PICU Debriefing Form

Date: .................................................................
Completed by: (optional) ________________________________

Check all that apply:  
☐ Code  ☐ Unplanned extubation  ☐ Dislodgement of CVL/chest tube  ☐ Medication error
☐ Nutrition  ☐ Procedural sedation  ☐ Equipment malfunction  ☐ Other

Describe event in detail: __________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Key Considerations:
Was communication clear and effective during event?  Were roles and responsibilities understood by all team members?
Was situational awareness maintained?  Was the workload efficiently/effectively distributed?
Were errors made or avoided?

<table>
<thead>
<tr>
<th>Issue</th>
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<tbody>
<tr>
<td>What went well?</td>
<td></td>
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<tr>
<td>What didn’t go well?</td>
<td></td>
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<tr>
<td>What could we do better next time?</td>
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</tbody>
</table>
Patient Factors
- Condition (complexity and seriousness)
- Language and communication
- Personality and social factors

Individual (staff) Factors
- Knowledge and skills
- Competence
- Physical and mental health

Work Environmental Factors
- Staffing levels and skills mix
- Workload and shift patterns
- Design, availability and maintenance of equipment
- Administrative and managerial support
- Environment
- Physical

Task Factors
- Task design and clarity of structure
- Availability and use of protocols
- Availability and accuracy of test results
- Decision-making aids

Team Factors
- Verbal communication
- Written communication
- Supervision and seeking help
- Team structure (congruence, consistency, leadership, etc.)

Organizational and Management Factors
- Financial resources and constraints
- Organizational structure
- Policy, standards and goals
- Safety culture and priorities

Care Delivery Problem

Fishbone Diagram