# Team Debriefing Form

|  |  |  |
| --- | --- | --- |
| **Person Completing Form:** | **Title:** | **Date of Emergency/Drill:** |

**Staff who Participated in the Emergency/Drill**

|  |  |  |  |
| --- | --- | --- | --- |
| **Staff Name** | **Role** | **Staff Name** | **Role** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Time Clinical Emergency/Scenario**  **Commenced:** | **Time Clinical Emergency/Scenario**  **Concluded:** | **Length of Time:** |

|  |  |  |
| --- | --- | --- |
| **Type of Clinical Emergency/Drill:** | **Recognition** | **Readiness** |
| **Obstetrical/Neonatal Emergency:**   * Code Blue * ED/OB Trauma * ED/OB/OR Trauma * Emergency airway (Neonatal) * Neonatal Resuscitation * Postpartum Hemorrhage * Prolapsed Cord * Sepsis (maternal) * Shoulder Dystocia * Uterine Rupture * Malignant hyperthermia * Anaphylactoid syndrome of pregnancy    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Describe the Emergency/Scenario:** | * Was there prompt recognition of the emergency/drill (Code blue/Pink called)?   **Hemorrhage**   * PPH risk assessments performed per protocol?   **HTN**   * Elevated BP confirmed with manual cuff?   **Sepsis**   * Oral temp < 96.8°F (36°C) or ≥ 100.4°F (38°C)? * HR > 110 bpm for ≥ 15 minutes? * RR > 24 bpm ≥ 15 minutes?   **Uterine Rupture**   * Loss of fetal station * Acute abdominal pain (severe/persistent)   **Malignant Hyperthermia**   * Muscle rigidity * Elevated end-tidal CO₂ * Hyperthermia | * Was there adequate staffing on the unit? * Was additional emergency staff alerted as required? * Did all staff have adequate clinical knowledge of emergency/scenario and treatment required? * Did all staff know how to access the emergency equipment? * Was the emergency equipment in working condition? |

|  |  |  |
| --- | --- | --- |
| **Response:** (check all that apply) | |  |
| * Was the team mobilized in a timely manner? * Was a clinical lead identified? * Were roles designated appropriately? * Were appropriate protocols and algorithms followed? * Was the safety of patient maintained? * Was the safety of the staff maintained? * Did staff worked as a team to adequately manage the emergency/scenario? * Did staff debrief and review the emergency/scenario? * Was documentation completed? * Was closed loop communication utilized?   **PPH**   * Blood loss quantified? * Blood readily available and administered in a timely manner?   **Code Blue**   * Manual left uterine displacement * Oxytocin &magnesium sulfate discontinued * Fetal heart monitoring devices removed prior to defibrillation   **Respective Maternity Care:** (Check all that apply)  **Prolapsed Cord**   * Manual elevation of presenting part until cesarean birth   **Malignant Hyperthermia**   * Hyperventilate with 100% O₂ ≥ 10L/min * Administer dantrolene or ryanodex * Serial blood gas every 15 minutes * Cool patient rapidly if temp > 102.2°F (39°C) | | **HTN**   * Provider notified (SBP ≥160 mm Hg or DBP ≥110 mm Hg)? * Antihypertensive medication given within one hour of severe range BP? * Antihypertensive medication algorithm followed? * Magnesium sulfate initiated when appropriate?   **Sepsis**   * Provider notified of MAP <65 mm Hg? * IV access obtained and bolus of 1-2 L IV fluid given? * Antibiotics administered ideally within one hour? * Team was conscious of potential bias? * Patient provided informed consent? * Patient and family treated with mutual respect? * Patient had ability to make self-governed decisions about their care * Team was accountable for their actions * Team and patient used shared decision making * Patient treated with dignity |
| **Areas of Opportunity:** (Check all that apply and provide details on page 3) | | |
| * Additional equipment needed * Additional staff training needed * Centralization of equipment (location change) * Clinical staff unsure of what to do (Confusion) * Cooperative planning with responders * Debrief not carried out or documented * Documentation not accurate or complete * Emergency equipment missing or not working * Emergency medications missing or expired | * Ineffective leadership and delegation * Absence of role designation * Ineffective response (staff assigned to respond did not responded in a timely manner/or not at all) * Improve knowledge of emergency equipment * Revise emergency procedures * System improvement for maintenance and checking of equipment * Update emergency supplies * Update/fix emergency equipment * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

|  |  |  |
| --- | --- | --- |
| **Area of Opportunity** | **Action Needed** | **Person Responsible for Follow-up** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |