

Critical Incident Stress Debriefing After Adverse Patient Safety Events

Reema Harrison, PhD, MSc, BSc, and Albert Wu, MD, MPH

It has long been recognized that clinical work carries an emotional burden. Healthcare workers are regularly exposed to loss, injury, traumatic stimuli, and undesirable patient outcomes. Adverse events (AEs) are common in medicine, with estimates that as many as 1 in 9 hospitalized patients are harmed by the healthcare they receive.^{1,2} Although preventable harm can be minimized, it is important to appropriately manage AEs when they occur.³ AEs can be traumatic not only for patients, their friends, and relatives, but also for the clinicians involved—referred to as second victims.⁴⁻⁸ Critical incident stress debriefing (CISD) has long been provided for professionals, such as disaster workers, who are exposed to traumatic and high-stress events; it is considered an effective strategy to promote resilience and recovery.^{9,10} This paper explores the potential value of providing CISD for health professionals involved in patient safety-related AEs and the instances in which this could be routinely implemented.

Clinicians who witness or contribute to the occurrence of an AE can experience psychological effects that disrupt their professional and personal lives and their ability to deliver high-quality, safe care.^{4,8} Anxiety, depression, and sleep disturbances are consistently reported, in addition to shame, guilt, loss of self-confidence, and feelings of incompetence and worthlessness.^{5,6} The severity of these effects is related to the degree of harm to the patient and the clinician's experience of the investigation process.^{5,6}

These symptoms have ripple effects, with adverse consequences for patients, clinicians, and the wider healthcare system. Patient safety can be threatened in the immediate aftermath of an incident, when a clinician's ability to manage other patients may be impaired.^{5,6,8} In extreme cases, clinicians may change careers or leave the profession.⁵ In the longer term, the ability for individuals and organizations to learn from AEs can be diminished if clinicians are reluctant to report incidents.^{5,7}

A survey of UK physicians reported that most (83%) had been involved in an AE and that 76% had experienced personal or professional distress that required support.⁸ Despite this, progress in providing effective support for these professionals has been slow.

At present, health professionals report difficulty in identifying appropriate sources of support after their involvement in an AE. CISD has been utilized in other healthcare contexts, but rarely in the context of patient safety-related AEs.¹⁰

Critical Incident Stress Debriefing

CISD is a structured, small-group, supportive crisis intervention process that proceeds in 7 phases (Figure) and is followed by individual sessions and follow-up engagement with other support services. It is one of many crisis intervention techniques that are included under the umbrella of a Critical Incident Stress Management (CISM) program.¹¹⁻¹³ There is evidence to suggest that CISM approaches are effective in reducing the negative psychological aftermath of a wide variety of critical incidents.^{9,10}

CISD is embedded within a web of crisis support services, such as pre-event education, follow-up services, and referral to professional care and postincident education programs.¹⁴ Utilizing CISD in the context of AEs offers the benefit of an established method in which many counselors are trained. Debriefings are designed for small, homogeneous groups who are unified by their encounter of a traumatic event, such as those involved in a patient safety-related AE. They are a form of psychological first-aid in the immediate aftermath of the event that aims to reduce feelings of distress and to restore group cohesion and performance.¹⁵

Selecting AEs for CISD

Each health professional has a unique set of needs in relation to his or her experience of an AE. Health professionals involved in some AEs, such as those that did not involve an error or did not lead to adverse consequences for the patients, may not feel that they warrant CISD. By offering CISD at an organizational level, health professionals can choose to access this when they consider it necessary or helpful to provide immediate support after an event, and access to resources and individualized support in the following days, weeks, and months. CISD may then be routinely implemented at a local level for specific types of AEs associated

with greater psychological distress (eg, the unexpected death of a child). Selecting the AEs for which CISD is routinely provided is challenging, given that the level of distress experienced following an event is subjective. Evidence of those events that lead to the greatest distress is limited, but studies indicate that those in which there is patient harm or harm that is severe are more damaging to the health professionals involved.^{5,6} Routinely providing CISD for these events may be an appropriate first step, and it may be possible to achieve consensus on a list of “must support” events.

Lessons From Current Support Programs for Clinicians Involved in AEs

Evidence of the need for psychological first-aid in the days and weeks that follow the event, in addition to a broader infrastructure of support and guidance, has provided the foundation for in-house interventions, such as the forYOU program at the University of Missouri Health System, the peer-support program at Brigham and Women’s Hospital, and the Resilience in Stressful Events (RISE) program at Johns Hopkins Hospital.¹⁶⁻¹⁸ Psychological first-aid used in these programs presents an adapted form of CISD, although evaluation is currently limited and a full CISD process has not yet been attempted. The ethical challenges associated with evaluating the effectiveness of such programs has been a key barrier.

Data on the development of such programs provide some guidance around the level of demand, as well as the organizational infrastructure and training needed to operate support programs. Data collected in the first year of the forYOU program at the University of Missouri Health System reported 30% of health professionals surveyed as being adversely affected by involvement in an AE over a 12-month period, with 15% experiencing serious professional implications (eg, considering leaving their profession).¹⁶ At Johns Hopkins, nearly 50% reported experiencing such an event at some point during their career.¹⁸

The forYOU team consists of 51 members to support the 5300 faculty, staff, students, and volunteer employees, whereas the RISE program has 29 on-call responders for approximately 10,000 employees. In Missouri, most staff (60%) can gain the necessary support from those in their local environment if staff have an understanding of the issues facing “second victims.” An additional 30% of health professionals benefit from self-referral to organizational peer support, and a further 10% require follow-up with external support services. In the first 10 months of operation, an average of 5 peer support sessions were requested per month, from which 13 employees were referred to external support services. One team debriefing was required every other month.¹⁶

Data from the development of the peer-support program at Brigham and Women’s Hospital and a cross-country study of UK

TAKEAWAY POINTS

- ▶ Health professionals can suffer negative professional and personal effects after involvement in patient safety–related adverse events (AEs).
- ▶ The quality and safety of patient care can be compromised when health professionals experience these negative effects.
- ▶ Most organizations do not provide any support for staff in relation to involvement in adverse events.
- ▶ Critical incident stress debriefing has long been provided for professionals exposed to traumatic and high-stress events and may be a useful strategy for those who experience AEs.

and US health professionals suggest that those seeking peer support locally or from trained peer supporters indicate a preference for support from members of their own profession who are at the same or slightly senior level, but that there are instances in which people receive support from those in other professions.^{17,19}

Practical Considerations

The application of CISD beyond AEs to a range of stressful events experienced by health professionals means that it is advantageous for health service providers to offer CISD for staff experiencing any type of traumatic event. Less resource-intensive mechanisms for providing support are particularly important in public health systems, such as the United Kingdom’s National Health Service. A further advantage of CISD is that there is a large reservoir of relief workers already trained and experienced in providing this kind of support. This is particularly useful for smaller organizations that do not already have institutional support services in place, such as employee assistance programs or formal support for “second victims.”^{20,21}

Current models of support for those affected by AEs reveal a number of practical considerations that must be considered in the utilization of CISD programs for this group. Although there is demand for support services, CISD will not be required every day

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.

CISD indicates critical incident stress debriefing.

or every week in relation to AEs, and the program structure must provide the necessary flexibility for this. Debriefings work best with small, homogeneous groups. If implemented at a local level, a team may be united by their involvement in the AE and their feelings of distress, but preference for peer support from the same profession must be taken into consideration.¹⁷

There may also be tension between individuals and professional groups around attribution of responsibility for the AE.²² Support services require organizational resources and, therefore, buy-in. Organizations also have to invest in making frontline providers and service directors aware of the support available and mechanisms for accessing the CISD program, if implemented, in addition to developing human resource policies and guidance for those affected and for those providing counseling.

Conclusions

Work is still needed to test the effectiveness of a full CISD program for "second victims" and to identify any modifications needed for healthcare workers experiencing this type of traumatic event. However, if successfully deployed, there are advantages for healthcare organizations. Routinely implementing a support process for staff following harmful AEs would demonstrate that organizations recognize patient safety-related AEs as a potentially distressing aspect of clinical work. Greater acknowledgement of the profound impact of AEs for those involved may facilitate the open discussion of AEs that are critical to constant learning and improvement. In these ways, CISD may be a useful strategy to support clinicians to promote resilience, recovery, and the continuous provision of safe patient care. Trial and evaluation of the applicability and effectiveness of CISD in the context of AEs is now needed. ■

Author Affiliations: School of Public Health, University of New South Wales (RH), New South Wales, Australia; Johns Hopkins Bloomberg School of Public Health (AW), Baltimore, MD.

Source of Funding: None.

Author Disclosures: The authors report no relationship or financial interest with any entity that would pose a conflict of interest with the subject matter of this article.

Authorship Information: Concept and design (RH; AW); analysis and interpretation of data (RH; AW); drafting of the manuscript (RH; AW); critical revision of the manuscript for important intellectual content (RH; AW).

Address Correspondence to: Reema Harrison, PhD, MSc, BSc, School of Public Health and Community Medicine, University of New South Wales, Rm 308 Samuels Bldg, New South Wales, Australia 2026. E-mail: reema.harrison@unsw.edu.au.

REFERENCES

1. Classen DC, Resar R, Griffin F, et al. Global trigger tool shows that adverse events in hospitals may be ten times greater than previously measured. *Health Affairs (Millwood)*. 2011;30(4):581-589. doi: 10.1377/hlthaff.2011.0190.
2. de Vries EN, Ramrattan MA, Smorenburg SM, Gouma DJ, Boermeester MA. The incidence and nature of in-hospital adverse events: a systematic review. *Qual Saf Health Care*. 2008;17(3):216-223. doi: 10.1136/qshc.2007.023622.
3. Conway JF, Federico F, Stewart K, Campbell MJ. Respectful management of serious clinical adverse events (second edition). Institute for Healthcare Improvement website. www.ihl.org/resources/Pages/IHWhitePapers/RespectfulManagementSeriousClinicalAesWhitePaper.aspx. Published 2011. Accessed March 16, 2017.
4. Wu AW. Medical error: the second victim. The doctor who makes the mistake needs help too. *BMJ*. 2000;320(7237):726-727.
5. Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall LW. The natural history of recovery for the healthcare provider "second victim" after adverse patient events. *Qual Saf Health Care*. 2009;18(5):325-330. doi: 10.1136/qshc.2009.032870.
6. Sirriyeh R, Lawton R, Gardner P, Armitage G. Coping with medical error: a systematic review of papers to assess the effects of involvement in medical errors on healthcare professionals' psychological well-being. *Qual Saf Health Care*. 2010;19(6):e43. doi: 10.1136/qshc.2009.035253.
7. Seys D, Wu AW, Van Gerven E, et al. Health care professionals as second victims after adverse events: a systematic review. *Eval Health Prof*. 2013;36(2):135-162. doi: 10.1177/0163278712458918.
8. Harrison R, Lawton R, Stewart K. Doctors' experiences of adverse events in secondary care: the professional and personal impact. *Clin Med (Lond)*. 2014;14(6):585-590. doi: 10.7861/clinmedicine.14-6-585.
9. Everly GS Jr, Boyle SH. Critical incident stress debriefing (CISD): a meta-analysis. *Int J Emerg Ment Health*. 1999;1(3):165-168.
10. Everly GS Jr, Flannery RB, Mitchell JT. Critical incident stress management (CISM): a review of the literature. *Aggress Violent Behav*. 2000;5(1):23-40.
11. Mitchell JT. When disaster strikes...the critical incident stress debriefing process. *JEMS*. 1983;8(1):36-39.
12. Mitchell JT, Everly GS. Critical incident stress management. *Response*. 1986;5(5):24-25.
13. Mitchell JT, Everly GS. *Critical Incident Stress Debriefing: An Operations Manual for CISD, Defusing and Other Group Crisis Intervention Services*. 3rd ed. Ellicott City, MD: Chevron; 2001.
14. Mitchell JT, Everly Jr GS. Critical incident stress debriefing (CISD) and the prevention of work-related traumatic stress among high risk occupational groups. In: *Psychotraumatology: Key Papers and Core Concepts in Post-Traumatic Stress*. New York, NY: Plenum Press; 1995.
15. McCabe OL, Everly GS Jr, Brown LM, et al. Psychological first aid: a consensus-derived, empirically supported, competency-based training model. *Am J Public Health*. 2014;104(4):621-628. doi: 10.2105/AJPH.2013.301219.
16. Scott SD, Hirschinger LE, Cox KR, et al. Caring for our own: deploying a systemwide second victim rapid response team. *Jt Comm Qual Patient Saf*. 2010;36(5):233-240.
17. Hu YY, Fix ML, Hevelone ND, et al. Physicians' needs in coping with emotional stressors: the case for peer support. *Arch Surg*. 2012;147(3):212-217. doi: 10.1001/archsurg.2011.312.
18. Edrees HH, Paine LA, Feroli ER, Wu AW. Health care workers as second victims of medical errors. *Pol Arch Med Wewn*. 2011;121(4):101-108.
19. Harrison R, Lawton R, Perlo J, Gardner P, Armitage G, Shapiro J. Emotion and coping in the aftermath of medical error: a cross-country exploration. *J Patient Saf*. 2015;11(1):28-35. doi: 10.1097/PTS.0b013e3182979b6f.
20. Monfils MK. Needs assessment and implementation of an employee assistance program: promoting a healthier work force. *AAOHN J*. 1995;43(5):263-269.
21. Seys D, Scott S, Wu A, Van Gerven E, Vleugels A, Euwema M, et al. Supporting involved health care professionals (second victims) following an adverse health event: a literature review. *Int J Nurs Stud*. 2013;50(5):678-687. doi: 10.1016/j.ijnurstu.2012.07.006.
22. Parker D, Lawton R. Psychological contribution to the understanding of adverse events in health care. *Qual Saf Health Care*. 2003;12(6):453-457.

Full text and PDF at www.ajmc.com