Scripted Debrief- NeoImPACTS
Premature delivery in ED or L&D

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IMPROVING PEDIATRIC ACUTE CARE THROUGH SIMULATION

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	I noticed that there was a failure to gather or effectively use all equipment and supplies needed to resuscitate this ill newborn… **OR** I liked how you were able to gather and effectively use all equipment and supplies needed to resuscitate this ill newborn…	*I was concerned that could delay your ability to perform necessary interventions during resuscitation* **OR** *I thought that helped you be ready for each step in neonatal resuscitation avoiding unnecessary delays*	*How do you see it?* **OR** *What are your thoughts?* **OR** *What were you thinking at the time?* **OR** *Help me understand how you decided that?*	Team gathered and utilized all equipment/supplies for resuscitation: ● Warmer on, APGAR timer ● Polyethylene bag (or wrap) and thermal mattress ● Hat ● Bulb suction, Towels ● Bag, Mask, Oxygen ● Pulse ox ● Intubation supplies ● Meconium aspirator ● Umbilical line supplies ● Code Meds (epi)

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Demonstrate the initial steps of NRP: D/S/S, PPV and MR.SOPA.	I was concerned that the team did not perform the initial steps of NRP properly for a preterm infant (Polyethylene bag, hat, cardiac leads and pulse ox to right wrist, 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 initiate NRP for a preterm infant (Polyethylene bag, hat, cardiac leads and pulse ox to right wrist, PPV for HR <100 after 30 seconds of D/S/S PPV)	*I was concerned that a delay in PPV in an apneic baby with HR <100 can make resuscitation less successful* OR *I was thinking that helped you be efficient and effective in successfully resuscitating the newborn*	*How do you see it?* OR *What are your thoughts?* OR *What were you thinking at the time?* OR *Help me understand how you decided that?*	If the team had difficulty with care of a preterm infant and PPV, inquire about the steps of MR. SOPA to help achieve effective PPV: ● Mask adjustment ● Reposition head ● Suction ● Oxygen ● Pressure (adjust) ● Alternative airway
Ability to secure an airway with intubation after prolonged poor respiratory effort.	I was surprised that the team did not successfully intubate this sick newborn OR I was impressed by the team's ability to appropriately intubate this sick newborn	*I think in situations where an infant does not adequately respond to PPV, intubation promotes a smoother resuscitation and eliminates the possibility of poor ventilation* **OR** *I agree when an infant does not adequately respond to PPV intubation provides a smoother resuscitation and eliminates the possibility of poor ventilation*	*How do you see it?* **OR** *What are your thoughts?* **OR** *What were you thinking at the time?* **OR** *Help me understand how you decided that?*	Review indication and timing of intubation per NRP guidelines
Ability to assign roles clearly during precipitous patient arrival.	*It appeared to me that the team had difficulty identifying and distributing roles during this resuscitation* OR *I noticed that you quickly identified roles and responsibilities during this resuscitation*	*I was thinking that might have made it difficult to perform an effective resuscitation without clear roles and responsibilities* OR *I had the impression that delineating clear roles and responsibilities helped you*	*How do you see it?* **OR** *What are your thoughts?* **OR** *What were you thinking at the time?* **OR**	Roles Needed: ● Team Leader ● Airway ● Cardiovascular ● Meds/code cart ● Access ● Documenter

		provide an effective resuscitation	*Help me understand how you decided that?*	• Others? Effective Role Clarity 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 noticed that the team appeared to have difficulty communicating effectively and I did not hear good closed loop communication:* OR *I heard the team use effective techniques communication including good closed loop communication:*	*I am concerned that failure to communicate effectively leads to mistakes and confusion…* **OR** *It seemed to me that helped the team communicate more effectively and prevent errors such as medication errors…*	*How do you see it?* **OR** *What are your thoughts?* **OR** *What were you thinking at the time?* **OR** *Help me understand how you decided that?*	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

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Systems Evaluation (10 minutes):

Debrief Objective	Plus/Delta Debrief		Categories of Latent Safety Threats to Explore	Debrief Tips
	Plus	Delta		
In this section of the debrief, faculty leads a learner driven discussion of strengths and latent safety threats (LST) found in their system.	*What do you think went well?* **OR** *What was easy for your team? Why?*	*What could have gone better?* **OR** *What was challenging for your team?*	**Tools/Technology/Equipment Resources:** Usability, accessibility, familiarity, design, variability, availability, quality, labeling, training **Internal Environment/Room Layout:** Clutter, layout, interruptions, ergonomics, distractions, room set up, noise, lighting, signage, wayfinding **Processes/Tasks:** Policies and Procedures, staffing levels, handoffs, workflow, staff experience, time of day/night/weekend, task complexity, sequence and/or ambiguity **People:** Staffing/Role Clarity/Responsibilities, poor training on equipment, fatigue, time of day/night, work overload, compliance with policies, communication, shared mental model, teamwork.	• 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.

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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?