Pediatric Emergency Department Staff Preferences for a Critical Incident Stress Debriefing

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CE Earn Up to 7.5 Hours. See page 471.

Contribution to Emergency Nursing Practice

- The current state of scientific knowledge on critical incident debriefing indicates that debriefing can reduce stress in staff involved with critical patient incidents, that all staff involved with critical incidents should be offered the chance to debrief, that debriefing facilitators should be trained, that the debriefing should be held before the shift ends or within 24 hours of the incident, and that there are evidence-based critical debriefing processes available for use.
- The main findings of this research are that pediatric ED nurses have pre-existing strategies to debrief themselves and others; that they want to hear positive reinforcement in a debriefing along with constructive critiques; that they do not want to discuss emotional aspects of the case during debriefing to maintain the ability to perform professional nursing responsibilities; that the debriefing should be optional; and that the debriefing should occur during the shift or within 24 hours of the incident, involve all who took part in the critical incident, and be facilitated by a charge nurse or assistant nurse manager present during the incident.
- Key implications for emergency nursing practice from this research are that staff desire optional-attendance debriefings as stress-coping mechanisms, but debriefings must fit within certain parameters. Microdebriefings may provide some positive aspects of a critical incident-stress debriefing if time does not allow for a formal critical incident stress debriefing during a shift.

Abstract

Introduction: There are significant and negative psychological effects that can occur in nursing staff caring for pediatric patients experiencing critical incidents. Debriefings can provide relief from the stressors caused by critical incidents. Adapting a pre-existing critical incident stress debriefing (CISD) process to ED staff is 1 way to provide staff debriefing.

Methods: This qualitative study used an emerging, descriptive design. Focus groups, (n = 3, total participant n = 19), consisting of pediatric emergency nurses and a nursing assistant, met for a minimum of 63 to a maximum of 83 minutes. Participants provided feedback on current debriefing strategies and suggestions for adapting a currently existing critical incident stress- debriefing process. Focus group questions included "Have you participated in a structured debriefing process? If so, tell us about it" and "What would you like to see in a structured debriefing process?"

Results: A theoretical orientation content analysis revealed 1 main theme—Clearing the Air and Finding Answers—and 6 subthemes: Current Debriefing Strategies; Positive Reinforcement; Constructive Critique; Clinical, Not Emotional; I've already moved on; and CISD Structure.

Discussion: Pediatric ED staff de-stress in a variety of ways, and a nonmandatory, formalized CISD process—open to staff involved and facilitated by an emergency nurse—could provide additional relief from stress. This debriefing process should include positive feedback and critiques to help improve care processes, information about mechanism of injury, and should occur before the end of shift or within 12 to 24 hours of the incident. Staff may deal with personal feelings outside of debriefing.

Key words: Critical incident stress debriefing (CISD); Pediatric emergency department; micro-debriefing; Qualitative research; Content analysis

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Emergency nurses often deal with patients who have been involved in critical incidents (CIs) such as traumatic injuries, sexual assault, or mass casualty incidents. Exposure to CIs can cause emergency nurses to experience burnout, compassion fatigue, low compassion satisfaction, an inability to cope, and secondary traumatic stress.[1,2]

Talking with others about the traumatic event in a formal or semiformal debriefing can provide some relief from the stressors caused by CIs.[2] A more specialized and formal debriefing process—a critical incident stress debriefing (CISD)—allows individuals to discuss the CI, offering health care providers—including nurses—a process to deal with the stress generated by a CI.[3,4] The CISD is facilitated by a trained CISD facilitator following a specific 7-phase supportive crisis-intervention process.[5] The goal of CISD is to mitigate the effects of CIs, facilitate a normal recovery process in persons who are otherwise mentally healthy, and screen for those who may need additional support or assistance.[3] CISD outcomes have been explored in emergency medical responders, police, firefighters, soldiers, and emergency nurses.[3] Participants of these studies reported the benefits of CISD including less anger, depression, anxiety, and alcohol abuse.[3] Experienced emergency nurses and physicians indicated debriefing is important after a CI.[6] CISDs can assist ED staff to cope with the emotional burden these CI situations leave in their aftermath.[7-9]

The purpose of this study was to obtain the perspectives of pediatric ED staff regarding an acceptable CISD process for the pediatric emergency department of 1 health care system. A customized CISD can provide unit-specific assistance to manage the stress and difficult emotions that surface during and after a CI. This study addressed the following research questions:

1. After experiencing a CI, what do ED staff identify as strategies to lower stress and address the emotional fallout?
2. Which aspects of a debriefing have/have not worked well in the past in lowering stress?
3. Which of these elements should be included in an evolving CISD?

Methods

This qualitative study used an emerging, descriptive design with theoretical orientation content analysis. Data analysis occurred immediately as data were collected, and themes describing staff needs began to emerge from the analyzed data. Purposive sampling of pediatric nurses and staff from a level-1 pediatric emergency department occurred. Participants (N = 18) self-selected into 1 of 3 focus groups (FGs)—FG1 n = 6, FG2 n = 5, FG3 n = 7—and completed a demographic survey, including general questions about CISDs (such as who should facilitate and attend the CISD).

This emergency department in a medium-sized, Midwestern city, had 34 patient-care beds plus 12 fast-track beds after 17:30 every day, 78 registered nurses, and 57,000 patient visits in 2016. Potential participants were recruited through e-mails, flyers, and staff-meeting announcements and met the following inclusion criteria: adult (≥18 years old) and ED staff membership, which included emergency nurses and nursing assistants (NAs). The University of Louisville Institutional Review Board (IRB) (approval #15.0515) and the health care system's research department provided IRB approval and ethics oversight.

Key participant questions included asking about past experience with personal/organized CISDs (To whom did you talk? What activities/behaviors/methods help you debrief? How have organized debriefings assisted you? What would you like to see in a structured CISD?). Discussions were audio recorded and transcribed verbatim, with the Principal Investigator (P.C.) verifying that the transcript record matched the audio recording.

Data were analyzed in the online qualitative data analysis program, Dedoose (Dedoose, Version 8.0.44, Sociocultural Research Consultants, Los Angeles, CA) uses the theoretical orientation content analysis, which involves reading and recognizing related statements made by participants across the focus groups and developing these statements into "codes."[10] Data collection ended when both data coders (P.C. and B.P.) agreed that saturation had been reached when no new information leading to new themes emerged from data analysis.[11]

Subthemes emerged simultaneously and were agreed upon by both data coders (P.C. and B.P.). Credibility of results (an assessment of internal validity) was confirmed by reviewing a summary of the focus group with participants and asking for additional feedback.[12] Additional credibility assessment occurred via "member checking," in which participants provided feedback on finalized study data. Member checking provided an additional credibility assessment and allowed participants to verify, refute, and/or clarify study results, increasing confidence in the study findings.[13] Member checking occurred by contacting 15 of the participants (4 had moved on to other positions with no forwarding contact information). Five of the 15 contacted members responded and agreed with the study theme and subthemes.

Results

Three focus groups convened between October 2015 and May 2016. The groups met for 63 to 83 minutes in a hospital conference room in a separate part of the hospital, away

TABLE
Demographics of CISD Study Participants

Demographics of participants	Total participants N = 18	
	Totals	%
Age		
18-30 years old	5	26%
31-40 years old	4	22%
41-50 years old	3	17%
50+ years old	6	33%
Current Position		
ED nurse	17	94%
ED Patient-care associate	1	6%
Education Level		
Associate degree	3	17%
Baccalaureate/master degree	15	83%

The time lengths of all participants in their current positions range from 2 weeks to 25 years. Average length of time is 7.7 years.

from the emergency department. Eighteen emergency nurses and 1 NA participated, with a well-distributed age range; most were baccalaureate prepared, with an average time of 7.7 years in their current position (Table).

One main theme and 6 subthemes emerged from the theoretical orientation content data analysis and provided an overview of the preferred CISD process for their emergency department (Figure 1). The main theme, Clearing the Air and Finding Answers, both summarizes current CISD process debriefing strategies, issues, and concerns and provides several different components that the pediatric ED staff wanted to incorporate into the CISD. Six subthemes emerged: (1) current debriefing strategies; (2) positive reinforcement; (3) constructive critique; (4) clinical, not emotional (debriefing about the mechanism of injury or cause of death, and not about current staff emotional status); (5) I've already moved on (ability to voluntarily chose to attend or not attend); and (6) CISD structure, which includes having a defined CISD facilitator, clear boundaries about who should attend a CISD, and a timeframe for CISD.

SUBTHEME 1: CURRENT STRESS REDUCTION STRATEGIES

Participants describe reducing stress through a variety of nonstructured, nonformalized strategies employed after a CI (independent of any formal debriefing process such as a CISD). These current strategies can be divided into 2 categories: stress reduction with others and stress reduction with self. Strategies categorized as "stress reduction with others" include crying with or holding one's own child after leaving the shift and returning to home (n = 6 participants), discussing the case with one's own family or friends (n = 6), discussing the case with peers (n = 5), and talking with the manager (n = 2) or the chaplain (n = 2). Stress reduction with one's own family was described as problematic because some of the CI details can disturb family members. Also, because of patient privacy concerns, often the emergency nurse could not discuss the case with his or her family completely, which lessened the positive stress-reduction impact. Regarding stress reduction with family, 1 participant shared the following: Participant I: "Crying and hugging your own kids." Several in the room provide affirmative responses. "A lot of kids get woke up at night or go in and get extra kisses, I'm sure; at least mine do." "Stress reduction with self" is a category describing a variety of strategies to personally deal with the post-CI emotions. These strategies include prayer (n = 6), taking quiet time (n = 5), becoming numb (n = 4), cleaning up the room or remaining with a deceased patient after the CI (n = 4), consuming alcohol when at home/at a restaurant or pub and no longer on duty (n = 3), and personal care such as showering (n = 1), exercising (n = 2), or watching movies or TV shows (n = 2). Participants described coping with stress that results from a CI by becoming numb while still on shift as a strategy to maintain objectivity and a professional demeanor amid the very emotional and rough circumstances of a CI. Two participants noted that becoming numb was a way to cope and be available for the next CI or patient. Participant E: "You become numb." Participant C: "You have to." E: "You gotta do your job." C: "That's your coping mechanism." E: "Because the tone's going to drop or the phone's going to ring and you gotta go." C: "Yeah, that's your coping mechanism."

SUBTHEME 2: POSITIVE REINFORCEMENT

Study participants discussed high-level knowledge brought to the patient-care environment during a CI. Nursing knowledge, fueled by nursing education and on-the-job experience, allows emergency nurses to perform amid high-stress circumstances. Caring for high-acuity patients, frequently working with high patient volumes, and providing care even when they see their own families and children in the families and the patients for whom they provide care are all part of these circumstances. They indicated that they wanted their work, grounded in this nursing knowledge base, recognized, especially after a CI.

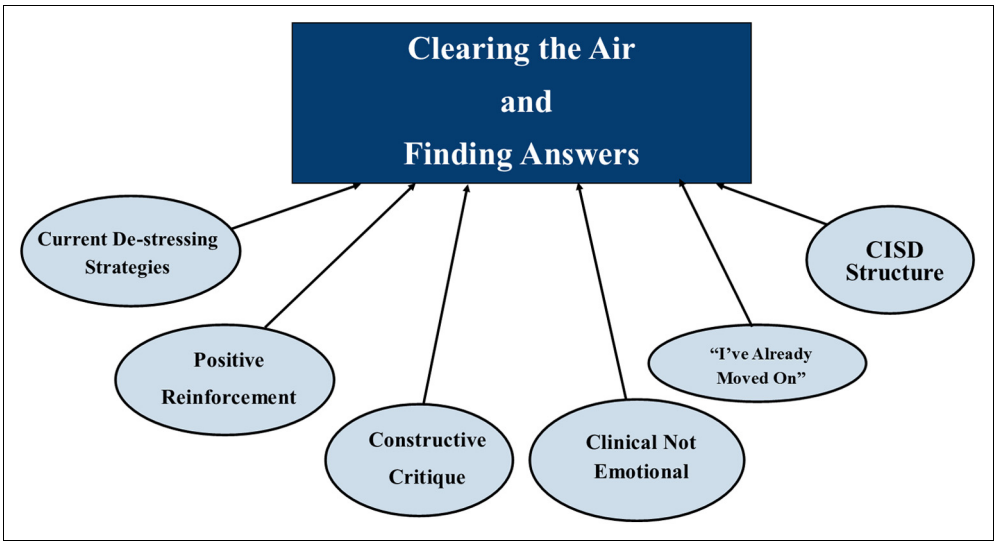


FIGURE 1
CISD themes and subthemes.

Participant A: "I guess it's like the positive reinforcement aspect of it that I would be helpful to be able to. . . " Participant B: "…we collaborated well, we came together, and we did it. And I feel like being able to—instead of being this traumatic thing to be able to say—pull some positive aspects out of it." Participant C: "And I feel like that's something that's sorely lacking, is positive reinforcement right now: super-duper lacking." Positive reinforcement reframes this CI, as Participant B noted, allowing "positive aspects" to come out of this highly stressful CI.

SUBTHEME 3: CONSTRUCTIVE CRITIQUE

During focus-group discussions, participants wanted an objective overview of what could be changed, fixed, or improved from the current CI so as not to repeat the same issues during the next CI. As Participant C noted, "I want to know what we did wrong to fix it for the next kid." Staff improvement was the primary purpose of providing constructive critique, which is used neither to criticize nor to provide negative feedback. Providing constructive critique for the benefit of improving care was highlighted in this comment by Participant N: "I do like an immediate clinical debriefing; What went well? What can we improve on? . . . I like to have that so people can learn what can we improve. . ." Along with positive reinforcement, participants also desired constructive critique to learn specific ways to improve.

SUBTHEME 4: CLINICAL, NOT EMOTIONAL

Nurses discussed at length not wanting to discuss the emotional aspect of these CIs. Rather than revealing that they were devoid of feelings for their patients and patients' family and friends, focus-group participants discussed needing to remain professional. Discussing the emotions generated by a CI, particularly having to respond to questions such as "How are you feeling?" caused staff to experience such strong emotions that they could not remain objective and were unable to perform at a high professional level. To protect themselves from being overcome by these strong emotions, some participants described creating a therapeutic wall or compartment that allowed them to put their personal emotions aside and thus remain professional during and after 1 or multiple CIs. Participant C: "You gotta go to the next one. That's why you have to categorize, compartmentalize; yes, you had a full arrest last night. Yes, that really sucks. I can't deal with you right now, full arrest, go in the back of your mind. Right, now go deal with helicopter (patient)." Participant E: "Right, can't deal with full arrest (patient). . ." During a CISD, participants want to focus on clinical issues, allowing them to maintain their professional objectivity during care of current CI patients: Participant N: "I'm just saying to have that wall, that holding of your emotions while you're cleaning, getting ready for the next patient, a little safety net…we've got to be ready for the next one."

SUBTHEME 5: "I'VE ALREADY MOVED ON"

Participants overall felt that anyone present for the CI could voluntarily attend a CISD but did not want the CISDs to be mandatory. Six participants stated that they would never attend a CISD because they had already dealt with the situation or "moved on." Participants de-stress in a variety of ways, including discussing the CI with peers either on or off the job, discussing some details with family members, or decompressing by spending time alone or with family/friends. For some participants, de-stressing using some of these techniques is sufficient, as with Participant J: "…I know what bothers me, not that I'm happy that anybody ever dies, don't get me wrong, but I don't need to come in here on a (day off) for a debriefing when I'm coping and doing fine." If participants dealt with CIs on their own, they said that they did not want to be a part of a formal CISD, no matter when the CISD occurred.

SUBTHEME 6: CISD STRUCTURE

The 3 main elements of the CISD structure were as follows: Who should facilitate the CISD, who should attend the CISD, and when should the CISD occur? Participants indicated that a nurse, preferably a charge nurse or assistant nurse manager, was the choice for CISD facilitator. As Participant E noted: "Yeah, mostly our charge nurses, if there's a full arrest or a death, if they're not an active participant in it, they're in the room; they know everything that happened; they know everyone who was in there; they know the whole story; there's no catching them up; they're there. And it makes it feel like they actually do understand. . ." Chaplains, although a part of the intradisciplinary team, may not be the best suited to facilitate a CISD. Participant N described why chaplains may prevent staff from maintaining that professional therapeutic demeanor: "There's one chaplain who is an excellent chaplain, but, without fail, [he] makes every single person cry . . . because [he is] so kind and so open and so just 'are you OK?' And it basically tears down your dam." As with Subtheme 3, participants reinforced their desire to maintain a therapeutic wall to retain objectivity, allowing them to provide professional care.

When queried about who should attend a CISD, participants indicated that any staff member involved in the CI, independent of discipline or job description, should attend the CISD. NAs, physicians, emergency nurses, unit clerks (who enter orders and encounter frantic family members during the CI), respiratory therapists, x-ray technicians, pharmacists, and the pediatric intensive care unit (ICU) nurses transporting a patient who survived a CI to the ICU should be involved. Housekeepers should be a part as well, as noted in this exchange: Participant C: "I think every single person in that room. I don't care if they were housekeeping. I think every person involved in that room is going to touch you in some way, even just literally coming in afterwards and cleaning up in that room." Participant E: "Cleaning up all the blood [on] the floor." Participant C: "Yeah, and taking out the garbage. Literally, that's housekeeping, but I'm sure that affects them, especially if you're used to just cleaning up garbage; you're not used to being in there with this dead body."

The majority of participants thought that the CISD should occur within 12 to 24 hours of the CI, preferring the CISD to occur before leaving the shift. Participant E noted: "And probably with me, if it's 2 days later, it's 2 days gone. A lot's happened in 2 days. I've moved on at that point; I'm not thinking about that anymore. So it has to happen that day. And I don't want to go back and think about it again." Some participants, like Participant H, did not want to come in on a day off, which was described by many as a way to debrief in and of itself: "My bed is fabulous. On Tuesdays, there's a [television show] marathon [*laughter*]. Like you better make this real damn good for me to get out of bed and drive all the way here. My day off is my day off." Personal issues, such as childcare, noted by Participant G, also prevent staff from coming in to debrief on their days off: "I have 2 small kids at home, so getting a babysitter is difficult sometimes on my off days . . ."

Discussion

This study was designed to seek pediatric ED staff needs and preferences to create an effective, unit-specific CISD process to help staff manage stressful emotions following CIs. Participants revealed multiple strategies to lower stress and address emotional fallout (research question 1), which included de-stressing with others (emoting and processing with family members, children, other [peer] staff members) and de-stressing with self that involved patient-care activities (including cleaning and attending to the body of a deceased patient), and personal activities (alcohol consumption, TV watching, exercising, or showering). Because of HIPAA concerns, participants indicated that one's own family was not always the best group with whom to debrief. Also, participants revealed that debriefing with other staff members not only maintained patient privacy but was more effective because staff (especially peer staff) more clearly understood what occurred, were more empathetic, and thus provided a better personal debriefing experience. Evidence that seeking support from family members, friends, and colleagues is an

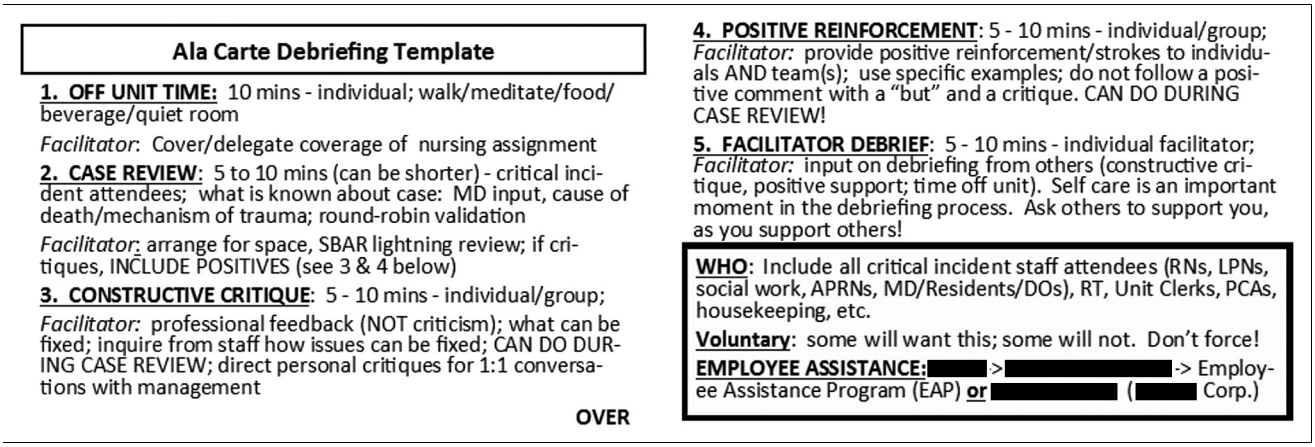
effective strategy for dealing with a CI is found in a literature review of studies of staff with an adverse patient health event.[13]

Participants also described what they would like to experience to lower stress after a CI (research question 2). Positive reinforcement is acutely needed and was the most common response. Participants wanted to know individually what they did well and wanted specific actions and behaviors recognized. Providing generalized comments, such as "You all did great!" were not as helpful as specific positive reinforcement, such as, "Juan, you and Carla quickly identified the immediate need of rapid sequence intubation and took the initiative to prepare the equipment and drugs. That saved time and contributed to the positive resuscitation result." Positive reinforcement during a debriefing may contribute to the resiliency of staff.[14] Along with positive reinforcement, participants welcomed constructive critiques following the CI. Participants desired to know what could be improved and wanted directions addressing problematic actions and behaviors to prevent the same issues from recurring. Although they wanted an opportunity to discuss the multiple facets of the CI, they were not interested in discussing feelings at that moment. To maintain a professional demeanor, they expressed a need to maintain a therapeutic wall by not discussing or dealing with the strong emotions that can accompany a CI during the debriefing. This wall maintains their professional composure so they can provide ongoing high-level, professional nursing care. Although all staff might not desire to—or be able to—push off dealing with their feelings until later, participants of this study noted they preferred to deal with their feelings when at home, when with family, or when with peers. Participants also do not want a CISD to be mandatory especially if they have "already moved on" and have dealt with the CI in their own way by providing care to the patient's family or by other ways of self–de-stressing.

As with other sources,[8,14] participants indicated that the structure of the CISD should include anyone directly involved in the patient-care room as well as those affected by this CI. Participants favored a charge nurse or assistant nurse manager who was directly involved in the CI as the CISD facilitators. Emergency nurses thought that a nursing peer best provides an effective debriefing because emergency nurses understand the staff perspective. These findings are consistent with other sources indicating that staff trained in CISD and charged with debriefing have a strong impact on the debriefing effectiveness if they are trusted by the staff being debriefed and are not in the role of manager or physician; staff in these positions may ask questions that trigger sensitive emotional issues.[9,13,15,16] Participants want the debriefing focused on the causes of injury or death, what went well, and what could be improved. Participants do not want to veer into the realm of emotion during the debriefing (as had been their experience with chaplain-led debriefings). Focusing on the quality of actions and behaviors during the CI and recognizing and acknowledging errors have the potential to improve staff processes and patient outcomes.[14]

A major roadblock was encountered with implementing a unit-specific CISD in this emergency department. As prescribed by the CISD process,[5] and as noted by the participants, the CISD should occur within 12 to 24 hours, with 9 of the 19 focus-group participants desiring to debrief before leaving the shift. Other sources advocate for debriefings immediately after the CI or within the same shift.[14,15,17] The difficulty with implementing a unit-specific CISD at this facility is that staff work 12-, 8-, and 4-hour shifts and leave at a variety of times (7 am, 11 am, 3 pm, 7 pm, 11 pm, etc). There is no common end-of-the-shift time for everyone. Given this reality, the only way to implement a CISD and debrief as a group before anyone leaves would be to suspend ED operations: not a feasible option.

As an alternative to a group CISD, a microdebriefing process was developed and implemented in this pediatric emergency department. Facilitators for this microdebriefing included experienced trauma nurses, charge nurses, and assistant nurse managers. Microdebriefing facilitators were provided with a 1-hour nursing continuing education unit (CEU) on individual or small-group debriefing. Four debriefing options, based on the results of this study, were taught and included the following (with approximate time required for each debriefing method in parenthesis): (1) provide individual staff time off the unit to walk/meditate/eat/drink/decompress in staff quiet room (10 to 15 minutes); (2) micro-case review debriefing with available staff to discuss what is known about the case, the mechanism of injury/mechanism of trauma, and round-robin validation of what went well and what could be improved (5 to 10 minutes); (3) positive reinforcement to individual staff and/or teams to validate specific individuals for specific, positive impact actions (5 to 10 minutes); and (4) constructive critique to provide feedback and solicit input about specific actions that require improvement (5 to 10 minutes). Facilitators were reminded to provide care for themselves by debriefing using 1 of these 4 methods. Microdebriefings can be provided to any staff members who were involved in the CI. A badge card was provided to facilitators with reminders of these



Ala Carte Debriefing Template

1. OFF UNIT TIME: 10 mins - individual; walk/meditate/food/beverage/quiet room

Facilitator: Cover/delegate coverage of nursing assignment

2. CASE REVIEW: 5 to 10 mins (can be shorter) - critical incident attendees; what is known about case: MD input, cause of death/mechanism of trauma; round-robin validation

Facilitator: arrange for space, SBAR lightning review; if critiques, INCLUDE POSITIVES (see 3 & 4 below)

3. CONSTRUCTIVE CRITIQUE: 5 - 10 mins - individual/group;

Facilitator: professional feedback (NOT criticism); what can be fixed; inquire from staff how issues can be fixed; CAN DO DURING CASE REVIEW; direct personal critiques for 1:1 conversations with management

OVER

4. POSITIVE REINFORCEMENT: 5 - 10 mins - individual/group;
Facilitator: provide positive reinforcement/strokes to individuals AND team(s); use specific examples; do not follow a positive comment with a "but" and a critique. CAN DO DURING CASE REVIEW!

5. FACILITATOR DEBRIEF: 5 - 10 mins - individual facilitator;
Facilitator: input on debriefing from others (constructive critique, positive support; time off unit). Self care is an important moment in the debriefing process. Ask others to support you, as you support others!

WHO: Include all critical incident staff attendees (RNs, LPNs, social work, APRNs, MD/Residents/DOs), RT, Unit Clerks, PCAs, housekeeping, etc.

Voluntary: some will want this; some will not. Don't force!

EMPLOYEE ASSISTANCE: [redacted] > [redacted] -> Employee Assistance Program (EAP) **or** [redacted] ([redacted] Corp.)

FIGURE 2
CISD micro debriefing "cheat sheet."

debriefing methods along with a way to contact the hospital system Employee Assistance Program if staff require further assistance that could not be supplied in a microdebriefing (Figure 2). This microdebriefing process is currently being implemented in the department. Further research is needed to determine the outcomes of the microdebriefing in light of effectiveness, staff turnover, burnout, and workplace engagement.

Limitations

This study included staff from 1 pediatric emergency department in a mid-sized, Midwestern state, and, as a result, these findings may not be generalizable to other facilities outside of these parameters. Other staff perspectives—such as respiratory therapists, social workers, chaplains, physicians, and additional patient care (nursing) assistants—were not included,. The inclusion of ED practitioners from other disciplines would have enriched results.

Implications for Emergency Nurses

Pediatric emergency nurses caring for patients and their families who experience significant injuries or who die in the emergency department require debriefing to help cope with these significant events. CISD is an evidence-based, effective process to help ED staff cope with these events; however, implementing the traditional CISD process in a level 1 pediatric emergency department in the timeframe required is challenging. Whether a CISD or a microdebriefing is provided, some process is necessary to review the case, understand what went well and what could be improved, and acknowledge the individual need for ED staff to find ways to cope with the secondary traumatic stress involved with CIs. Including a debriefing process can potentially inoculate emergency nurses from burnout, compassion fatigue, and further trauma, creating a more positive work experience and a healthier workforce.[1,18,19]

Conclusions

Understanding the importance of CISD and the challenges of implementing a unit-specific CISD process is important for pediatric ED staff. Meeting these challenges by providing microdebriefings may provide ED staffs the opportunity to be mentally and physically ready for the next CI and to provide higher-quality, safer patient care with each CI encountered.

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