

From Chaos to Clarity: A Five-Minute Critical Event

Debriefing Tool for the PACU

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Background

Critical event debriefing is a meeting following any critical event to review the process and provide immediate feedback to improve team performance and patient outcome (Toews et al., 2021). Structured critical events debrief not only increases patient safety outcomes but also helps mitigate psychological distress among staff and supports staff mental wellbeing (Porteous et al., 2024). However, the common barriers preventing debriefs are time constraints and the fear of blame culture (Porteous et al., 2024). Despite widespread evidence supporting debriefing, actual use remains rare, occurring in fewer than 20 percent of cases across many hospitals. Similarly, in Walter 3 PACU which is a high-acuity unit managing 45–55 cases daily across multiple surgical specialties, there were 18 instances of critical events documented in TAPS 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.

Purpose

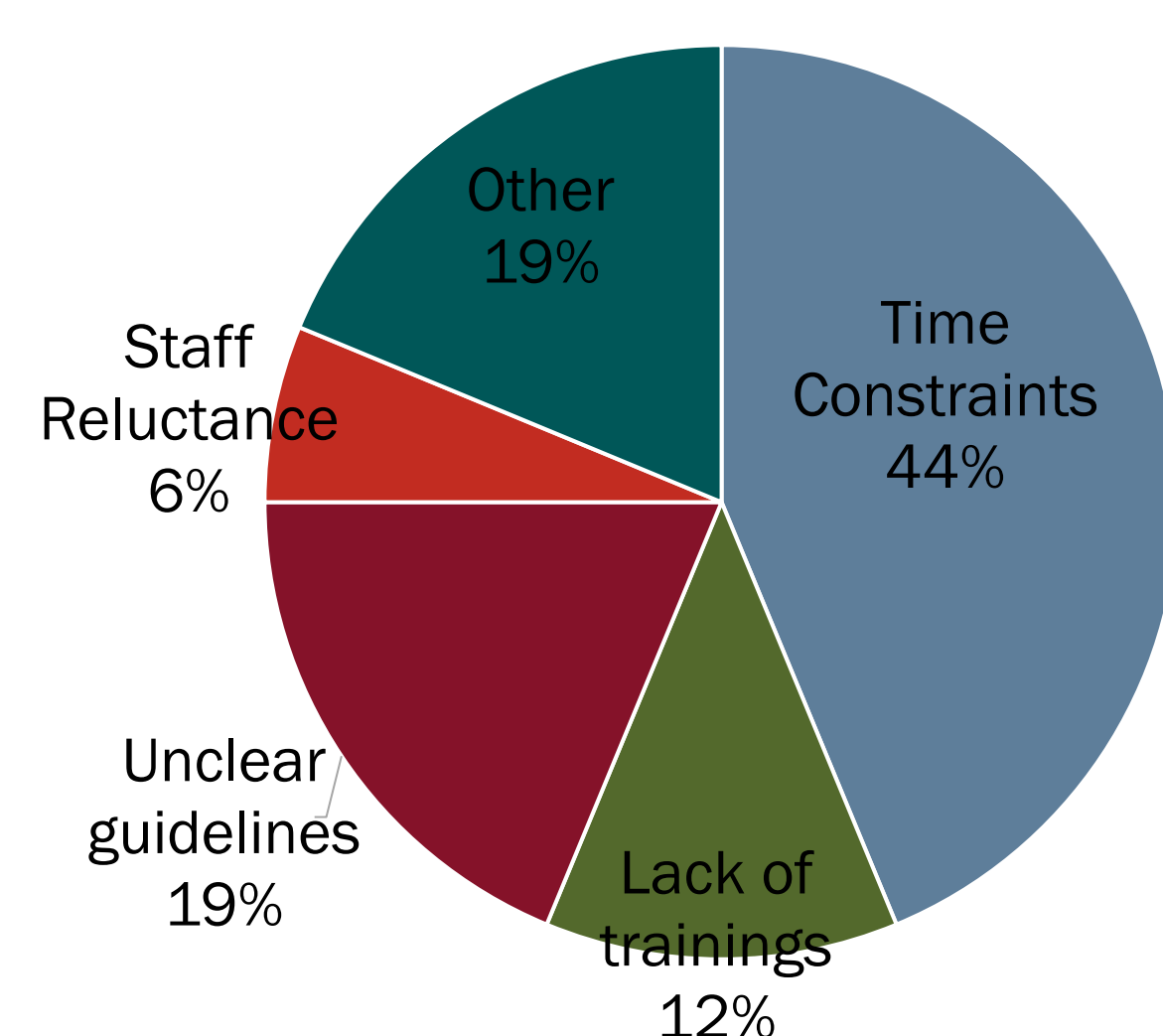
The purpose of this study is to create an electronic debriefing tool for PACU which is based on STOP5 modules, which only takes five minutes for debriefing, anticipating a measurable increase in debriefing frequency following implementation.

Methods

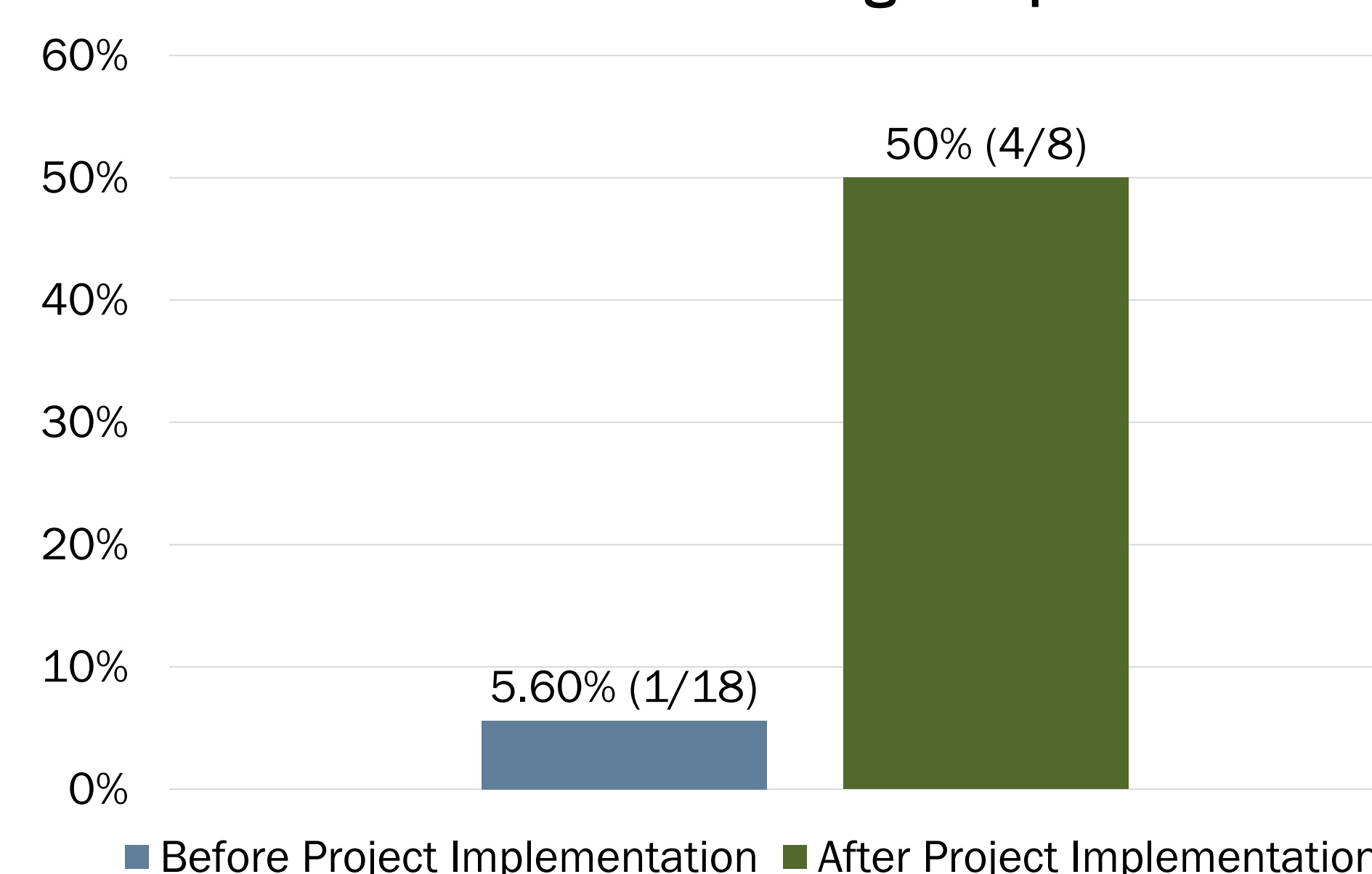
This project supports Exemplary Professional Practice by promoting a culture of safety, reducing repeated errors, and enhancing staff psychological well-being. This initiative is guided by the PDCA (Plan-Do-Check-Act) quality improvement methodology. A presurvey was conducted to find out about the staff's knowledge of debriefing, and the barriers preventing debriefing. The survey was anonymous and 16 staff responded to the survey. Nearly 50 % of the respondents mentioned that they have no training on debriefing. The major barrier for debriefing identified was time constraints (50%) and no standard guidelines and protocol (19%). Considering the busy environment of the PACU, an electronic debriefing tool based on STOP5 module was created using Microsoft forms which typically takes 5 minutes to complete. A link to the electronic debriefing tool is available on unit's SharePoint site and QR code on the charge nurse desk. The unit manager and educator have access to the electronic documents.

Result

RN Perceived Barriers to Effective Debriefs



Debriefing Compliance



Critical Event Debriefing Tool for PACU

Before you begin: Gather the participants and read the following script: Start with "IS EVERYONE OKAY?" If yes, then continue: "Thank you all for taking a moment to participate in this quick debrief. The goal is to learn as a team, support each other emotionally, and identify anything we can improve—NOT to assign blame or evaluate individual performance. Everything shared here is confidential and focused on system and team learning. I'll go through a few short questions, and you're welcome to speak up or just listen. Please be honest, respectful, and brief so we can keep this under 5 minutes."

STOP 5	Questions
S	Summary of the event What type of clinical event occurred? What intervention or escalation was required?
T	Things that went well What went well during the event?
O	Opportunities to improve What opportunities for improvement were identified during this event?
P	Points to Action and Responsibilities What could be improved to better manage similar events in the future? Any suggestions for training, or process improvement?
5	Did it take around 5 minutes to do this debriefing?

Electronic Tool: The link to the electronic debriefing tool is available on the unit's SharePoint site and QR code is available on the Charge Nurse's Desk.

SOURCE: The STOP5 debriefing model is designed by Edinburgh Emergency Medicine and the Scottish Centre for Simulation and Clinical Human Factors (SCSCHF) for rapid, post-critical event reflection of critical events in high-acuity settings

Results/Implications

Simulated PACU case scenarios were utilized to test and confirm that the structured debriefing process could be consistently completed in five minutes. The debriefing champions provided an education to the staff on the importance of debriefing and trained the charge nurses on using the tool and conducting the debriefing calmly and in a respectful manner. Following project implementation, there were 4 debriefing done out of 8 reported in the TAPS from mid-August to mid-November. The completion rate increased from 5.6% (1/18) to 50% (4/8), demonstrating a substantial improvement in compliance with the targeted practice.

Future Actions

The implementation of this project helps reduce risk or repeated errors, enforces reflective practice and continuous learning, empowers nurses to voice concerns, streamlines communication during stressful situation and improves teamwork. 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. Additional studies could explore adaptation to other perioperative and critical care settings, as well as comparisons with longer debrief models to balance efficiency with depth of reflection.

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- WT-3 PACU Charge Nurse: Natalie Jones, BSN, RN, CPAN

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