The Use of Facilitated Emotional Debrief Sessions after a Distressing Clinical Situation

MCW IHER conference roundtable

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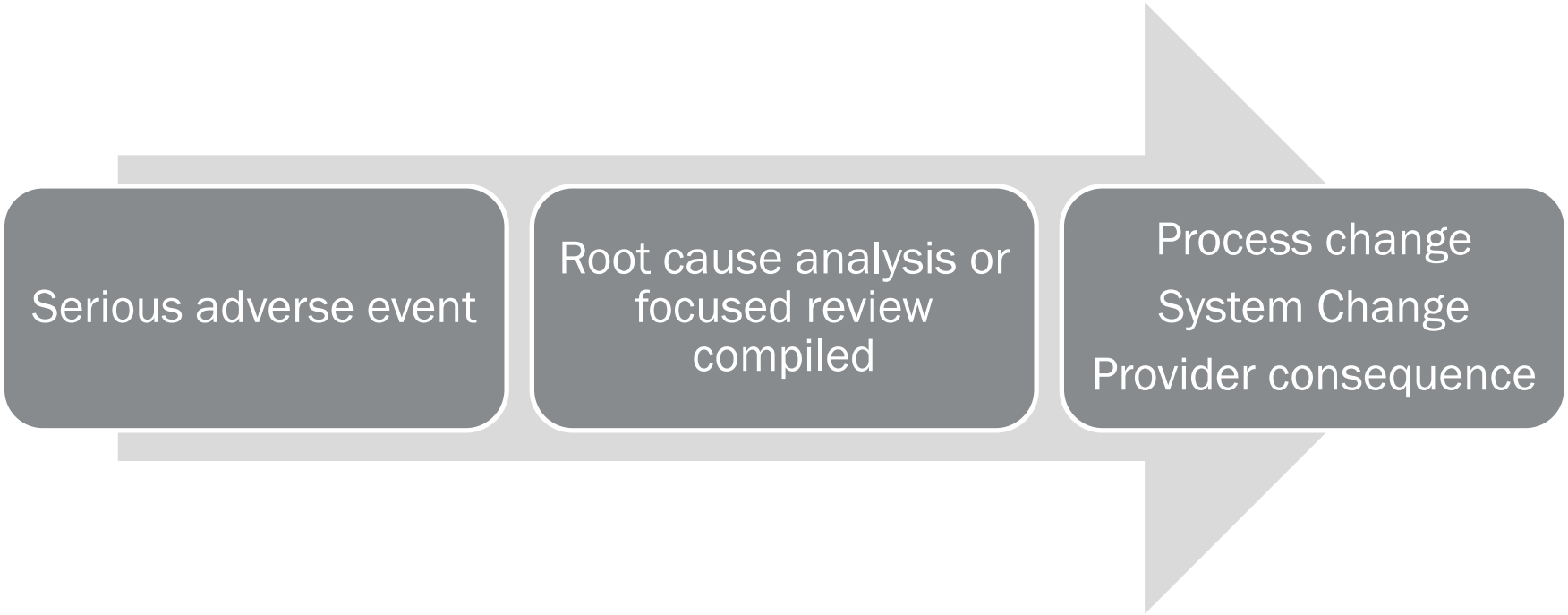
MEDICAL COLLEGE OF WISCONSIN

Quality Improvement Debrief



Emotional Debrief/ Psychological First Aid (PSA)

- Providers working with patients during an epidemic/pandemic at increased risk of psychologic stress and more
- Need provision of psychosocial support to protect mental well being
- Adverse events effect providers as well

Decreasing Burnout and improving wellness

Figure 2. The path of bundle strategy to reduce burnout of physicians and nurses.

Anesthesia Events

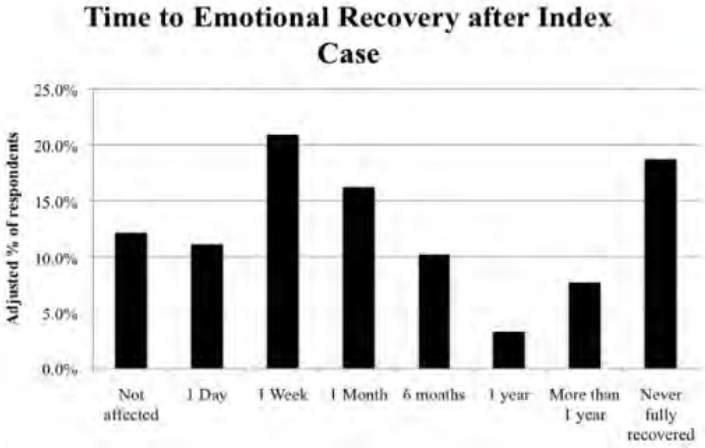


Figure 3. Time to emotional recovery after index case. Respondents were asked how long after the event it took to recover emotionally. Adjusted percentage of respondents who chose each of the time periods is shown.

Table 3. Postevent Support Desired

Resource	Percentage who felt resource would be helpful in the future	Percentage who felt resource should be standard operating procedure
Talking with anesthesia personnel	98%	87.5%
Debriefing with entire operating room team	89%	67.6%
Talking with patient's family	87%	63.2%
Talking with own spouse/family	88%	NA
Talking with professional counselor	64%	24.3%
Intradepartmental morbidity and mortality	81%	56.0%
Interdepartmental morbidity and mortality	77%	NA
Confidential hospital quality-assurance meeting	75%	50.4%

The second column shows percentage who felt that the resource listed would be helpful to providers. The third column shows percentage who felt that th debriefing resource should become standard operating procedure, or mandatory.
NA = not applicable.

Different methods of debriefs

FIGURE. Phases of Critical Incident Stress Debriefing

1. Introduction: CISD team members introduce themselves and describe the process, guidelines, and ground rules.
2. Facts: extremely brief overviews of the facts are requested to facilitate discussion.
3. Thoughts: participants are asked to recount their initial cognitive reaction to the event.
4. Reactions: participants discuss their feelings and the worst aspect of the experience for them.
5. Symptoms: participants discuss the day-to-day impact of the event and their cognitive, physical, emotional, and behavioral symptoms.
6. Teaching: explanations of the participants' reactions are discussed, along with topics pertinent to their concerns. Other stress management information is also provided.
7. Re-entry: participants ask questions, discussions are summarized, and final explanations, information, actions, and guidance are offered.

Updated 8/6/19

Critical Event Debriefing Tool

Place patient label here

Date of event: ____/____/____
Time of event: _____ Patient's Primary Service: _____

Critical Incident	[ ] Cardiac Arrest/CPR [ ] ECMO activation/cannulation [ ] Intubation (emergent) [ ] Massive Transfusion Event (MTE) Activation [ ] *Other:* _____
UMMSafe Event Report:	Event report filed in UMMSafe?: [ ] YES - [ ] NO UMMSafe Incident Number: _____ (appears after you submit the event report)
Complete if ***NO** Debrief:*	Select reason why a debrief was **NOT** held: [ ] Unable to make time due to urgent clinical issues [ ] Debrief unnecessary [ ] *Other:* _____

Use during debrief:

Instructions:	1. Find a quiet location 2. Thank team members for being present 3. State, "The purpose of debriefing is for education, quality improvement, and emotional processing. Everyone's participation is welcome and encouraged. We will plan to take ~ 10 minutes. If you have to attend to urgent issues, feel free to excuse yourself. I will review the patient summary, then as a team we can discuss what went well and what could have gone better. Feel free to ask questions and provide clarification" 4. Provide information about RISE and EAP
Notes:	Debrief documenter (name): _____ Team Members Present: [ ] Nurse [ ] Attending [ ] NP/PA [ ] *Other:* _____ [ ] Charge Nurse [ ] Fellow [ ] RT [ ] *Other:* _____ [ ] PCT/CNA [ ] Resident [ ] Pastoral Care [ ] *Other:* _____
What went well? *(describe)*	

What could have gone better?	Please brainstorm possible solutions
What could have gone better?	

Disclosure	Was the patient/family made aware of this critical event? [ ] YES - [ ] NO
Referral	Do you recommend this event for cold debrief including leadership? [ ] YES - [ ] NO

Place completed form _____
This form is NOT part of the medical record. *Confidential, for quality improvement purposes only*

Adverse Event Support Protocol (U Maryland)

What constitutes an "Adverse Event" and triggers the protocol:
The following will occur:

Same day:

1. The attending, resident, CRNA involved in the event will be relieved from additional clinical responsibilities as quickly as possible
2. Clinical team should debrief with the surgical and nursing teams to consider all relevant information
3. The anesthesiologist and surgeon should meet jointly with patient's family as appropriate
4. The anesthesiologist should complete all relevant documents/charting
5. Inform Vice Chair of PSQI or Executive Anesthesiologist on call, Division Chief, and Department Chair

Ensuing days follow-up:

1. Consider speaking with a representative from legal affairs/patient services
2. Meet with a Peer Support Team member. Discuss support services available, including mental health support services and Peer Support team followup .
3. Consideration should be given for the following day's assignment/schedule to the involved members of the team in the days following the event

Effect of Facilitated Debrief on Provider Wellbeing after Adverse Outcomes- University Hospitals Cleveland Medical Center Experience

- ✓ Established at this institution in 2019 in response to critical events:
  - maternal death, intrapartum fetal death, shoulder dystocia, intraoperative death, code blue, major medical error or surgical complication.
- ✓ The facilitated debrief was led by a trained provider not involved in the incident
- ✓ Includes all involved providers.

Statement	*Strongly Disagree*	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*
The debrief was a safe, non-punitive space to discuss the adverse event.	5.6%	5.6%	0%	16.7%	72.2%
The debrief assisted in re-evaluating the scenario and providing insight/perspective.	11.1%	5.6%	0%	27.8%	55.6%
The debrief improved feelings of internal inadequacy and bolstered my confidence in my knowledge and skills.	0%	11.1%	16.7%	55.6%	16.7%
The debrief helped restore personal integrity and feelings of acceptance among work/social structure.	5.6%	5.6%	27.8%	27.8%	33.3%
The debrief lessened physical and psychosocial symptoms incurred from the event.	5.6%	5.6%	16.7%	61.1%	11.1%
The debrief improved the experience of the formal institutional follow up (RCA, MMM, etc.).	0%	5.6%	33.3%	38.9%	22.2%
The debrief facilitated moving on from the incident and returning to a normal work/life balance.	0%	5.6%	11.1%	66.7%	16.7%
I am glad that the debrief was held, as I would not have sought other personal/professional support.	0%	11.1%	27.8%	11.1%	50%
By having a formal response to the adverse outcome, I felt valued and supported by my department.	0%	5.6%	5.6%	33.3%	55.6%
The sessions have decreased the stigma surrounding being involved in an adverse outcome.	5.6%	0%	5.6%	44.4%	44.4%

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Positive response 72%

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Positive response 89%

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Table 2: Responses to additional statements from faculty and residents surveyed.

Statement	*Strongly Disagree*	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*
I sought additional support following the facilitated debrief.	22.2%	44.4%	11.1%	22.2%	0%
The time for the facilitated debrief was a burden and I wish it was not scheduled.	55.6%	38.9%	5.6%	0%	0%

- ✓ **Overall, the facilitated debrief was found to have a positive effect on provider wellbeing after adverse outcomes, especially in the resident group.**
- ✓ **It is important to recognize that the facilitated debrief alone is insufficient, and additional support should be offered, particularly for faculty providers.**

Types of caregiver distress

Second Victim Syndrome

- Term coined by Dr. Albert Wu in 2000
  - In any medical error/near miss/adverse event, first victim is the patient/their family. Second victim is any care team member involved in the event and is subsequently traumatized
  - Guilt, anxiety, shame, depression, sleeplessness, loss of confidence, isolation, even suicidality

Secondary Traumatic Stress and Vicarious Trauma

- Secondary exposure to one or many traumatic or distressing events
  - Often rapid onset of symptoms associated with a specific event
  - Can lead to PTSD, anxiety, depression
  - Can lead to compassion fatigue, moral injury, burnout, etc
  - Significant mental, emotional and physical symptoms (i.e. fear, difficulty sleeping, constant unwanted thoughts about the event)

Healthcare worker distress

- Most forms of distress benefit from peer support
- Formal resources (i.e. EAP, mental health, spiritual services, etc) are also beneficial, yet stigma still remains
- Emotional debrief can also be beneficial, yet needs to be done thoughtfully and with facilitation to avoid creating further emotional distress

Current state at F&MCW

- Supporting our Staff (SOS) Peer Support Program
  - 3-tiered program, proactive support, connection and referral to formal support
  - >300 trained peer supporters from multiple professional backgrounds
  - Effective with 1:1 support, looking to improve skills to facilitate group emotional debriefs
- Employee Assistance Program
  - Available at both FH and MCW
  - Onsite EAP at FH, trained for both 1:1 and group debriefs
  - Some resistance from healthcare team to reach out because of stigma and unfamiliarity
- Spiritual Services
  - Available at FH
  - Can assist following patient deaths, difficult patient situations, group and individual debriefs
- Behavioral and Mental Health Services
  - Available for both F&MCW
  - Individual support, often requires time to schedule, may still have stigma associated

Discussion questions

- What should trigger an emotional debrief in the clinical environment?
  - Unexpected patient death?
  - Death of a young patient?
  - Multiple patients with bad outcomes in a short period of time within a clinical area?
  - Patient harm?
  - Clinician or learner experiencing their first patient death?
  - Community high profile event?
  - Unexpected death of a colleague and/or family member/significant other of a staff member?
  - Others??

Discussion questions

- What should be the timing of an emotional debrief?
  - ASAP?
  - Within 24-48 hrs?
  - Within 1 week?
  - As needed and/or regularly scheduled?
- What should the format be?
  - Virtual?
  - In person?
  - Hybrid?

Discussion questions

- How to streamline the process for initiating an emotional debrief?
  - Who schedules it currently?
  - Who should facilitate the debrief?
  - Should facilitators be trained (i.e. peer supporters, critical incident stress management, etc)?
  - What would make the process of scheduling a debrief easier?
- Who should be present?
  - How do we involve the entire care team?
  - How do we cross over departments/specialties?

Discussion questions

- How do we create a culture of acceptance and participation in emotional debriefs?
  - Do we allow clinicians and staff to be excused from work to attend?
  - Should this be a requirement if involved in the event? Strongly encouraged? Opt out?
  - Do staff get paid to attend?
  - How do we measure effectiveness of the debriefs?

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    - Third level