From Chaos to Clarity: A Five-Minute Critical Event Debriefing Tool for PACU

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Introduction: Critical event debriefing is essential to review the process and provide immediate feedback to improve team performance and patient outcome. It provides an opportunity for reflection and real-time education. Although many literatures emphasize the importance of debriefing, actual debriefing occurrences are rare.

Identification of the Problem: In a 56 bedded, 24-hour PACU, there were 18 instances of critical events documented from January to May 2025, requiring interventions such as calling code blue, CERT BERT, re-intubation, return to OR, and transfer to a higher level of care. However, only one debrief was documented. As PACU has mostly internal code and other emergencies are managed by Anesthesia, it is important to keep track of the critical events and prevent future errors.

QI Question/Purpose of the Study: The purpose of this study is to create an electronic debriefing tool for PACU, based on STOP5 modules.

Methods: This initiative is guided by the PDCA (Plan-Do-Check-Act) methodology. An anonymous presurvey conducted showed that nearly 50 % of the respondents had no training on debriefing and identified time constraints (50%) and no standard guidelines and protocol (19%) as barrier for debriefing. Considering the busy environment of the PACU, an electronic debriefing tool was created using STOP5 module. Debriefing champions and Charge Nurses are trained to lead the session.

Outcomes/Results: Simulated PACU case scenarios were utilized to test and confirm that the structured debriefing process could be consistently completed in five minutes. Staff feedback indicated that the tool streamlined communication and supported reflective practice without disrupting workflow.

Discussion: This project demonstrated that a structured five-minute debrief is feasible and effective in the PACU setting. Case scenario testing confirmed that meaningful team reflection and communication can occur within the time frame, supporting both patient safety and staff well-being.

Conclusion: Overall, this project closes the identified gap of lack of a standardized tool to reflect, learn, and support staff after critical events. The implementation of this project helps reduce risk or repeated errors, enforces reflective practice and continuous learning, streamlines communication during stressful situation and improves teamwork.

Implications for perianesthesia nurses and future research: Future research should examine the impact of the five-minute debrief tool on patient safety outcomes, staff well-being, and long-term adoption in the PACU.