



Journal Club Summary June 2018 : "First Aid"



## Expert Opinion: Liz Crowe

*"The greatest risk to patient safety is a failure to learn from incidents and events"*

## The Article :

### "Charge nurse facilitated clinical debriefing in the emergency department."

Rose, S. & Cheng, A. (2018).  
[CJEM, 1-5. doi:10.1017/cem.2018.369.](https://doi.org/10.1017/cem.2018.369)

#### Case & Summary Author :

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#### Expert Commenter :

- Liz Crowe

#### Editors :

- Dr Victoria Brazil
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#### First Published :

Simulcast Journal Club is a monthly/ series that aims to encourage simulation educators to explore and learn from publications on Healthcare Simulation Education.

Each month we publish a case and link a paper with associated questions for discussion.

We moderate and summarise the discussion at the end of the month, including exploring the opinions of experts from the field.

#### The Case :

"I was wondering if you could arrange a debrief for the team, Cath?" said Christine quietly. "I know it was a week ago, but I'm getting a lot of questions from my staff about the outcome for the patient and the choices we made on the day."

Cath swivelled her chair towards the window and frowned.

"I agree it'd be a good idea, and I've been wanting to get some critical event debriefs happening for months, but we don't have anyone trained in that area! I can debrief a simulation pretty well, but there's some evidence that doing this badly could worsen PTSD symptoms! And the times I've tried to get one going, people are off shift or unable to come in and anyway it's frankly uncomfortable debriefing an event that I was in charge for. I think we need to wait until we've got some trained professionals to do this sort of thing. I'm sorry Christine."

Christine eyes flared with frustration. "I don't think you quite understand. I'm having trouble staffing Resus! A few nurses have asked to just do short stay only for a while, Andrew's called in sick twice this week, and that's not like him, and there are also some systems issues that came up with that trauma that frankly we need to acknowledge and fix before the next serious paediatric trauma comes in."

"I agree that physicians shouldn't always be in charge of debriefing." She continued. "But you guys are the only ones who get leave and enough pay to cover an expensive debriefing course. Surely there has to be another way we can do this?"

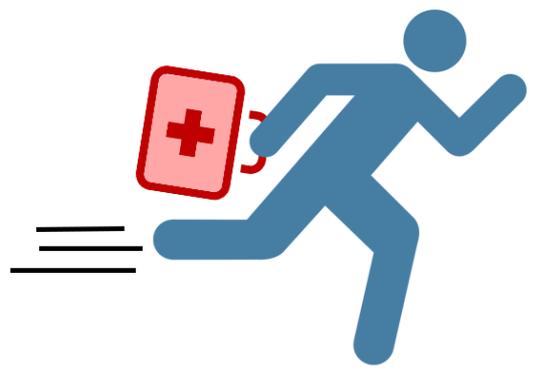
#### Discussion :

Clinical educators are increasingly being asked to participate or contribute to the development of critical event debriefings in the hospital environment, but numerous barriers can get in the way. In this month's article from Stuart Rose & Adam Cheng, we examine a system implemented in 3 hospitals in Calgary, Canada that utilised Charge nurses to facilitate over 200 critical event debriefs in their emergency departments.

For the journal clubbers this month, what did you think of the article? Have you been asked to get involved in critical event debriefing? What have been the barriers for you? Does this article point you towards another potential solution?

### Article Summary :

After a Resus, physicians and ED nurses are often immediately pulled away to see other patients, making debriefs rare.



But Charge Nurses don't tend to have a single patient load, are situationally aware, experienced and team minded...



So they can also make great debriefers!

So in 3 Hospitals in Calgary, *Rose & Cheng* created a new, tightly scripted model for ER debriefing that involves immediate, on site debriefing by ED charge nurses. It is triggered by either CPR, Intubation, Level 1 Trauma or staff request and is called the **INFO** model.



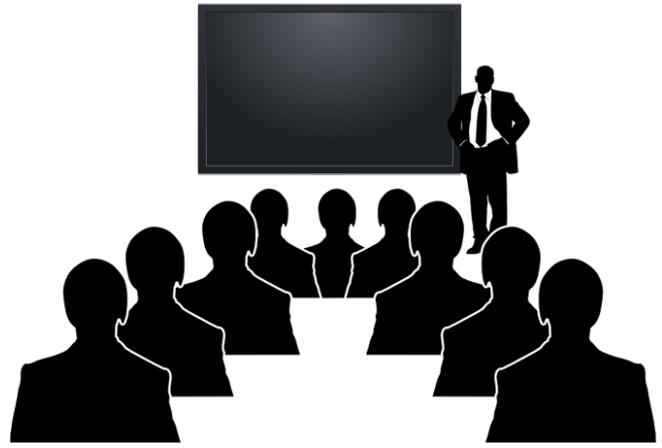
**INFO** model =  
**I**mmEDIATE,  
**N**ot for Assessment,  
**F**ast, **F**acilitated, **F**eedback  
**O**pportunity to ask questions.

Rollout included a 4 hour train the trainer for nurse educators and local champions, and then a 2 hour program to teach the scripts and principles to Charge Nurses.

They have now completed :

**254** debriefs involving  
**1300** staff

Could the INFO model help your department implement debriefing?



## Expert Opinion: Ms Liz Crowe



Liz Crowe is an Advanced Clinician Social Worker who has worked extensively for 20 years with individuals, families and children impacted by grief, loss, trauma, crisis and bereavement. She has worked in Brisbane’s major children’s hospitals in intensive care, emergency departments, cancer wards and all areas associated with children’s health. In her current job in a children’s intensive care unit, she is exposed daily to death, violence, trauma and illness and is now recognised as one of the most experienced counsellors in this field in Australia.

Liz is currently a PhD Candidate with the School of Medicine, The University of Queensland. The focus of her research is *Staff Wellbeing in the Paediatric Intensive Care Unit*. She regularly speaks on the national and international circuit regarding : *Loss and Grief, Staff Wellbeing, Difficult Conversations, Talking to Children about Loss and Grief, Working with Schools in crisis, Mental Health at Work, Resilience for children and adults, Self Care, Gender Relationships, Parenting, New Mothers and Sexuality, Adjustment to Parenthood*.

You can follow her on Twitter @LizCrowe2 .

You can listen to Liz’s podcast on [clinical debriefing here](#) at St Emlyn’s blog.

“There is a legal and moral responsibility to protect staff from workplace distress, trauma and its consequences. Regardless of where individuals currently work in healthcare there should be an expectation to do what is reasonably practical to eliminate or minimise risk to worker health and safety. Organisations that have awareness that employees may be exposed to distressing events need to have a consistent and effective management strategy for those who may be exposed (Greenberg, 2001). Yet the reality in most health institutions is vastly different. Staff involved in any type of critical incident have a ‘hunger’ for something to occur either formally or informally as means to learn, grow professionally and at times more importantly validate their own feelings and emotions. Debriefing is an efficient and cheap resource that is offered in the absence of anything else. Debriefing is frequently perceived as a ‘safe’ option despite no standardisation in the literature, no strong evidence for outcomes, that facilitators rarely have any formal training and no appropriate tool for evaluation as to its perceived risks and benefits.

Staff who work within the healthcare environment are routinely exposed to potentially stressful and significant events due to the very nature of their work (Huff,2006). Stress and poor health amongst health care staff is a contributing factor to organisational inefficiency, high staff turnover, decreased quality and quantity of care, increased costs of health care and poorer rates of job satisfaction (AbuAlRub, 2004). Sadly, for most hospitals a systematic response to staff wellbeing, particularly in relation to a critical event, is dependent on the good will of senior staff. Across the globe it is led by either medical and nursing staff or in some institutions by staff with a psychological background such as social workers, psychologists or those with mental health training. Most staff who provide debriefing are operating outside their role descriptions and without any formal agreement from health leadership. Typically, these clinicians will have been directly involved in the critical event themselves. This has both benefits and risks. Every day events that create distress are often internalised by staff with unknown consequences and outcomes. Occupations such as the Police, paramedics, fire services and the armed forces that have similar exposure to trauma, death and the impact of illness and violence have established infrastructure, resources and policies for response with counselling, debriefing, psycho-education and peer support structures.

Another major challenge for the establishment and understanding of the impact and effectiveness of debriefing is that there are numerous processes conducted in the health setting that use the term ‘debriefing’ though what this constitutes varies enormously. There are ‘hot’, ‘cold’, ‘operational’, ‘emotional’, ‘defusing’, ‘distress’, ‘clinical’, ‘formal’ and ‘simulation’ debriefings. There is no global consensus for what ‘debriefing’ means.

With the release of the Cochrane Review in 2002 (Rose et al) debriefing of any nature was deemed to be at best benign and at worst dangerous. Health professionals were told to cease all debriefing with no other mechanism or intervention suggested as an alternative. It is important to note that the Cochrane Review was evaluating single session interventions for a very different population than health professionals. The cohorts who were involved in compulsory debriefings included MVA victims, relatives of seriously injured individuals 12 hours post the injury, women who experienced miscarriage, acute burns victims who were still undergoing active treatment and women who had just given birth. Only one study included second responders. Out of the 11 studies the outcomes of debriefing were that 3 groups improved, 2 groups were psychologically worse and in 6 groups there was no significant difference. From this small sample size of varied populations debriefing has been labelled 'dangerous'.

Rose and Cheng have done a wonderful job in their paper '**Charge Nurse Facilitated Clinical Debriefing in the Emergency Department**' of describing and discussing their current model of providing 'hot' or immediate debriefing following critical events which they have called INFO (*immediate, not* for personal assessment, *fast* facilitated feedback and *opportunity* to ask questions). Development of a 'feasible and sustainable' debriefing structure in an emergency department is a solid foundation to further research and understanding of impact as well as sending an important message to staff that their skills and contributions are valued. The use of an ED charge nurse who is present at resuscitations, though not directly involved, has benefits in that the person will be known to the team and so hopefully is respected and accepted. Previous research has demonstrated that the majority of occupations want to be debriefed by someone who has credibility and intimate knowledge of the work, rather than an external facilitator.

The INFO tool is clear and the use of a 'script' keeps the facilitator on task allowing the process to be conducted and completed in the 10-15 minutes allocated timeframe following an event, recognizing that staff are required to return to clinical duties or proceed to a change of shift. Creating a "Teach the Teacher" model ensures there is a pool of trained facilitators and that the model should not be depleted over time due to staff attrition. Objectives for the INFO debriefings are centered around improved communication, education and an efficient way to provide feedback about concerns within the system which are reportedly met and implemented quickly. The article reports on practice and cultural outcomes as a result the introduction of INFO. This model is clearly able to be replicated in other health settings which is always important in published papers. One of the limitations of the study would be the subjective reporting of benefits without any real evaluation and no benchmarking on, before and after implementation. It is also unclear whether the quality and outcomes of debriefings have varied since the facilitation role was transferred from physician led to nursing led.

One of the greatest challenges in advancing the use of debriefing is how to provide evidence in relation to outcomes. Evaluating the effectiveness of a debriefing process is complicated. How do you evaluate individual outcomes in a group intervention when those individuals will have started with a variety of psychological baselines, will engage in various self-help or self-destruction activities post the event and will also be exposed to personal and professional traumas and rewards during the evaluation period? A post-traumatic stress disorder (PTSD) measurement tool is frequently cited as the gold standard. Yet PTSD can not be diagnosed until 4-6 weeks after the traumatic event and debriefing of any description would typically occur before these this. Measurement of PTSD following a critical event may also not be the most appropriate benchmark, impact on sleep, use of substances, irritability, impact on concentration and anxiety may be more significant and tangible? Another major barrier for evaluation is the ethics of the use of randomized control trials following a critical incident allowing some staff to be supported and others to fend for themselves. Tuckey and Scott (2014) did conduct a randomized control study with emergency service personnel using four measurements- , namely, post-traumatic stress, psychological distress, quality of life and alcohol use. They found that those who engaged in debriefing used significantly less alcohol and reported greater post intervention quality of life. As is reported in other studies they did not find any effects on post-traumatic stress or psychological distress – this may be because the measurement tool is wrong rather than debriefing has no value.

However, how to successfully evaluate and provide any supporting scientific basis for debriefing remains confusing with subjective reporting common. Therefore, the lack of evaluation of this article should not be seen as a flaw.

There are several points worthy of reflection in relation to the article and model. Firstly, I would like further information on who is included and excluded from the debriefing experience? Is it only staff who were directly involved in the event itself? Are administration and staff support personnel such as wards people included? In our hospital there are strict criteria for who can and cannot attend debriefs. Debriefing is only offered to clinical staff who were directly involved in the event. Support staff and line managers are not allowed to attend as it changes the focus and level of safety disclosure. Should support staff require any type of support this is done outside the clinical debriefing format with a more emotional focus.

The article implies that the INFO process is a forum for feedback and discussion rather than what is traditionally known and understood as debriefing. The term 'feedback' is used several times in the tool. There appears to be no articulated space for anything more than individual reporting which the authors may argue is the defined purpose of a debrief immediately post a critical event? The exclusion of any emotional content or space for distress is also interesting. Humans are emotional beings by nature. Personal observation of over 15 years of facilitating debriefs immediately post an event or in the subsequent weeks that follow is that it is the emotions attached to the event or the operational conduct that is causing distress or disturbance to work and to neglect these components in the debrief heightens distress.

The INFO model presents as having a strong system response for feedback and without any emotional inclusion I am curious as to how psychological safety is established so that staff can talk about any concerns around team dynamics, communication or leadership within the event? While open to debate on the issue of note taking and scribing during a debrief, it is not something that is supported by literature or experience. Debriefing is not the place to evaluate staff performance or conduct investigations. Anything that is written down during a debrief can later be used in a processes or health investigation and should be thought through very carefully. It also gives an impression of performance review. If there is something concerning that has arisen from the debriefing it can be consented amongst the group verbally to report back to management without note taking ever occurring.

The other area of interest to me with the INFO model is it only appears to follow a resuscitation. Emergency Departments and hospitals are dynamic environments with unpredictable events. Is the INFO model ever used to debrief events following episodes of violence or aggressive behaviour, unexpected death, confronting cases or moral distress?

With no evidence I can only report that the best debriefings I have been involved with achieve a combination of objectives. Debriefs similar to the INFO process occurring immediately after an event bring the team together to pause and hold them in a space to reflect and learn on what has just occurred, assess any risk and decide whether or not they may need to gather again in the future. A more in-depth and delayed debriefing should only occur if staff who were involved in the incident believe it is required and would be useful to them on any level. The purpose of a more detailed debrief 5-7 days post the event (this is optimal timing so that people are less heightened and have more objectivity) is again multifactorial. Personally, we start with a full history and understanding of the event which is important given that not all staff ever really have all the details. To explore what happened during the event, perspectives on leadership (not judgement), what was happening with communication, what occurred operationally, what were the learnings? Then to reflect on how people have felt subsequently about the event. Interestingly often when the history and operational functioning of the event have been unpacked many staff, particularly junior staff will state their distress had been around concerns they failed to act quickly enough or be a functioning contributor to the event and now with all the details this distress is eliminated. We then talk at length about what is a 'normal' emotional response to a critical event and provide discussion of a psychoeducational nature. Staff benefit from awareness of the symptoms of acute distress in the days following an event and an understanding that the majority of first line responders endure the temporary state of acute stress disorder and

return to normal function with minimal disruption (Aucott & Soni, 2015). Staff are empowered to recognize emotional responses that could be described as 'coping' and does not require pathologizing or intervention. We also always use two facilitators for the delayed debrief. Debriefing in the immediate post event space is common in our organization. A more formal delayed debriefing is only instigated at the request of staff recognizing there is an under-estimation of resilience in the health workforce.

The greatest risk to patient safety is a failure to learn from incidents and events, medically and psychosocially. Following a critical incident or resuscitation staff want to want to engage in debriefing (Berg, 2014). The commencement of any formalized system to provide debriefing is a strong foundation to understand further the needs of staff with regard to education, development of skill levels, post traumatic growth, increased psycho-educational needs and the addressing of emotional needs. The INFO model of debriefing is a solid starting ground that is able to be replicated and developed further by other health environments.

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## Summary of this Month's Journal Club Discussion :

### Blog Contributors :

- Farrukh Jafri, Ben Symon, Stuart Rose, Susan Eller, Ian Summers, Derek Louey, Lucinda Mithen
- Sarah Janssens, Laura Rock, Suzanne Nelson, 'Leo'.

This month's article caused some enjoyable controversy and disagreement, with 3 strong themes being :

- Admiration for the simplicity of the INFO tool and its local success
- Desire for more detail within the article itself
- Disagreement regarding whether to separate technical debriefs from emotional debriefs.

### Admiration for the simplicity of the INFO tool and its local success :

The discussion began with Farrukh, Ben and Stuart sharing reflections about event debriefing within their local services. Farrukh expressed admiration for the simplicity of the INFO approach and its use of Charge Nurses to enable consistent debriefing standards.

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*"The shifts are always so busy and I often feel overloaded, so it often now does not dawn on me to debrief. This is the complaint I get also from other staff members who have not debriefed, it's just too busy. This is why I really like the idea of a designated member to debrief, a charge nurse sounds perfect." – Farrukh Jafri*

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### Desire for more detail within the article itself :

Seemingly in response to appreciation for what the paper had to say, multiple bloggers asked for more detail from the article itself. Sarah Janssens, Susan Eller and Derek Louey all expressed a desire for more information, with Derek expressing concern regarding the editorial nature of the paper.

### Disagreement regarding whether to separate technical debriefs from emotional debriefs :

Much of the meat of the discussion came from debate about whether psychological 'first aid' should be included in post event debriefings. By the end of the month, there appeared to be two main camps : Those who felt emotion could not be separated from cognition, and thus needed to be acknowledged; and those who voiced concerns regarding the potential psychological damage of addressing emotionally distressed staff without expert training within that field.

Stuart (the author), Farrukh and Derek each expressed the dangers of turning a post event debrief into a counselling session. Derek highlighted a Cochrane review that cautioned debriefing may be associated with higher PTSD scores, while Stuart argued that debriefing emotional issues takes time, and as such should be done at a later stage when it can be facilitated more thoroughly. He also noted engaging in too many emotional issues in a 'hot debrief' could lead to the lengthiness of the process becoming a barrier to debriefing at all.

Others in the discussion such as Lucinda Mithen, Suzanne Nelson and others felt more strongly that emotional defusing was an important part of a post event debrief. Ian Summers argued :

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*"I have found in clinical debriefing (and sim) debriefing that a failure to hear and acknowledge the inherent emotion or sadness of an event to be a barrier to some of the people there." – Ian Summers*

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Laura Rock contributed the final comment of the month, arguing :

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*I do think we should seek two goals for managing intense emotion: 1) diminish intensity of emotion by naming and validating it to allow for effective cognitive processing and 2) explore the emotion to better understand what's behind it. Emotions are a window into what really matters to people and if we take emotions at face value we risk losing a better understanding of ourselves and others. – Laura Rock*

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I don't think we all reached agreement. :p

### **Acknowledgements :**

Thank you to Liz Crowe for her expert commentary this month.

Thank you to all commenters this month for sharing your thoughts and allowing us to learn from you.

Simulcast would like to thank the creators of the ALiEM MEDiC series for the inspiration for the journal club's blog format and their ongoing support and contributions to the project.

### **References and Further Reading :**

1. Rose, S., & Cheng, A. (2018). Charge nurse facilitated clinical debriefing in the emergency department. *CJEM*, 1-5. doi:10.1017/cem.2018.369
2. Crowe, L. (2018). Debriefing in Critical Care with Liz Crowe. [online] Ebem.podbean.com. Available at: <http://ebem.podbean.com/e/debriefing-in-critical-care-with-liz-crowe/> [Accessed 1 Jul. 2018].
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