Brief mental rehearsals\textsuperscript{25} or walkthrough of new or complex procedures to be done
• Encouragement to support each other using check-ins

**Proactive peer support and micro check-ins**

An effective program to mitigate stress and trauma is proactive—not relegated to fixing broken clinicians after a difficult event. Circle Up “micro check-ins” are \textit{ad hoc} informal peer support\textsuperscript{26} encounters interwoven with work. The principles behind micro check-ins include invitation to talk, use of empathy and exploring (vs only advising) and listening to understand before determining how to support. The supporter is not tasked with “fixing” their colleague or only addressing the problem at hand. Instead they are there to listen, validate, clarify, and facilitate follow-up if necessary with the goal of supporting resilience and the ability of each team member to continue their contribution to high-quality care. There are free, publicly-available, open-access models\textsuperscript{27,28} to guide interactions of this type. The mnemonic “GIVE,\textsuperscript{27}” for example, is a tool for offering a skilled, empathic response to emotion: \textbf{G}et that emotion is present and requires listening and connection, \textbf{I}dentify what they might be feeling, \textbf{V}alidate by acknowledging feelings, and \textbf{E}xplain to understand what might be driving the emotion expressed.

\begin{quote}
\textit{Emotional support for clinicians is not simply a “nice thing to do;” it is practical because it supports the clinician’s continued participation on the healthcare team, rather than calling in sick, quitting, or leaving the profession.}"
\end{quote}

Emotional support for clinicians is not simply a “nice thing to do;” it is practical because it supports the clinician’s continued participation on the healthcare team, rather than calling in sick, quitting, or leaving the profession. Emotional support for clinicians can be conceptualized as a continuum from informal peer support, to formal peer support, to mental health treatment. Clinicians most want support from their colleagues rather than from mental health practitioners, particularly during highly stressful professional circumstances.\textsuperscript{12,26} The foundation of peer support is giving focused presence to our colleagues, something we rarely experience. Informal peer support can normalize and destigmatize discussing emotions, strengthen team relationships, and identify team members who might benefit from formal peer support or other resources.

Check-ins do not replace, but are complementary to, formal peer support involving trained practitioners. Trained peer supporters typically have advanced communication skills and may assist with coping strategies and referrals to counseling services.
Debriefing

The debriefing starts with the team reflecting on work processes and communication during the shift. Debriefings also provide a pathway to discuss the emotional impact of providing care.

Circle Up debriefings may include these elements:

- Greeting/introductions/invitation to speak up and share one’s point of view
- Discussion of successes and ideas for improvement
- Capturing action items to improve future care
- Check in on emotions/support for team members
- Expression of appreciation for the team’s work

Implementation and key tips for success

Figure 3 describes essential steps for implementing Circle Up. It requires a guiding team of local and organizational leaders that understands the value of the intervention and can help operationalize and sustain it. This process begins with the creation of a vision for the program and its impact on individuals, teams, and the organization. This guiding group of sponsors and leaders includes administrative, clinical, and safety-quality staff with interest and accountability for sustaining the at-risk healthcare workforce, as well as authority to schedule and enable participation in Circle Up activities.

FIGURE 3

Circle Up Implementation Process

Source: Rock et al, Center for Medical Simulation
NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society

The budget for implementing Circle Up includes funding for consulting (or internal resources) to select and guide the leadership team, training to prepare facilitators for briefing-debriefing, and funding or dedicated staff time to capture and communicate process improvement ideas that emerge from Circle Up activities. A robust example of these post-debriefing follow up activities and their impact is described by Rose and team.29
Circle Up briefings and debriefings include a team member scribe to capture knowledge and concerns from team discussion that can be shared with other team members as well as “up” to organizational leadership. Without follow-through on these insights, colleagues quickly become discouraged and disengage from the process. When clinicians see that their ideas are heard and implemented, it drives a virtuous cycle of increasing engagement. Also vital to sustained engagement is normalizing expressing appreciation of each other, and mutual support for coping with the demands of care.

It can be daunting to implement a new group conversation and there will be day-to-day variations in feasibility and perceived value. We have learned that acknowledging and linking to communication processes already in place (e.g. huddle) is helpful. One measure to lower the threshold for initiating Circle Up may be a preliminary implementation among individual professional teams (e.g., nurses) or to brief and debrief a procedure or care episode (as in Figure 2).

Key factors for making briefings and debriefings successful include: short duration; convenient location and a layout that promotes conversation (all sitting or all standing where people can hear each other); time selection that minimizes interference with workflow (avoiding change-of-shift report and clinical tasks); recognition that patient care may preclude participation; visible leadership support. Leveraging an existing patient-focused team conversation, such as a morning huddle, and adapting it to incorporate interprofessional communication and connection will promote the teamwork and support elements without burdening clinicians and staff with additional meetings. Any meeting that pauses clinical work in a continuous patient care environment, such as inpatient or critical care units, is a disruption. Choosing a time that is the least disruptive and captures the most people will facilitate participation. One unit successfully conducted daily debriefings from 4:00-4:10PM because the attending shift changed at 5:00PM and the nursing shift changed at 7:00PM. This time was chosen to minimize interference with afternoon procedures and avoid conflicting with end-of-shift documentation and transition of care. Participants often brought a coffee and expressed appreciation for the “break and a chat” mid-afternoon.

“Leveraging an existing patient-focused team conversation, such as a morning huddle, and adapting it to incorporate interprofessional communication and connection will promote the teamwork and support elements without burdening clinicians and staff with additional meetings.”

It may seem impossible to add anything into an already busy day, or unnecessary to conduct these conversations daily. Buy-in is facilitated by including at least one champion among nursing and medical leadership to motivate and organize their group’s participation. In our experience the daily conversations are quickly appreciated and embraced. Daily briefings are described by participants as promoting connection and a “jolt of fun” to start a shift. Participants are grateful for a short debrief to transition home after a difficult shift, saying even a few minutes of discussing challenges and feelings among the group is “like a giant exhale” and a way to “doff the day.” Since clinical work may preclude participation, scheduling debriefings daily will allow more clinicians...
to participate. The composition of teams changes frequently, and people tend to discuss issues relevant to the current shift, making daily debriefs important to capture those issues and include the involved personnel in the conversation.

**Early results**

In this section we introduce preliminary self-reported data from Circle Up instances, implications, and recommendations for implementation.

We collected and analyzed data from the experience of eight units (including Intensive Care, Emergency Departments, and Labor and Delivery) across five hospitals in the United States, Spain, and South America. We interviewed Circle Up leaders and participants and used thematic analysis to identify the themes presented in Figure 4. These preliminary data suggest that Circle Up activities influence process improvement, speaking up, sense of agency, emotional support, and teamwork. Specifically, participants report greater interprofessional peer connectedness and less psychological distress. Those who actively helped others through the “citizenship behaviors” of check-ins experienced direct benefit for themselves in addition to feeling good about helping others. Some reported a flattening of the traditional hierarchy and a stronger sense of trust among the team. Specifically, participants reported that checking in throughout the workday and during debriefings conveyed a sense of caring and that the invitation to share concerns made them feel encouraged to speak up more throughout the day and with colleagues they would not normally approach. Descriptions of early experiences with Circle Up indicate that it offers a proactive, rather than reactive, process of peer support that seems to work synergistically with clinical process improvements.
**Discussion and conclusion**

Circle Up is a framework of supportive and adaptive interactions that fill an important void. Our preliminary data indicate that the combination of peer support and process improvement disrupts cycles of fear, uncertainty, and the moral distress of worrying if one is providing adequate care. Circle Up is designed to transform ineffective and demoralizing communication cycles into productive ones that enhance control and meaning and promote an esprit de corps that supports ongoing process improvement and community.¹⁹

While there is high face validity and widespread belief by clinicians that briefing and debriefing is important, it is not widely practiced.³² Preliminary data and experience with Circle Up tracks with diverse clinical briefing and debriefing programs that have demonstrated a greater sense of connectedness, a reduction in overall stress, a commitment to the well-being of others, improved work efficiency, process outcomes, and contributions to reductions in patient mortality.²⁹,³³-³⁵ Circle Up application also tracks with research that opportunities to reflect in debriefing appears to mitigate moral distress.³⁶
The “Circle Up” framework of briefing, peer check-ins and debriefing is simple, low cost, and broadly applicable. A key ingredient is pairing high standards for workflow excellence with caring and high regard for our patients and for each other. This commitment to pairing excellence with caring and enacting that at predictable moments during a shift promotes a “safe container” where clinicians can examine their daily practice, and learn to improve it. The process also strengthens the practice of assuming the best of each other. We hope this may point the way for other initiatives that use reflection on daily work as a source of meaning, growth and joy.

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References

1. Grasselli G, Pesenti A, Cecconi M. Critical Care Utilization for the COVID-19 Outbreak in Lombardy, Italy: Early Experience and Forecast During an Emergency Response. JAMA. 2020;323(6):1545-6

2. Richardson S, Hirsch JS, Narasimhan M. Presenting Characteristics, Comorbidities, and Outcomes Among 5700 Patients Hospitalized With COVID-19 in the New York City Area. JAMA. 2020;323(6):2052-9

3. Nembhard I, Burns L, Shortell S. Responding to Covid-19: Lessons from management research. NEJM Catalyst.

4. Maunder R, Hunter J, Vincent L. The immediate psychological and occupational impact of the 2003 SARS outbreak in a teaching hospital. CMAJ. 2003;168(6):1245-51

5. Maunder RG, Lancee WJ, Balderson KE. Long-term psychological and occupational effects of providing hospital healthcare during SARS outbreak. Emerg Infect Dis. 2006;12(6):1924-32

6. Wu AW, Connors C, Everly GS. COVID-19: Peer Support and Crisis Communication Strategies to Promote Institutional Resilience. Ann Intern Med. 2020;172(6):822-3

7. Carroll JS, Rudolph JW, Hatakenaka S. Learning from experience in high-hazard industries. Res Organ Behav. 2002;24(6):87-137

8. Roussin CJ, MacLean T, Rudolph JW. The Safety in Unsafe Teams: A Multilevel Approach to Team Psychological Safety. J Manage. 2016;42(6):1409-33

9. Roussin CJ, Weinstock P. SimZones: An Organizational Innovation for Simulation Programs and Centers. Acad Med. 2017;92(6):1114-20

10. Minehart RD, Pian-Smith MC, Walzer TB. Speaking across the drapes: communication strategies of anesthesiologists and obstetricians during a simulated maternal crisis. Simul Healthc. 2012;7(6):166-70

11. Forneris S, Fey M. Critical Conversations: the NLN Guide for Teaching Thinking. Washington, DC: National League for Nursing; 2018.

12. Rudolph JW, Raemer DB, Simon R. Establishing a safe container for learning in simulation: the role of the presimulation briefing. Simul Healthc. 2014;9(6):339-49

13. Rudolph JW, Simon R, Dufresne RL, Raemer DB. There’s no such thing as “nonjudgmental” debriefing: a theory and method for debriefing with good judgment. Simul Healthc. 2006;1(6):49-55

14. Hu YY, Fix ML, Hevelone ND. Physicians’ needs in coping with emotional stressors: the case for peer support. Arch Surg. 2012;147(6):212-7

15. Gittell JH. High Performance Healthcare: Using the Power of Relationships to Achieve Quality, Efficiency and Resilience. 1 ed. New York: McGraw-Hill; 2009.
16. Edmondson AC. Teaming: How organizations learn, innovate, and compete in the knowledge economy. San Francisco: Jossey Bass; 2012.

17. Lam CF, Wan WH, Roussin CJ. Going the extra mile and feeling energized: An enrichment perspective of organizational citizenship behaviors. J Appl Psychol. 2016;101(6):379-91

18. Giddens A. Central problems in social theory: Action, structure, and contradiction in social analysis. Berkeley: University of California Press; 1979.

19. Groves PS, Meisenbach RJ, Scott-Cawiezell J. Keeping patients safe in healthcare organizations: a structuration theory of safety culture. J Adv Nurs. 2011;67(6):1846-55

20. Swensen SJ. Esprit de Corps and Quality: Making the Case for Eradicating Burnout. J Healthc Manag. 2018;63(6):7-11

21. Perlo J, Balik B, Swensen S, et al. IHI Framework for Improving Joy in Work. IHI White Paper. Cambridge, MA: Institute for Healthcare Improvement; 2017.

22. Chaplin LR, Molloy L, Wright F. Implementation of Situational Awareness in the Pediatric Oncology Setting. Does a ‘huddle’ Work and Is it Sustainable? J Pediatr Nurs. 2020;50(6):75-80

23. Purdy E, Alexander C, Shaw R, Brazil V. The team briefing: setting up relational coordination for your resuscitation. Clin Exp Emerg Med. 2020;7(6):1-4

24. Goldenhar LM, Brady PW, Sutcliffe KM, Muething SE. Huddling for high reliability and situation awareness. BMJ Qual Saf. 2013;22(6):899-906

25. Driskell JE, Copper C, Moran A. Does mental practice enhance performance? J Appl Psychol. 1994;79(6):481-92

26. Shapiro J, Galowitz P. Peer Support for Clinicians: A Programmatic Approach. Acad Med. 2016;91(6):1200-4

27. Rock L. Don’t answer feelings with facts. British Medical Journal; https://blogs.bmj.com/bmj/2020/04/13/laura-k-rock-dont-answer-feelings-with-facts/.

28. Talk2Support. Center for Medical Simulation, 2020. (Accessed May 1, 2020, at https://harvardmedsim.org/resources/talk2support/.)

29. Schmutz JB, Eppich WJ. Promoting Learning and Patient Care Through Shared Reflection: A Conceptual Framework for Team Reflexivity in Health Care. Acad Med. 2017;92(6):1555-63

30. Rose MR, Rose KM. Use of a Surgical Debriefing Checklist to Achieve Higher Value Health Care. Am J Med Qual. 2018;33(6):514-22

31. Boyatzis RE. Transforming Qualitative Information: Thematic Analysis and Code Development. Thousand Oaks: Sage; 1998.
32. Sandhu N, Eppich W, Mikrogianakis A, Grant V, Robinson T, Cheng A. Postresuscitation debriefing in the pediatric emergency department: a national needs assessment. CJEM. 2014;16(6):383-92

33. Neily J, Mills PD, Young-Xu Y. Association between implementation of a medical team training program and surgical mortality. JAMA. 2010;304(6):1693-700

34. Ramsay G, Haynes AB, Lipsitz SR. Reducing surgical mortality in Scotland by use of the WHO Surgical Safety Checklist. Br J Surg. 2019;106(6):1005-11

35. Tannenbaum SI, Cerasoli CP. Do team and individual debriefs enhance performance? A meta-analysis. Hum Factors. 2013;55(6):231-45

36. Browning ED, Cruz JS. Reflective Debriefing: A Social Work Intervention Addressing Moral Distress among ICU Nurses. J Soc Work End Life Palliat Care. 2018;14(6):44-72