

Initial Phase - Open Ended Questions (5-10 minutes):

1. How did that scenario make you feel?
2. What was the clinical situation for this newborn?
3. What roles were identified within the team and how?
4. How effective was communication as a team?

Middle Phase Specific Questions Based on Learning Objectives (20 minutes):

Learning Objective	Identification of Performance Gaps OR Appreciation of Effective Actions	Determining the Frame		Teaching Points & Notes
		Rationale / Advocacy	Open Ended Question/ Inquiry	
Demonstrate how to adequately stock and use NRP equipment in the ED	<p>I noticed that there was a failure to gather or effectively use all equipment and supplies needed to resuscitate this ill newborn... OR</p> <p>I liked how you were able to gather and effectively use all equipment and supplies needed to resuscitate this ill newborn...</p>	<p><i>I was concerned that could delay your ability to perform necessary interventions during resuscitation</i> OR</p> <p><i>I thought that helped you be ready for each step in neonatal resuscitation avoiding unnecessary delays</i></p>	<p><i>How do you see it?</i> OR</p> <p><i>What are your thoughts?</i> OR</p> <p><i>What were you thinking at the time?</i> OR</p> <p><i>Help me understand how you decided that?</i></p>	<p>Team gathered and utilized all equipment/supplies for resuscitation:</p> <ul style="list-style-type: none"> ● Warmer on, APGAR timer ● Bulb suction, Towels ● Bag, Mask, Oxygen ● Pulse ox ● Intubation supplies ● <u>Meconium aspirator</u> ● Umbilical line supplies ● Code Meds (epi)

<p>Demonstrate the initial steps of NRP: D/S/S, PPV and MR.SOPA.</p>	<p>I was concerned that the team did not perform the initial steps of NRP properly (PPV for HR <100 after 30 seconds of D/S/S)... OR I was impressed by the team's ability to recognize that the HR <100 at 30 seconds of life and quickly initiated PPV</p>	<p><i>I was concerned that a delay in PPV in an apneic baby with HR <100 can make resuscitation less successful</i> OR <i>I was thinking that helped you be efficient and effective in successfully resuscitating the newborn</i></p>	<p><i>How do you see it?</i> OR <i>What are your thoughts?</i> OR <i>What were you thinking at the time?</i> OR <i>Help me understand how you decided that?</i></p>	<p>If the team had difficulty with proper PPV, inquire about the steps of MR. SOPA to help achieve effective PPV:</p> <ul style="list-style-type: none"> ● Mask adjustment ● Reposition head ● Suction ● Oxygen ● Pressure (adjust) ● Alternative airway
<p>Identify and describe how to follow the most important indicator of effective ventilation (heart rate)</p>	<p>I was concerned that the team did not adequately follow the heart rate as a measure of effective ventilation... OR I was impressed by the team's ability to recognize that the infant had persistent bradycardia (HR <100) after 30sec of effective PPV and started effective ventilations...</p>	<p><i>I was concerned that this led to inappropriate feedback about ventilation</i> OR <i>I was impressed that closely following the heart rate enabled you to measure the effectiveness of PPV.</i></p>	<p><i>How do you see it?</i> OR <i>What are your thoughts?</i> OR <i>What were you thinking at the time?</i> OR <i>Help me understand how you decided that?</i></p>	<p>Review importance of following HR as an effective means of PPV</p> <p>Review the most effective and timely way to follow HR (ECG leads)</p>
<p>Ability to assign roles clearly during precipitous patient arrival.</p>	<p><i>It appeared to me that the team had difficulty identifying and distributing roles during this resuscitation</i> OR <i>I noticed that you quickly identified roles and responsibilities during this resuscitation</i></p>	<p><i>I was thinking that might have made it difficult to perform an effective resuscitation without clear roles and responsibilities</i> OR <i>I had the impression that delineating clear roles and responsibilities helped you provide an effective resuscitation</i></p>	<p><i>How do you see it?</i> OR <i>What are your thoughts?</i> OR <i>What were you thinking at the time?</i> OR <i>Help me understand how you decided that?</i></p>	<p>Roles Needed:</p> <ul style="list-style-type: none"> ● Team Leader ● Airway ● Cardiovascular ● Meds/code cart ● Access ● Documenter ● Others? <p>Effective Role Clarity</p> <ol style="list-style-type: none"> 1) Team member roles and tasks are identified by team member

				or team leader (Each Role has One Person) 2) Team members focus on their individual roles 3) Team demonstrates effective handoff of roles within team
Ability to use effective communication, specifically, closed loop communication	<i>I noticed that the team appeared to have difficulty communicating effectively and I did not hear good closed loop communication:</i> OR <i>I heard the team use effective techniques communication including good closed loop communication:</i>	<i>I am concerned that failure to communicate effectively leads to mistakes and confusion...</i> OR <i>It seemed to me that helped the team communicate more effectively and prevent errors such as medication errors...</i>	<i>How do you see it?</i> OR <i>What are your thoughts?</i> OR <i>What were you thinking at the time?</i> OR <i>Help me understand how you decided that?</i>	Point out on video an example of effective or ineffective closed loop communication Also discuss how using closed loop communication can help with prevention of medication errors

Systems Evaluation (10 minutes):

Debrief Objective	Plus/Delta Debrief		Categories of Latent Safety Threats to Explore	Debrief Tips
	Plus	Delta		
<p>In this section of the debrief, faculty leads a learner driven discussion of strengths and latent safety threats (LST) found in their system.</p>	<p><i>What do you think went well?</i> OR <i>What was easy for your team? Why?</i></p>	<p><i>What could have gone better?</i> OR <i>What was challenging for your team?</i></p>	<p>Tools/Technology/Equipment Resources: Usability, accessibility, familiarity, design, variability, availability, quality, labeling, training</p> <p>Internal Environment/Room Layout: Clutter, layout, interruptions, ergonomics, distractions, room set up, noise, lighting, signage, wayfinding</p> <p>Processes/Tasks: Policies and Procedures, staffing levels, handoffs, workflow, staff experience, time of day/night/weekend, task complexity, sequence and/or ambiguity</p> <p>People: Staffing/Role Clarity/Responsibilities, poor training on equipment, fatigue, time of day/night, work overload, compliance with policies, communication, shared mental model, teamwork.</p>	<ul style="list-style-type: none"> • To clearly catalogue LST's, draw two columns (Plus/delta) on white board or butcher block paper. • Assign each LST a category to discover patterns. • Begin a discussion on potential mitigation plans for each LST. • Consider assigning responsible parties to work on specific LST's after the debrief. • For more thorough categorization and prioritization of LST, consider building a health care failure mode effects analysis table.

Ending Phase: Wrap Up and Summary of Key Take Home Messages (5-10minutes)

1. How will this simulation impact your performance next time?
2. What are the main take home messages you will apply to a similar patient you see in the future?
3. What did you learn?