The Role of Debriefing After Neonatal Resuscitation – Resident Doctors' Perspectives from London

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Introduction: Neonatal resuscitations are time-critical, complex, and often led by junior clinicians, requiring rapid, high-stakes decision-making.[1] Whilst common practice in other specialties, less is known regarding utilisation of debriefs in neonatal care, despite frequent pressurised resuscitations and known benefits of debriefing such as improved clinical learning, emotional processing, and patient care.[2]

Objectives

1. To identify existing guidelines or tools used to facilitate post-resuscitation debriefs.
2. To evaluate resident doctors' experiences, perceived benefits, and barriers associated with participation in post-resuscitation debriefs.

Methods

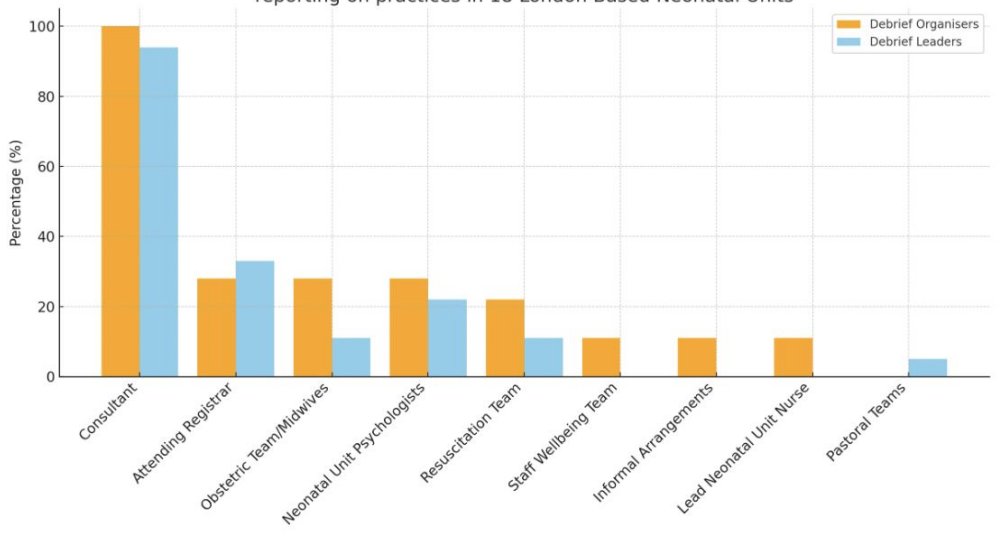
Conducted two surveys across 25 hospitals, with a range of Level 1 to Level 3 units:

- Survey One - sent to REACH local hospital leads to assess department debriefing practices.
- Survey Two - responses from 73 residents to explore experiences using qualitative thematic analysis.

Results

Survey One: with 72% response rate (18/25 hospitals) we saw no standardised debriefing tools or guidelines. Debriefs were triggered by various events - poor outcomes, complex cases and staff request - with consultants most commonly organising and leading them.

Table 1. Debrief Organisers and Leaders, as mentioned in Resident Doctor responses reporting on practices in 18 London-Based Neonatal Units



Survey Two: From 73 residents surveyed, nearly all had participated in neonatal resuscitation and two-thirds in debriefs. Registrar's reported greater involvement than senior house officers, especially in Level 3 NICUs, and thematic analysis highlighted both shared and differing perspectives on debriefing.

Themes	Summary: Senior House Officers (SHO) vs Specialty Registrar (SpR)
Structure & Routine	SHOs valued immediate hot debriefs with later cold debriefs for learning, whilst SpRs stressed structured cold debriefs as part of routine practice to support reflection and system improvement.
Emotional Support	SHOs prioritised immediate emotional support, whilst SpRs highlighted the value of facilitated reflection with trained staff.
Blame-free Environment	Both SHOs and SpRs valued psychological safety and avoidance of blame.
Team Involvement	SHOs focused on team-based practical support, whilst SpRs highlighted educational value and involvement of the wider staff group.
Accessibility & Flexibility	SHOs stressed access, protected time, and junior involvement, whilst SpRs prioritised structured yet flexible facilitation to support participation.
Leadership & Structured Guidance	SHOs highlighted practical case-based leadership, whilst SpRs stressed formal frameworks, senior-led culture, and structured approaches.
Guidelines & Training	SHOs emphasise staff training and consistent guidelines, whilst SpRs focus on policy development and trained facilitators for structured, safe debriefs.

Conclusion

Debriefing improves clinical outcomes and is widely valued, yet regional practices show limited consensus and institutional support in neonatal care. We recommend standardised, flexible debriefing tools, facilitator training within curricula, and protected time to ensure effective implementation.

References

1. Resuscitation Council UK. Newborn resuscitation and support of transition of infants at birth [Internet]. London: Resuscitation Council UK; 2021 May
2. Shore H. After compression, time for decompression: debriefing after significant clinical events. Infant. 2014;10(3):90–3.