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| **Organization Name** |
| **Debrief Policy and Procedure** |

**Scope:** This debrief policy and procedure applies to all departments within the organization.

**Effective Date:**

**Last Revised Date:**

**Purpose:** To describe the evidence-based structures and processes used to implement team debriefs that are intended to improve system outcomes.

**Rationale:** Organization Name uses debriefs conducted by trained, designated leaders because:

1. Conducting debriefs is a key strategy to improve organizational resilience in response to internal and external challenges.[[1]](#endnote-1),[[2]](#endnote-2)
2. Designated leaders who are trained to conduct short, structured debriefs can improve performance of clinical and non-clinical teams by up to 25%.[[3]](#endnote-3) These designated leaders include providers, shift charge nurses, circulation OR nurses, and department managers.
3. Conducting debriefs is associated with improved management of critical perinatal events (e.g., obstetric hemorrhage, emergency C-section, intrapartum fetal demise, unexpected maternal transfer to ICU, unexpected admission of term infant to neonatal ICU).[[4]](#endnote-4)
4. Debriefs are practical/feasible strategies to identify and mitigate clinical and operational defects in surgical care and improve perceptions of OR safety culture and teamwork.[[5]](#endnote-5),[[6]](#endnote-6) Consequently, the Joint Commission recommends that a debrief is conducted as part of every surgical sign-out.[[7]](#endnote-7)
5. Debriefs in the form of post-fall huddles can decrease the risk of repeat falls and improve perceptions of organizational safety culture.[[8]](#endnote-8)

**Responsibility:**  Administrative and clinical leaders are responsible for designating who is accountable for conducting post-event debriefs in their respective departments. Human resources staff is responsible for integrating the requirement to conduct debriefs into relevant designated leader job descriptions. Quality improvement/patient safety personnel are responsible for developing an organization-wide Debrief Coordinating Team.

**Procedure:**

1. Quality improvement/patient safety personnel develop a Debrief Coordinating Team consistent with the Debrief Team Charter.
2. Members of the Debrief Coordinating Team conduct periodic training sessions for designated leaders using the Debrief Fact Sheet, the Debrief Pocket Guide, the Post-Fall Huddle Documentation Form, and the Debrief Log for Facilitators.
3. Designated leaders conduct short, structured debriefs using the Debrief Pocket Guide, complete the Debrief Log after each debrief, and return the Debrief Log to the Debrief Coordinating Team.
4. The Debrief Coordinating Team develops a database for Debrief Logs and analyzes the prevalence of individual and organizational errors identified in the logs and makes recommendations for system improvements to mitigate these errors.
5. The Debrief Coordinating Team regularly reviews and revises this policy/procedure for conducting debriefs.

Date Approved:

Approved by:

1. References

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5. Bandari J, Schumacher K, Simon M, et al. Surfacing Safety Hazards Using Standardized Operating Room Briefings and Debriefings at a Large Regional Medical Center. The Joint Commission Journal on Quality and Patient Safety. 2012;38:154-160. [↑](#endnote-ref-5)
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