IN THE AGE OF THE RAPID DIAGNOSTIC TEST, ARE THE RAPID DEBRIEF: A TOOL THAT TRANSFORMS LEARNING AND SYSTEM CHANGE

Aim To test the rapid debrief tool as a way of extracting immediate learning to implement system changes following the care of the critically ill child; overcoming the dispersion of people and memories in the traditional incident reporting cycles.

Method A rapid debrief was tested immediately after the care of a critically ill child was completed by the team. A template was used to collect what improvements were needed technically (resources, skills) as well human factors such as communication and leadership. Action plans were generated by the team. The debrief and action plan was then circulated to all staff and discussed at the weekly service meetings. Outcomes were monitored by the Paediatric Resuscitation Group.

Results A total of 29 rapid debriefs were completed over 12 months, generating 81 action plans, of which 50 have been completed. Many of the actions were completed before the incident forms reached the clinical governance system. 20 related to equipment, 5 to medications, 7 to team issues (communication, leadership), 10 training issues and 11 planning and organisation wide issues. Compared to the year previous to the rapid debrief, clinical Incident reporting now shows a 1.7 times increase of low risk incidence reporting; incidents of moderate or high risk have been reduced by half. Staff feedback has been very positive.

The learning outcomes include the development of safe hand-over tools, improving resuscitation resources and team needs, incorporating human factors into the resuscitation training to build team resilience and an open challenging culture.

Conclusion The rapid debrief has helped improve our care of the critically ill child through the immediate extraction of learning and implementation of improvements. The tool enables faster system change compared to traditional reporting governance systems.