The Resident Experience with Psychological Safety During Interprofessional Critical Event Debriefings
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Abstract

Resident physicians can benefit from direct interprofessional feedback and shared learning during clinical critical event debriefings. These high-stakes encounters differ from more often studied simulated scenarios; they are complex, varied, and the interprofessional feedback may not have the advantage of an established teacher-learner relationship. This is a qualitative study of emergency medicine resident physicians’ experience of interprofessional feedback during debriefings to further characterize the factors that contribute to or detract from their psychological safety.

The authors interviewed resident physicians, coded transcripts, generated themes, and analyzed the data using a thematic approach. The findings suggest that cultivating a safe learning environment for residents in debriefings involves the following: 1) allowing space for validating statements, 2) supporting strong interprofessional relationships, 3) providing structured opportunities for interprofessional learning, 4) having attendings who model vulnerability and set the tone for honest, specific feedback, 5) standardizing the process of debriefing, 6) rejecting unprofessional behavior, and 7) creating the time and space for the process in the workplace.

In contrast to simulated encounters, debriefing in the clinical setting presents important key differences. Residents needed to overcome competing clinical demands, a lack of dedicated physical space and time, and occasionally a perceived lack of team buy-in to initiate and lead a debriefing session. A resident’s personal need for emotional processing impeded their ability to engage in some cases. Commitment to team improvement and team learning through the debriefing process allowed some residents to overcome these barriers.

The prioritization of self-preservation over engagement in debriefing was a recurrent theme in our interviews. The tension between credibility and vulnerability was present to varying degrees depending on experience, confidence, and relationships. Achievement goal theory and dismantling the traditional hierarchy may facilitate intellectual candor during debriefings. Further research can explore how these specific interventions impact psychological safety and the learning environment.

Introduction

Feedback and debriefing, both experience-informed dialogues or “learning conversations,” have common goals and attributes, but different theoretical roots in medical education literature. Clinical critical event debriefing challenges the “contextual divide between feedback and debriefing, highlighting the overlap in purpose and structure.” This process encourages team and self-reflection with the end goal of incorporating improved behaviors and teamwork.
skills into clinical practice.\textsuperscript{2,3} Resident physicians who lead or participate in critical event debriefings can simultaneously experience direct interprofessional feedback and the shared learning of debriefing. Integrating feedback and debriefing into one standardized interprofessional session may not only be practical but could advance both conversational strategies as educational tools.

Much of the literature on interprofessional feedback after critical events has been conducted in simulated sessions, which differ from critical event debriefings in important ways. Simulated sessions have been coined “safe containers” for learning, with a predictable structure, and trained facilitators.\textsuperscript{4,5} Unlike simulated patient care encounters, critical events in the clinical setting are high stakes, unpredictable, and without protected time and space to debrief. Furthermore, critical event debriefing participants—both the givers and recipients of feedback—have varied relationships and levels of training. Because the clinical team composition is often different from one critical event to the next, interprofessional feedback in critical event debriefings may not have the advantage of an established teacher-learner relationship or educational alliance of traditional resident-teacher feedback that is often present in simulations.\textsuperscript{6}

It is important to understand and optimize the residents’ sense of psychological safety during clinical critical event debriefing and feedback sessions to capitalize on these learning conversations. Dr. Amy Edmonson defines team psychological safety as “a shared belief that the team is safe for interpersonal risk taking.”\textsuperscript{7} In critical event debriefing, team members may take risks by admitting errors or discussing opportunities for individual and team growth in clinical care, procedural skills, communication, or leadership skills. These real-world learning conversations in a team setting benefit from mutual respect, trust in the team, caring for each other as individuals, and confidence in oneself. When learners feel unrestrained from the judgment of the team and the feeling that they need to always project competence, they can fully engage with the learning opportunities, are more productive, and are more satisfied with their learning environment.\textsuperscript{5,6,8-10} On the other end of the spectrum, psychological distress leads to poor workplace relationships, provider burnout, and cognitive barriers to learning.\textsuperscript{5,9} Furthermore, low psychological safety has been shown to be associated with decreased engagement in adverse event reporting.\textsuperscript{11}

When residents, as the primary learners, are a focus of interprofessional feedback in critical event debriefings, they may experience greater benefits from the learning conversation if they have greater psychological safety. This study aims to explore residents’ experiences with psychological safety during debriefings to identify the fragilities and success factors in these dynamic and complex learning conversations.

**Methods**

**Study Design**

We conducted a qualitative study of emergency medicine resident physicians’ experiences of feedback and debriefings in an established critical event debriefing program. We explored the
factors that contributed to the psychological safety of residents during this process. Data were collected from a sample of residents who participated in a debriefing in the previous three months using semi-structured interviews allowing residents to (a) describe their experiences participating in the debriefing sessions, (b) discuss the nature of feedback received, and (c) reflect on factors that made them feel safe during these sessions (Appendix A). The local institutional review board approved the study.

Study Setting
The study was conducted at the University of California San Francisco Fresno (UCSF Fresno) Department of Emergency Medicine at Community Regional Medical Center (CRMC). CRMC is a level one trauma and burn center located in Fresno, CA with an Emergency Department (ED) volume of approximately 110,000 annually. CRMC serves as the main site for the UCSF Fresno Department of Emergency Medicine residency program with forty-four residents spread over four class years. The critical event debriefing program was started in the winter of 2017 as a joint effort between CRMC and UCSF Fresno Department of Emergency Medicine. In addition to the emergency medicine resident physician team leader, these debriefings can include EMS personnel, nurses, technicians, respiratory therapists, social workers, pharmacists, attending physicians, other residents or medical students, and occasionally consultants. They usually occur immediately after a critical event (i.e. cardiac arrest, difficult intubation, unexpected patient decline, precipitous delivery, rare ED procedure, medication or communication error, etc.). Anyone on the team can initiate a debriefing and they are optional. During the debriefing, the team reviews group performance and is prompted to provide specific feedback to the resident physician team leader. A standardized critical event debriefing form is used to guide the session (Appendix B). Each session lasts approximately five to fifteen minutes. The process and data collection form were adapted from Dr. Paul Mullan’s DISCERN program. The first critical event debriefing session was completed in March of 2018.

Data Analysis
We coded interview transcripts and generated themes inductively given our baseline understanding of resident experiences with psychological safety in these clinical critical event debriefing and feedback sessions. We analyzed the data using a thematic approach and categorized themes using concepts from social ecological theory. Social ecological theory views individual behavior as a complex interplay between intrapersonal factors, interpersonal processes, institutional factors, community factors, and public policy. For the purposes of this analysis, we focused on the first three to analyze individual behaviors in this research setting. This organizational framework, referred to as a transactional model between the individual and the environment, shaped how we categorized and understood the limiting and success factors of the learner’s psychological safety in clinical critical event debriefing sessions.

Two researchers (LH, SSV) coded the data separately using NVivo software, a program to aid in the processing and analysis of qualitative data. They met regularly to develop and revise the coding key, review dominant themes, define and name the themes, and discuss interpretation of the data and conclusions. The final themes were discussed and approved by all investigators.
The researchers used reflexivity about how their position and participation in debriefings could influence data collection. During the interview, the interviewer (LH) acknowledged her role as a champion of the critical event debriefing program, a resident evaluator, and an attending physician. The researcher acknowledged this in the interviews to address potential power dynamics by emphasizing the goal of understanding the process and improving feedback to the study participants. CB, LH, and MY received feedback as residents during debriefing sessions and acknowledged their own personal experiences when analyzing the data. JM, LH, and SSV acknowledged their role as attending physicians participating in debriefing sessions and champions of the program.

Results
Fifteen emergency medicine residents led a critical event debriefing in the previous three months and were invited to participate in the study. Eight residents completed an interview. This sample included one second year, three third year, and four fourth year residents. Ten major themes were identified and grouped into (a) intrapersonal, (b) interpersonal, and (c) institutional factors that impacted their psychological safety during a critical event debriefing. Table 1 provides an overview of the major themes with representative quotes.

Intrapersonal Factors. Residents found meaning in validating statements from the interprofessional team. This contributed to their confidence in their roles as physician team leaders during resuscitations, in the medical care they provided in cases of poor patient outcomes, and in their medical knowledge at their stage of training. Having their actions validated by the team helped counter negative internal dialogue. Residents appreciated hearing that a poor outcome was unavoidable or that similar decisions were made by a different set of providers facing a similar clinical scenario. Validation during the current debriefing session and in prior sessions increased their willingness to ask members of the interprofessional team to share their perspective about the case and about their performance as team leader.

Residents cited prior experience with feedback, both within and outside of medicine, and a positive mindset around feedback as increasing their comfort in the debriefing sessions. Two interviewees noted that participation in athletics, and the normalization of continuous feedback, contributed to their ability to be vulnerable during feedback sessions. Residents commonly described being less open to critical feedback during debriefings if they lacked overall clinical confidence at the time of the event, if the resident felt that they had made a mistake or did not provide adequate leadership, or if the resident needed time for personal emotional processing. This phenomenon is generally referred to here as the need for self-preservation. Even in residents reporting a positive mindset around feedback and interprofessional debriefing, the need for self-preservation superseded the perceived benefits of interprofessional feedback.
Interpersonal Factors. The importance of relationships was a dominant theme for all residents. Longitudinal relationships with the interprofessional team allowed for mutual trust, respect, and investment in each other’s development. Residents also found debriefing with the team and being vulnerable deepened new or existing relationships, allowing for future meaningful feedback both in and outside critical event debriefings.

Several residents noted that attending physicians had the opportunity to set the tone of a debrief that either allowed for honest exchange of feedback or more canned responses. Residents felt encouraged to be more open to critical feedback if attendings or co-residents modeled vulnerability. In addition, the resident-attending relationship preceding a critical event impacted the willingness of residents to engage in an interprofessional debriefing session. Some residents expressed feeling uncomfortable being vulnerable if they did not have an existing relationship with the attending or other members of the interprofessional team involved in the session. Unprofessional behavior between team members during the critical event or in past interactions was mentioned as a factor that discouraged a resident from initiating critical event debriefings.

When a resident felt that it was their duty as physician team leader to facilitate a debriefing for team learning and emotional processing after an event, they were more willing to engage deeply in the session and take risks for the betterment of the team. Not all residents identified with this role.

Institutional Factors. Clinical demands and the perceived lack of time was cited most frequently as a barrier to team debriefing. Residents were reluctant to both initiate and engage in a debriefing session if they sensed reluctance from the team. If the resident sensed reluctance, they would either not initiate or they would rush through the process, limiting opportunities for meaningful feedback. A lack of private and easily accessible space was another common limiting factor. Often the debriefings were held in the room with a deceased patient. Some residents felt this interfered with their sense of safety and openness.

Standardizing the process and providing department-wide education on the importance of the debriefing helped. One resident noted that the debriefing guide’s introductory script that reinforces that it is a safe space for feedback and learning was specifically helpful.

A workspace supportive of learning with multiple interprofessional learners allowed for vulnerability and openness to feedback. Residents were more willing to acknowledge their role as a learner if they were accompanied by other learners. When other members of the interprofessional team were also in explicit learning roles, it changed the resident’s sense of hierarchy, and allowed the resident to feel more comfortable also identifying as a learner.

Discussion
There is a complex interplay of intrapersonal, interpersonal, and institutional factors that impact a resident’s psychological safety during the learning conversations that take place within
critical event debriefings. The social ecological model for health promotion helps us understand that changes in the social environment produce changes in individuals, and those individual changes then alter the environment and culture of an institution. Given this complexity, it may be rare that all the necessary components are present for a resident to experience psychological safety in each clinical scenario. However, given the known benefits of psychological safety to a learner’s education, well-being, and relationship building, it is worth striving for.

This study suggests that cultivating a safe learning environment for residents in critical event debriefing involves the following key elements: 1) allowing space for validating statements, 2) supporting strong interprofessional relationships, 3) providing structured opportunities for interprofessional learning, 4) having attendings who model vulnerability and set the tone for honest, specific feedback, 5) standardizing the process of debriefing, 6) rejecting unprofessional behavior, and 7) creating the time and space for the process in the workplace. Many of these components have been discussed in prior simulation-based studies and apply to our clinical setting.

Debriefing in the clinical setting in contrast to simulated environments highlights several notable factors. The resident needed to overcome competing clinical demands, a lack of dedicated physical space and time, and occasionally, a perceived lack of team buy-in to initiate and lead a debriefing session. A resident’s personal need for emotional processing also impeded the ability to engage in a session in certain cases. Residents were sometimes able to overcome these barriers via a commitment to team improvement and team learning through the debriefing process.

The prioritization of self-preservation over engagement in debriefing was a recurrent theme in our interviews. Critical event debriefing is a high-stakes activity that can threaten a resident team leader’s reputation and credibility. In the high stakes field of medicine, revealing imperfection and weaknesses can be daunting, especially amongst learners. The pressure for a resident to appear competent and hide vulnerabilities impedes learning and can cause significant mental stress. Throughout residency training, residents continually work to build their credibility within the interprofessional team and with their attending physician supervisors while simultaneously growing their own fund of knowledge. This tension was felt more strongly by different individuals in our study and was influenced by the individual’s experience, relationship with others on the care team, and the specific clinical scenario. While it may be impossible to predict when a resident will need to prioritize self-preservation over deep learning conversations, we can work towards a greater understanding of these competing interests and develop tools to normalize, if not overcome, this tension.

Achievement goal theory may also help us understand how learners engage with feedback in critical event debriefings. In achievement goal theory, individuals are described as either performance- or mastery-oriented. Performance-oriented learners view mistakes as failures and as such, feedback can be threatening. Mastery-oriented learners view mistakes as an opportunity to learn and the feedback does not affect their self-worth. Mastery-oriented
learners may be more likely to engage in interprofessional critical event debriefings in scenarios in which performance-oriented learners may opt out. Although both types of learners can be successful, an understanding of one’s tendency toward mastery or performance orientation might allow for increased engagement in learning conversations and intellectual candor. Molloy and Bearman propose that intellectual candor, described as “the verbalization of thinking with respect to a genuinely complex problem or situation...without a demand for perfection,” may be a tool to navigate learning while managing the tension between vulnerability and credibility. Those who take on the role of a clinical educator while showing intellectual candor and vulnerability can build trust and deepen relationships. In this study, several residents identified with clinician educator role— they viewed their role in the debrief as important for team learning and team emotional processing and were willing to be vulnerable to achieve these goals. For the individual residents or certain scenarios where this is not the case, intellectual candor could be modeled by attending physicians first who have more established credibility.

Acknowledging and dismantling the traditional hierarchy often present in the interprofessional healthcare team may also facilitate intellectual candor during debriefings. Residents are part of a complex hierarchy in interprofessional teams—they are the nominal team leader but are often the novice in the room and lack the experience of the nurses and other staff on the team. When residents are either forced to or opt to defer team leadership or decision making to more experienced team members, they expose their weaknesses and vulnerabilities. Van Schaik et al. raise the possibility that education and transparency on this complex hierarchy may improve teamwork. This could be facilitated by normalizing the learning process and the expectation that the resident will not always perform perfectly.

The learning conversations that take place during critical event debriefings are high-stakes and complex scenarios for the resident physician team leader. Educators who model intellectual candor, encourage learners to prioritize mastery-oriented goals, and acknowledge the complex hierarchy at play within the interprofessional care team can preserve resident credibility as team leaders while also supporting them as learners. Further research should be done to understand how these specific interventions support psychological safety in this dynamic clinical learning conversation.

Limitations
This study has several factors that limit the generalizability of our findings. This is a single-center study with a limited sample size that only looks at residents who have completed a critical event debriefing session in the ED. This study does not capture the perspective of residents who have not had the opportunity or have chosen not to lead a session. This study also did not explore the role of age, gender, ethnicity, sexual orientation, or other personal identifying characteristics on psychological safety. The tension of credibility and vulnerability will vary depending on personal identifying characteristics. Further research that addresses these in the feedback experience is critical to understanding and improving the learning environment.
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Other Disclosures
Not applicable

Ethical approval
This project was approved by the Community Medical Centers Institutional Review Board in Fresno, CA.

Disclaimers
None

Previous presentations
None

References
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<tr>
<th>Topic Area</th>
<th>Theme</th>
<th>Representative Quotes</th>
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<tr>
<td>Intrapersonal</td>
<td>Validation from the interprofessional team during debriefing contributes to professional identity development.</td>
<td>“I think it is good having other people share the journey, be present, maybe make you feel just a little bit more confident that despite something not going as you had hoped, there were things that were good, and you know these things.” (int 1)</td>
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<td>“I came across as very nervous when I was early in second year, so I got a bunch of pep talks in my early debriefings, people reassuring me that I was doing a good job or that I was being loud enough for running the room adequately.” (int 5)</td>
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<td>Prior experience with feedback increased comfort with team debriefing.</td>
<td>“I think when you play sports, you know your coaches are always giving you feedback all the time and so you just kind of get used to like feeling vulnerable. But you kind of realize it’s not personal or you just realize, it’s just part of it, you know.” (int 8)</td>
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<td>“If I’m not getting feedback, then I’m not going to be improving. And then I’m going to be doing wrong by somebody in the future because I didn’t receive feedback and I’m going to learn a habit that is bad…I don’t want to just slide by and be okay, I want to be a good physician” (int 6).</td>
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<td>Residents prioritize self-preservation over debriefings.</td>
<td>“When you are transitioning to a higher acuity zone there is a potential for bad things to happen. I think it is a little bit harder to be as vulnerable…sometimes the feedback that you’re getting from many different sources can be a little bit overwhelming, it’s all important, but it can be just a little bit hard to chew.” (int 1)</td>
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<td>“I just always kind of baseline feel like I’m doing a bad job…I just don’t want to like open up to receive negative feedback in front of other people because I feel like that’s what I’m going to receive if I ask for it.” (int 5)</td>
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<td>“…actually, that’s the only time that I have bawled afterwards. [Name omitted] gave me a hug and it was not a, I think, I would not have been in an emotionally good place to take that feedback at that time.” (int 7)</td>
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<td>Interpersonal</td>
<td>Residents consider pre-existing relationships and respect for interprofessional team members prior to initiating debriefing.</td>
<td>“I think with time as you build up more confidence and especially when you build up relationships with your team, they are able to be more honest with you and I think when you take their feedback, you take it very honestly also. You know that they’re not doing it because they don’t trust you or believe in you, they’re doing it because they want to see you grow and I think that just takes time.” (int 2)</td>
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<td>“Sometimes for example when you go into [the trauma zone], and you’re new…it takes a little bit of time for you to develop those relationships with the trauma nurses. So, when you’re in the debrief you almost kind of want to maintain a calm, cool, collected attitude a little bit.” (int 2)</td>
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<td>Attending partnership matters.</td>
<td>“I feel just like attendings, the nurses watch us grow and they know what our weak points and strong points are at least the ones that have been up in [the high acuity zones] for a long time and so they have kind of watched our progression over years and they have a little bit better insight into what we’re doing well and not doing well and so they can be really valuable people to get feedback from.” (int 5)</td>
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<td><strong>Unprofessional behavior limits safety.</strong></td>
<td>“I think when it gets emotional and volatile and when people start either yelling, cussing, or being more abrasive…that makes me less inclined to want to engage with that person.” (int 8)</td>
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<td><strong>The resident's perception of their position on the team affects their attitudes towards debriefing.</strong></td>
<td>“I think once you realize that can actually contribute to the way that you are as provider and a person then maybe it motivates you to do more. That the end of a code is not the end of that experience. There could be something you can do to motivate yourself and the team.” (int 2)</td>
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<td><strong>Institutional</strong></td>
<td>A standardized process lowers barriers to initiating team debriefing.</td>
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<td>“I think that for me feedback is a way to give a lot of meaning and purpose to really tough situations. Like okay, this is really hard, this patient is really sick, like what can we learn from this to make this situation, as hard and tough and it was, or if someone passed, you know, how sad it was for the family…how do I make this experience more meaningful so that person and that person’s illness has a bigger purpose than even just that experience?” (int 6)</td>
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<td><strong>Lack of private space and uninterrupted time limits engagement.</strong></td>
<td>“I’m certainly not a person to push people if I get an immediate like reluctance to it. I think initially there was that and it’s become that debriefing has become a little bit more ingrained in the culture where it becomes easier, and because it becomes easier, I feel safer even to bring it up in the first place if that makes sense.” (int 4)</td>
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<td><strong>Having a department with multiple interprofessional learners increases resident’s participation.</strong></td>
<td>“It’s understood that it’s to improve patient care and it improves the way that the team can provide care for them, for the patient, and so I think the feedback that’s delivered, it’s for good intentions. If anything, the feedback that’s received is ultimately to become a better clinician from the resident standpoint and from our team’s standpoint it’s just to be better providers. So, I think it’s a good setting for us to be honest with each other and to kind of point out some issues that we can hope to improve on in the future.” (int 2)</td>
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<td>“I mean our department is kind of hectic all the time and it’s hard to get people to all gather in one space at all but then to find a space where you can kind of talk and have things be quiet and subtle for a little while is difficult.” (int5)</td>
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<td>“I’ve always done the debrief in the room with the patient which I think actually could interfere especially if the patient has passed and such.” (int 6)</td>
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<td>“I think another thing that kind of made me feel very safe is the fact that the nurses that were there that day were also learners…and so those people also had their own feedback for themselves and so I felt like everyone was kind of on the same page of like okay we’re all trying to figure this out together, and we all kind of know how things are supposed to happen, but someone is better at this than us.” (int 3)</td>
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<td>“I think when you’re willing to be vulnerable you like drop yourself way down [in the hierarchy] and you allow yourself to be a position where if people want to, they could really take advantage of that. But I think in my experience when people see you do that, they also are willing to kind of step down into your level and open up the space where you all are at that and improving and growing (int 6).</td>
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Appendix A - Semi-Structured Interview Guide

1. Tell me about your experience with receiving feedback during debriefing sessions.
2. Describe how you feel during debriefing sessions. Do you feel like you are “psychologically safe” during these sessions, meaning, can you be vulnerable and take risks when seeking feedback without fear of negative consequences?
3. What do you think factors into this?
   a. Level of training
   b. Relationships with the team
      i. Attending physician
      ii. Other learners
   c. Case outcome
   d. Clinical confidence
   e. Physical space
   f. Structure of the debriefing session
   g. Other factors

Appendix B - Critical Event Debriefing Form

DO NOT SCAN OR PUT INTO PATIENT’S CHART

Critical Event Debriefing Form
Place the completed form in lock box in red doc box

Read this out loud: The purpose of debriefing is for education, quality improvement and emotional processing. This is not a blaming session. Everyone’s participation is welcome and encouraged.

The physician will briefly review the patient’s summary. Then as an entire team, we can discuss what went well and what could have gone better. Please feel free to ask any questions.

Form completed by:__________________
What triggered the debriefing:
☐ Code
☐ Other:__________________
What went well during our care of the patient:
____________________________________________________________________
____________________________________________________________________

What could have gone better during our care for this patient:
☐ Equipment Issue:__________________
☐ Staffing:__________________
☐ Communication:__________________
☐ Knowledge:__________________
☐ Medication Issue:__________________
☐ Transitions of Care:__________________
☐ Procedural Issue:__________________
☐ Systems Issue:__________________

Action Items & Suggested Solutions:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Group feedback to the resident team leader on leadership, team management, communication, and resource utilization skills:
____________________________________________________________________
____________________________________________________________________

For the Resident - Thoughts on how to improve leadership, team management, communication, resource utilization skills for next critical event:
____________________________________________________________________
____________________________________________________________________

*If anyone needs or requests a referral for free counseling, call your supervisor, ED Social Worker or INSIGHT 1-800-422-5322.
Residents can also call 499-6551 24/7 for UCSF Fresno Support Services*
Information is privileged and confidential pursuant to Evidence Code Section 1157 For Quality Improvement Purposes Only