Scripted Debrief- NRP
Meconium Delivery

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IMPROVING PEDIATRIC ACUTE CARE THROUGH SIMULATION

Initial 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	
Ability to prepare needed equipment and supplies in preparation for resuscitation	**I noticed that there was a failure to anticipate, gather and prepare all needed equipment and supplies needed to resuscitate this critically ill newborn…** **OR** **I liked how you were able to anticipate, gather, and prepare all needed equipment and supplies needed to resuscitate this critically 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 all equipment/supplies in anticipation of a full resuscitation:** • **Warmer on, APGAR timer** • **Bulb suction, Towels** • **Bag, Mask, Oxygen** • **Pulse ox** • **Intubation supplies** • **Meconium aspirator** • **Umbilical line supplies** • **Code Meds (epi)**

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Ability to perform next steps of NRP: D/S/S, PPV and MR.SOPA if needed	**I was concerned that the team did not perform the next 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**	*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 proper 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 perform ETT intubation & meconium aspiration in nonvigorous newborn	**I was concerned that the team did not perform endotracheal intubation and aspiration of meconium per NRP …** **OR** **I liked how you were able to perform endotracheal intubation and aspiration of meconium…**	*I was thinking that could negatively affect your ability to be successful in next steps of neonatal resuscitation* **OR** *I was thinking that was beneficial in next steps of neonatal resuscitation*	***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?***	**Ensure that team performed intubation and aspiration, but did not take too long doing this in an already depressed infant**
Ability to assign roles clearly during a complex resuscitation and difficult conversation	*It appeared to me that the team had difficulty identifying and distributing roles during this code* **OR** *I noticed that you quickly identified roles and responsibilities during this code*	*I was thinking that might have made it difficult to perform an effective resuscitation with a parent in the room* **OR** *I had the impression that helped you provide an effective resuscitation and communicate with the parent*	*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?*	Roles Needed: • Team Leader • Airway • Cardiovascular • Meds/code cart • Access • Documenter • Family Liaison • Others? Effective Role Clarity 1) Team member roles and tasks are identified by team member

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				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 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?*	Review aspects of closed loop communication

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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?
3. What did you learn?