PREHOSPITAL CARE

Introduction of an electronic debrief and governance tool in prehospital care

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Background: The Tayside Trauma Team is a mobile medical team that is deployed from Ninewells Hospital, Dundee, UK at the request of the ambulance service.

Aim: To describe the implementation of a formal debrief and governance tool to ensure the ongoing provision of a high-quality prehospital service.

Methods: A questionnaire was devised to examine key issues relating to clinical governance and distributed to all members of staff involved in the provision of prehospital care.

Results: A number of areas of concern were revealed, including a lack of understanding on how to report critical incidents occurring in this field and a low level of opportunity to fully discuss events and vocalise concerns. These areas of concern were used to formulate an electronic debrief tool to be available to staff after each incident attended. Reports were considered and actioned and data collected for audit purposes and to provide a framework for discussion at monthly morbidity and mortality meetings.

Conclusion: Any patient requiring the services of a healthcare professional in the prehospital setting has a right to expect the same level of quality of care that they would receive within the hospital. The development of a debrief tool will achieve ongoing quality of care in this specialised area of healthcare.

The Tayside Trauma Team is a mobile medical team that is deployed from Ninewells Hospital, Dundee, UK, at the request of the ambulance service. It is an emergency department-based, consultant-led service and the team comprises the duty consultant, specialist registrar and a senior staff nurse. The team is available 24 h per day and responds, on average, 2.2 times per week and provides the full spectrum of critical care skills in the prehospital environment.

This paper describes the implementation of a formal debrief tool to ensure the ongoing provision of a high-quality service.

The National Health Service (NHS) Plan, July 2000, put clinical governance at the top of its agenda, the core principle being that people can expect a consistently high service at whatever point of contact they make with the NHS.¹ Prehospital care is often the first point of contact people have with the NHS. It is no different from any other aspect of the NHS in this regard and should be included under the same umbrella as any other speciality and subjected to the same rigorous quality assurances.² This can often be difficult as the quality of care delivered is difficult to measure and the pressure of concomitant working practice makes it difficult to find time for reflection, appraisal and feedback after each particular response to an incident.³ This is particularly relevant with the Tayside Trauma Team as the members of the team will be involved in the ongoing resuscitation of the patient on return to the resuscitation room of the emergency department. There is often little time to debrief and identify any area of concern because of clinical pressures.

Strategies must be in place to ensure that an active clinical governance programme is undertaken by those parties involved in the provision of clinical care in the prehospital setting.⁴ This has recently been addressed by The Faculty of Prehospital Care who have established a code of practice that has been agreed and endorsed by the Ambulance Service Organisation.⁵ The key issues highlighted for an active clinical governance programme were as follows:

- audit
- adverse clinical incident reporting
- health and safety policy
- a no blame culture to facilitate review of incidents of concern
- an appropriate research strategy
- continuous professional development
- risk management

Our aim was to design a debrief tool that could be available electronically to each individual after attending an incident with specific questions addressing a number of the above issues and hence ensuring an ongoing driver of quality in the provision of prehospital care.

METHODS

A questionnaire was devised to examine key issues relating to clinical governance (fig 1, appendix). This questionnaire was distributed to all members of medical and nursing staff involved in the provision of prehospital care and its aim was to ascertain what the current level of understanding was with regard to clinical governance issues and to identify any area of concern. The answers were used to aid the development of a formal debrief tool that would be available electronically to each individual involved after each incident attended.

RESULTS

A total of 45 questionnaires were distributed, of which 34 were returned completed (75.5%).

Figure 1 represents the graphs showing the responses to the questions posed to the members of the team. Figure 2 shows the mobile Tayside Trauma Team debrief tool.

DISCUSSION

Clinical governance implies corporate and personal responsibility for the quality of healthcare. It encompasses a framework

Figure 1 Tayside Trauma Team survey.

of activities, all aiming to improve the standards and services that any patient-care service provides.

Our questionnaire revealed a number of areas of concern that provided information on which to base our debrief tool in order to provide some solutions to these deficient areas (fig 1). The main concerns were the lack of understanding on how to report critical incidents occurring in this field and therefore the concern that any incidents were not being dealt with appropriately. It was also apparent that team members were not getting the opportunity to fully discuss events and vocalise any concerns. There was a reported desire to have regular meetings to discuss aspects of particular incidents and provide individual feedback on performance. Also, no clear individual was identified to report any equipment malfunction and therefore it was not clear who was responsible for replacing or reporting equipment failure. The free text section about perceived risks

showed a number of concerns about high-speed driving to the scene (box). All drivers are obliged to undertake a high-speed driving course and this is reviewed annually. The debrief tool was based on these areas of concern and it is available to individuals after each incident attended. The reports were considered and actioned appropriately and data collected for audit purposes and to provide a framework for discussion at monthly morbidity and mortality meetings. The debrief tool is available to all staff at <http://www.taysidetraumateam.org>. It is an HTML form that is posted on a commercial internet service provider and passed by email to an NHS mail account. There are no patient identifiers involved and the form is anonymous unless signed by the submitter. It is the authors' intention to recirculate the questionnaire (appendix) after 12 months of form collection and compare the outcomes.

Date _____ Time _____
 Incident Location and Nature _____
 What was your main task at incident? _____
 Procedures—What worked well and what did not work well? _____
 Action required: _____
 Equipment—What worked well and what did not work well? _____
 Action Required _____
 Concerns or Recommendations: _____
 Journey Out: _____
 On Scene: _____
 Journey Back: _____
 Does this case warrant further discussion? _____

Figure 2 Tayside Trauma Team debrief tool.

Box: Reasons given for feeling at risk while responding to incident

- Lack of safety awareness and training
- On single track
- If car or person is on a hillside/place difficult to access
- Not informed of all hazards at scene
- Incident involving crash because of ice
- Vehicle being driven at excessive speed

CONCLUSION

Any patient requiring the services of a healthcare professional in the prehospital setting has a right to expect the same level of quality of care that they would receive within hospital and thus experience a “seamless” journey from the initial contact to discharge.⁶ Clinical governance is formed by utilising knowledge of nationally recognised standards and regional expertise and applying them to a particular area. Arguably, the most important aspect is the overseeing and monitoring of all clinical activities and ensuring that processes for ensuring the quality of clinical care are in place. It is also important that clinical risk assessment processes are implemented, as well as critical incident reporting and audit activity.

As the speciality of prehospital and retrieval medicine develops and competency frameworks are developed, it is imperative that professional regulation of the delivery of this specialised area of healthcare develops simultaneously to ensure ongoing quality of care.^{7,8} We hope that developing a debrief tool at a local level will go some way to achieve this ongoing quality of care.

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APPENDIX

QUESTIONNAIRE TO EXAMINE KEY ISSUES RELATED TO THE CLINICAL GOVERNANCE OF THE TRAUMA TEAM

Dear Trauma Team member,

We are conducting a survey as part of the governance of the team and would value your opinion on the following questions. Please be assured that your answers will be confidential and putting your name at the bottom of the survey is voluntary.

Once completed please place in envelope provided and put in collection box in staff room or folder at staff base or hand to Mike Donald.

Please circle the appropriate answer:

1. How would you rate communication between team members:

a) Before leaving for incident?

Excellent

Good

Average

Below average

Poor

b) During course of incident?

Excellent

Good

Average

Below average

Poor

c) After incident?

Excellent

Good

Average

Below average

Poor

2. Do you get the opportunity to discuss events as a team after the incident?

Always

Sometimes

Never

3. How often do you get feedback on your individual performance?

Always

Sometimes

Never

Would you like feedback?

Yes/No

4. Do you think regular meetings to discuss individual cases would be of benefit?

Yes

No

5. Are you aware of any confidential reporting system for critical incidents occurring in the field?

- Yes
No
6. Have you ever felt at risk while on a call?
Always
Sometimes
Never
Please explain:
7. If there is an equipment malfunction in the field who would you report it to?
Consultant in charge
Registrar
Senior Nurse
Any additional comments:
- Thank you for your time in completing this survey
Date Time
Incident Location and Nature
What was your main task at incident?
Procedures—What worked well and what did not work well?
Action required:
Equipment—What worked well and what did not work well?
Action Required:
Concerns or Recommendations:
Journey Out:
On Scene:
Journey Back:
Does this case warrant further discussion?

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