# CLINICAL DEBRIEFING DATA INSTRUMENT / DO NOT PLACE OR SCAN INTO PATIENT CHART

All information discussed and recorded in the Clinical Debriefing process is developed under PHL 2805-j as part of a medical malpractice prevention program and is confidential and not subject to disclosure under PHL 2805-m.

» Did this event have the potential to be a *psychologically traumatic event* to debrief? If yes, please state "This seemed to be a very tough case for everyone involved. We are going to hold off on our discussion for now. Please feel free to find me later." Initiate predefined support mechanisms.

► **Introduction Key Points (Facilitator):** Safe Environment, Debrief Length/Objectives, Permission to Leave

| Event Summary | | | | Participants Present for Debrief | | |
|---|---|---|---|---|---|---|
| Resuscitation Team Leader: | ☐ Attending ☐ Resident ☐ Nurse | | | Physicians | EM Attendings | ☐ Primary ☐ Secondary (How Many _____ ) |
| Facilitators: | | | | | EM Residents | ☐ Primary ☐ Secondary (How Many _____ ) |
| Date: | Resuscitation End Time: | | | | Rotating Residents | ☐ How Many _____ |
| Debrief Start Time: | Time Spent Debriefing: | | | | Consultants | ☐ Cardiology ☐ General Surgery<br>☐ Anesthesia ☐ Critical Care<br>☐ ENT ☐ OB<br>☐ GU ☐ Ortho<br>☐ Pediatric ☐ Trauma<br>☐ Neurology ☐ Other _____ |
| Patient Outcome | ☐ Alive ☐ Expired | | | | | |
| Potential second victims? | ☐ Yes ☐ No | | | Registered Nurses | | ☐ Primary ☐ Charge ☐ Other (How<br>☐ Recorder ☐ Triage Many _____ ) |
| Major Safety Issues Identified? | ☐ Yes ☐ No | | | ALP's | | ☐ PA (How Many _____ ) ☐ NPs (How Many _____ ) |
| **Clinical Case Descriptors** *(check all that apply)* | ☐ Geriatric (>65)<br>☐ Adult (18-65)<br>☐ Peds (<18)<br>☐ Pregnant | ☐ Trauma<br>☐ Respiratory Distress<br>☐ Stroke<br>☐ STEMI<br>☐ SEPSIS<br>☐ Code / Arrest | ☐ Dysrhythmia<br>☐ Hypotension<br>☐ Overdose<br>☐ AMS<br>☐ Environmental<br>☐ Other:_____ | Allied Health Professionals | | ☐ Patient Care Technician<br>☐ Respiratory Technician<br>☐ Radiology Technician<br>☐ EKG Technician<br>☐ Prehospital Practitioner |
| | ☐ EMS Notification<br>☐ Ambulance Triage<br>☐ Walk-In Triage | | | Administrators | | ☐ Nursing (How Many _____ )<br>☐ Physician (How Many _____ )<br>☐ Other (How Many _____ ) |
| **Critical Interventions** *(check all that apply)* | ☐ Intubation / Cric<br>☐ Noninvasive Ventilation<br>☐ Chest Compressions<br>☐ Defibrillation / Cardioversion | ☐ Activated Alert ("33", Trauma, etc.)<br>☐ Chest Tube<br>☐ I/O<br>☐ Central Line<br>☐ Vasopressors | ☐ Rapid Infuser<br>☐ Active Cooling / Rewarming<br>☐ Labor and Delivery<br>☐ Transfusion<br>☐ TPA | Other Support Staff | | ☐ Security<br>☐ Patient Representative / Advocate / Expeditor<br>☐ Pharmacist<br>☐ Social Work<br>☐ Religious Support (Priest, rabbi, etc.)<br>☐ Registration / Clerks<br>☐ Scribe<br>☐ Interpreter |

| High Performance Teamwork Discussion<br>(mark subcategories, and briefly describe) | | Safety & Systems Issues<br>(list identified systems issues in most appropriate category with brief description; also list and describe any potential solution) |
|---|---|---|
| In the observed event, did you observe a *threat to patient safety, near miss, medical error, or other high risk event?* | | ☐ Yes          ☐ No |
| **Leadership:** | | ☐ Medications: |
| | | ☐ Environment/Room: |
| ☐ Decisive<br>☐ Big Picture kept in focus<br>☐ Fosters Conflict Resolution<br>☐ Flatten hierarchy<br>☐ Manages resources<br>☐ Role Models<br>☐ Team Leader is recognized | ☐ Uses Briefs and Huddles<br>☐ Facilitates information sharing<br>☐ Gives/Solicits Feedback<br>☐ Ensures Role Clarity<br>☐ Delegation<br>☐ Maintains calm atmosphere<br>☐ Balance workload within team | ☐ Devices/Equipment: |
| | | ☐ Staffing: |
| **Communication:** | | ☐ Protocols: |
| ☐ Appropriate depth of volume<br>☐ Call outs – specific and timely<br>☐ Closed Loop / Check Backs<br>☐ Organized information exchange (i.e. "SBAR" or similar) | ☐ Organized Handoffs to other providers<br>☐ Team members request/provide situational updates<br>☐ Speak with patient / family | ☐ Knowledge/Decision Making: |
| **Situational Awareness:** | | ☐ Other Category: |
| ☐ Reassess patient status<br>☐ Critical actions timed appropriately<br>☐ Adapt to resource availability<br>☐ Ask for clarification | ☐ Aware of limitations/call for help<br>☐ Help overworked colleagues<br>☐ Role flexibility<br>☐ Call attention to potential errors | Solution #1) |
| **Mutual Support:** | | Solution #2) |
| ☐ Task assistance<br>☐ Gives Feedback<br>☐ Perform conflict resolution | ☐ Advocate for patient<br>☐ Assert corrective actions<br>☐ Use critical language to voice concerns (i.e. "CUS" or similar) | Solution #3) |

## Facilitator Reference Materials

**Example of Scripted Introduction (Facilitator):**

► "Thank you all for taking a few minutes to discuss how we worked together. Specifically, the purpose is to provide a forum for an honest, respectful, and educational discussion of our care during the resuscitation. We are expecting the discussion to last about 10 minutes, and will focus on reviewing the events of the resuscitation, systems related issues, and team performance. During this time, if an emergent patient care issue develops, please feel free to attend to it. Everyone's participation is welcome and encouraged."

► "Let's start by introducing ourselves. Please state your name, clinical position, and role in the resuscitation. Can we have the Team leader please give us a summary of the clinical event."

| *Debriefing Strategies* | | Scripted Statements (Facilitator): |
|---|---|---|
| **Advocacy:**<br>Identify performance gaps and desired actions. *Be objective*.<br><br>**Examples:**<br>I noticed that we did/ did not…..<br>I saw that we did/ did not….<br>I heard you/someone say that…<br>I was concerned to see that we did/did not….<br>I was impressed by how we did/ did not…. | **Inquiry:**<br>Questions for reflection in spirit of true curiosity. *Be genuine.*<br><br>**Examples:**<br>How did you/we see it?<br>I was wondering what your/our thoughts are?<br>What were you/we thinking at the time?<br>Help me understand how you/we decided that?<br>How could you/we have done that differently?<br>How could you/we have improved? | **Example Opening Statement for Systems Issues:**<br>"Let's discuss any potential systems issues encountered in this case" -- Give examples if needed "Equipment, medications, protocols, etc."<br>    Step 1: Allow for clinicians to discuss<br>    Step 2: Utilize a debriefing strategy to deepen discussion<br>    Step 3: Engage Clinicians in proposing possible solutions<br><br>**Example Opening Statement for Teamwork Discussion:**<br>"Let's discuss our teamwork"<br>    Step 1: Allow for clinicians to discuss<br>    Step 2: Utilize a debriefing strategy to deepen discussion<br>    Step 3: Use teamwork bullets as anchors to deepen discussion<br>**Best Practice Tips:** Link specific events to specific team behaviors<br>    Avoid speaking in general terms |
| **Plus (+)**<br>What went well? | **Delta (Δ)**<br>What could have been done better? | *Notes:*<br>☐ Log systems issues identified by most appropriate category<br>☐ Track education of team skills by marking of the types of specific tools/behaviors that were discussed. Note, this is not an assessment of how the team did, but rather the teaching points made (for ex, can be "positive" or "critical" feedback)<br>☐ For validated users, complete Modified Mayo Teamwork Assessment<br>*(only when not directly involved with patient care – do not Self-Assess)* |
| **Discuss:** Why did it go well? Why do you feel it could have been better? What would you do differently if you had to do it all over again? | | |

**Example of Scripted Closure (Facilitator):**

**Scripted Closure:** In an effort to respect everyone's time, I'd like to wrap up by summarizing some of our "take-away" points - *Summarize in one minute and relate to future goals – Use the SMART format (Specific, Measurable, Achievable, Realistic, and Timely)*. Thanks again for taking the time to discuss ways we can improve patient care. If anyone wants to continue the conversation off line, please feel free to find me later.