# Irish Paediatric Acute Transport Service

# Clinical Template

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The Irish Paediatric Acute Transport Service (IPATS) has produced this clinical guideline. It has been designed for nurses, doctors and ambulance staff to refer to in the emergency care of critically ill children.

This guideline represents the views of IPATS and was produced after careful consideration of available evidence in conjunction with clinical expertise and experience. The guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient.

# Critical Care Post Event Debriefing Template

Suggested for use following the management and/or transfer of a critically ill child

## What is a Critical Care Post-Event Debrief?

- The debrief is a multidisciplinary meeting. It can take many forms. This particular tool has been designed to be a supportive tool for a team who have just been through a paediatric emergency and/or transfer
- Paediatric emergencies can be highly stressful events and frequently utilise multiple members of staff who may be unfamiliar with each other and unfamiliar with paediatrics
- In the absence of a debrief, staff may be left traumatised following a difficult scenario, and countless studies have shown consistent benefits to staff well-being and resilience, not to mention clinical outcomes, following the introduction of a debrief process after a critical incident

## Who should attend the debrief and when should it take place?

- The debrief is a multidisciplinary process. It should be attended by as many of the people involved in the event as possible.
- The debrief should be a 'hot' debrief. Where possible, it should take place as soon as possible after the event to ensure that staff receive support as soon as possible, and that the majority of those involved are available.

## Introduction and Shared Mental Model

**Debrief lead**: We are going to do a quick debrief of that event. It should only take a few minutes. The goal is to improve our performance as a team and the care we provide. We also want to ensure that staff have an opportunity to discuss the case in an open, safe and confidential environment. Let's start with a description of the key clinical events.

## What went well, and what could have gone better?

- Did the team follow established guidelines and protocols? If not, why not (Do they exist?/Should they?)
- Were there any technical, equipment or procedural issues? If so – What?
- Discuss 2-3 behavioural skills relevant to the situation. How did the team feel they performed in this area?

## What will the team do differently next time?

- Discuss changes in team performance that will be implemented in the future, based on the discussion above
- Identify individuals responsible to follow up on these changes and arrange a follow up timeline

## Follow up issues?

- What issues, if any, should be deferred for more in-depth discussion at a later time?
- Discuss if the case is suitable for discussion at the next Morbidity and Mortality meeting for greater shared learning

## Conclusions

- Thank participants for their time
- Offer contact information for personal follow up or suggest referral pathway for individual concerns as appropriate