



Post-Event Debriefing

Why Debrief?

- **Education & Quality Improvement-**
 - Opportunity to improve patient outcomes & identify & reduce errors
 - Opportunity to improve interdisciplinary practice & communication
 - Opportunity to identify latent safety threats in systems, processes, & environments
 - Individual & team performance & efficiency has shown to improve 20 – 25% through debriefing (*Tannenbaum & Cerasoli; 2013*)
- **Emotional Processing-**
 - Exposure to potentially traumatic events can have significant impacts on the overall wellbeing of personnel & everyone processes things differently
 - Healthcare personnel generally have a high sense of resilience, vicarious trauma is easily overlooked when we are busy attending to others, & the cumulative effects of experiencing traumatic events can have significant impacts on one's emotional & psychological health
 - Team members should feel as though the session(s) are a **SAFE SPACE**, not a time for blaming or penalization
 - Opportunity to defuse emotions & tension after events

Debriefing Tips

- Involve the entire interdisciplinary team that was involved in the event if practical
- Utilize trained individuals/facilitators to lead the formal debriefing process if possible
 - Utilize/develop relationships internally (*e.g., risk management office; emergency management office; OSHA; fire/police/EMS; mental health personnel; etc.*) and/or externally (*e.g. health department; fire/police/EMS; emergency management personnel; mental health personnel; hospital/medical personnel; etc.*)
- Debrief positive events, adverse events and/or unexpected outcomes, & pre-identified events
- Encourage personnel to engage in good self-care practices & seek assistance when necessary
- Continue to maintain a good culture of offering each other support
- Utilize resources such as [AT Cares](https://forms.nata.org/ats-care-contact) (<https://forms.nata.org/ats-care-contact>; 972-532-8821) often & when necessary
- Immediately create a timeline of events & document all discussions as much as possible
- Should be low-stress, no fault environments

Debriefing Ground Rules-

- Focus on processes & systems, not people
- Highlight what was done correctly
- Anonymize comments when appropriate
- Request a problem/solution format (i.e., "... no problems without a solution")
- Keep the focus on one topic at a time

- Consider mixed-response formats (e.g., ability to submit feedback via instant message, text, or email as an alternative means of communication) to account for different personalities & comfortability of team members

Hot/“Hotwash” Debrief -

- Takes place within minutes of the event (e.g. when you return to the sideline)
- Completed with as many members that were involved in the event as possible
- Informal debriefing to review immediate observations & lessons & capture key insights and/or “front of mind” lessons following an incident while saving deeper analysis for later (“Cold Debrief”)
- Qualitative in nature; completed with limited data; relies on participant recall of events, interactions, & thought processes
- Foundation to start learning from an incident & improve processes as close to the event as possible & better understand your capabilities while memories are still fresh & issues are clear
- See template at end

Warm Debrief -

- Takes place within hours of the event (e.g. after the event; pre-departure at the end of a shift)
- Completed with as many members that were involved in the event as possible
- Informal debriefing to review immediate observations & lessons & capture key insights and/or “front of mind” lessons following an incident while saving deeper analysis for later (“Cold Debrief”)
- Qualitative in nature; completed with limited data; relies on participant recall of events, interactions, & thought processes
- Opportunity to learn from the incident, improve processes, & better understand your capabilities while memories are still relatively fresh & immediate issues are clear
- See template at end

After-Action Review (AAR)/Cold Debrief -

- Typically occurs days to weeks after the event & involves a wider multi-disciplinary audience than event members
- Quantitative in nature
- Integrates data (i.e. patient records; CPR feedback; patient monitors; etc.)
- See template at end

“Hot Wash”/“Warm Debrief”	After-Action Review (“Cold Debrief”)
- o Informal & immediate - o Individuals directly involved attend (if possible) - o Designed to gather immediate observations & lessons - o Open, agile discussion format - o Go over the next steps & future improvements - o Designed for brainstorming & collaboration	- o Formal & structured - o All key stakeholders should attend if possible - o Deeply analyze objectives, planning, & execution - o Discussion follows an established framework - o Identify strengths, weaknesses, opportunities, & threats - o Designed for organizational improvement & future development



Hot-Wash or Warm Debrief Template

Date & Location of Debriefs:

Individuals In Attendance:

Recap of the Event:

Plus/Delta:

Plus – What went well? What brought value & how do we repeat it?

Delta – What was challenging? What didn't go as well as you would have liked/could have gone better?

Key Takeaways, Feedback, and/or Recommendations:

Review of Current Available Resources

Personnel:

Equipment:

Transportation:

Roles & Responsibilities:

Immediate Needs of Involved Individuals

Student-Athletes:

Coaches:

Staff / Others:

Support Needs Before Returning to Work

Is there anything that anyone needs?

What can I do to help you prior to returning to work?



Cold Wash Debrief Template

Pre-Debrief

Identify key parties:

Set an accessible location:

Gather pertinent data:

Use/Develop resources and/or relationships to identify a trained facilitator:

Develop a loose agenda/objective(s):

Beginning (Reactions Phase)

Thank personnel for their participation and presence.

Reiterate confidentiality/privacy of the discussion.

Reiterate SAFE SPACE concepts.

Encourage participation by all attendees.

Review/establish ground rules and psychological safety guidelines.

Brief summary of the event course (< 1 min):

Middle (Analysis Phase)

Brief review of patient's summary:

Plus – What went well?

- What came easily or brought value?
- How does the team repeat it?
- Key strengths & actionable takeaways:

Delta – What challenges were identified?

- What didn't go as well as hoped?
- What changes would improve performance?
- Needed equipment or policy/procedure updates?
- What could be done differently next time?

Additional Questions

- How prepared were we for the event?
- Were the right people involved and in correct roles?
- How comfortable were you with your role and the incident?
- How confident were you in your role and response?
- Was there confusion about who the team leader was?
- Did the team follow established protocols? If not, why?
- Were there technical/equipment/procedural issues?
- Opportunities for improvement or threats?

Ending (Summary Phase)

- Discuss 2–3 key behavioral skills and team performance:
- Identify training/review/rehearsal needs:
- Key takeaways or follow-up issues:
- Feedback/Recommendations for improvement:
- Support needs before returning to work:

Post-Debrief

- Encourage self-care for participants.
- Distribute ATs Cares and/or self-care resource contact info.
- Write an After-Action Report (AAR):
 - Incident date/time/location/individuals:
 - Incident summary:
 - Debrief date/time/location/individuals:
 - Summary of key points/takeaways/feedback:



Athletic Trainer Readiness Checklist

Below is a concise athletic trainer readiness checklist that can be reviewed prior to every event, taking ~ 60 seconds. It may be modified based on specific circumstances/facilities.

Emergency Preparedness:

- ☐ Coaches, staff members, & student-athletes are aware of safety protocols and/or emergency procedures?

Personnel:

- ☐ Roles & responsibilities of on-site personnel are delineated & communicated prior to the start of the activity? (e.g., Initial assessment; activate EAP; open gates; retrieve emergency equipment; etc.)

Communication Tools:

- ☐ Primary & secondary means of communication are identified & operational (e.g., cellular phone; landline phone; 2-way radio; phone app; etc.)
- ☐ Emergency action plan & emergency contact numbers are accessible?
- ☐ Perform radio check

Emergency Equipment:

- ☐ AED is operational & easily accessible to meet "Drop to Shock" time of less than 3 minutes?
- ☐ AED location & emergency equipment location is known by all staff members in attendance?
- ☐ Emergency equipment (e.g., splints, emergency bag, airway/ventilation equipment, uncontrolled bleeding supplies, spinal motion restriction equipment; etc.) is accessible?
- ☐ Exertional heat stroke management equipment (e.g., cold-water immersion modality; rectal thermometry; etc.) is accessible & prepared when applicable?
- ☐ Transportation vehicle is appropriately fueled/charged, operational, & parked in the established location? Location of keys?

Weather/ Environmental:

- ☐ Weather forecast has been checked for any potential issues (e.g., lightning, extreme heat, extreme cold, air quality) & is being appropriately monitored?
- ☐ Potential weather-related adjustments to the event have been made and/or communicated?

Facility Access and Safety:

- ☐ Access to gate(s), doors, etc. are unlocked, clear, & functional for emergency ingress and/or egress?
- ☐ Event area is free of any hazards or obstacles?
- ☐ Field & individual equipment has been checked & is safe for use?
- ☐ Special considerations (e.g., construction, traffic congestion, etc.) have been communicated to appropriate personnel?

Final Check:

- ☐ Take a deep breath, center yourself, ensure that you are physically and mentally prepared to provide the best care for the student-athletes

CULTURE plays a vital role in emergency preparedness! A strong culture prioritizes safety, communication, collaboration, education and training, being positive and proactive, and maintaining an environment where everyone feels empowered to speak up, ask questions, and share concerns.