

Debriefing after failed paediatric resuscitation: a survey of current UK practice

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ABSTRACT

Objectives: Debriefing is a form of psychological "first aid" with origins in the military. It moved into the spotlight in 1983, when Mitchell described the technique of critical incident stress debriefing. To date little work has been carried out relating to the effectiveness of debriefing hospital staff after critical incidents. The aim of this study was to survey current UK practice in order to develop some "best practice" guidelines.

Methods: This study was a descriptive evaluation based on a structured questionnaire survey of 180 lead paediatric and emergency medicine consultants and nurses, selected from 50 UK trusts. Questions collected data about trust policy and events and also about individuals' personal experience of debrief. Free text comments were analyzed using the framework method described for qualitative data.

Results: Overall, the response rate was 80%. 62% said a debrief would occur most of the time. 85% reported that the main aim was to resolve both medical and psychological and emotional issues. Nearly all involve both doctors and nurses (88%); in over half (62%) other healthcare workers would be invited, eg, paramedics, students. Sessions are usually led by someone who was involved in the resuscitation attempt (76%). This was a doctor in 80%, but only 18% of responders said that a specifically trained person had led the session. Individuals' psychological issues would be discussed further on a one-to-one basis and the person directed to appropriate agencies. Any strategic working problems highlighted would be discussed with a senior member of staff and resolved via clinical governance pathways.

Conclusions: Little is currently known about the benefits of debriefing hospital staff after critical incidents such as failed resuscitation. Debriefing is, however, widely practised and the results of this study have been used to formulate some best practice guidelines while awaiting evidence from further studies.

Debriefing is a form of psychological "first aid" that has its origins in the military. General Marshall, chief historian of the United States Army during World War II, advocated the use of debriefing techniques and sessions on the battlefield. The sessions were intended to gather information about the fighting day, but he noticed they had a spiritually purging and morale-building effect on the troops.¹

Debriefing moved into the spotlight in 1983, when Mitchell² described the technique of critical incident stress debriefing (CISD). It forms part of the wider strategy known as critical incident stress management, which comes under the umbrella term of "crisis management". In CISD the debriefing is provided after a traumatic event and is a

structured, seven-stage, group session provided 24–72 h after the event, facilitated by skilled mental health workers and trained peers. It was initially described for use in pre-hospital emergency workers in the United States and was mandatory, taking 3–5 h to complete.

Over the years debriefing has come to mean many different things and is usually not the formal CISD technique described by Mitchell.² It has been applied to a wide variety of groups of individuals including trauma victims, women after childbirth, cancer patients, rescue workers involved in natural disasters, rape victims, children in schools where traumatic incidents have taken place and many other situations. A Cochrane review, published in 2002, was updated in 2006.³ The authors concluded that "there is no evidence that single session psychological debriefing is a useful treatment for the prevention of post traumatic stress disorder after traumatic incidents. Compulsory debriefing of victims of trauma should cease." None of these studies truly looked at the Mitchell model of CISD. Interventions were conducted with individuals rather than groups and many times it occurred outside of the 24–72 h window described by Mitchell.² The Cochrane review has, however, fuelled the debate on the usefulness of CISD. In 1997, Mitchell and Everly⁴ published a review of the evidence for CISD. They cited a number of studies that use the Mitchell model in groups of pre-hospital emergency workers, who found benefits from the intervention, such as a reduction in the signs and symptoms of distress. To date little work has been carried out on debriefing hospital staff. At the 2004 Association of Paediatric Emergency Medicine autumn meeting, a session was dedicated to debriefing after failed paediatric resuscitation. It became clear from the discussions that debriefing was frequently carried out, but not to any particular standard and without good evidence for its effectiveness. It was suggested that, as the practice of debriefing seems popular and is endorsed by a number of organisations, it might be sensible to review the literature and survey current practice in order to aid the development of some "best practice guidelines". This is the basis of this study.

METHODS

Study design

This study was a descriptive evaluation using a structured questionnaire survey of clinicians in UK hospitals. The questionnaire collected general data regarding trust policy and practice and also information about individuals' own experience of debriefing after failed paediatric resuscitation.

Table 1 Response rate of different clinical groups

| Clinical group | Response rate n/N (%) |
|-------------------------|--------------------------|
| Paediatric senior nurse | 40/45 (89) |
| Paediatric consultant | 32/45 (71) |
| ED senior nurse | 36/45 (80) |
| ED consultant | 36/45 (80) |

ED, emergency department.

An initial pilot study of 10 trusts was used to validate the questionnaire. The questionnaire was then sent to 50 UK trusts.

Study setting and population

The population of interest comprised all clinicians involved in debriefing after failed paediatric resuscitation. An attempt was made to generate a representative sample by selecting 50 trusts, which included a teaching hospital and district general hospital from each deanery across the United Kingdom. We attempted to identify four clinician groups in each trust: the lead clinicians and lead nurses in emergency medicine and paediatrics. A final sample size of 180 was generated.

Study protocol

All eligible clinicians were invited to participate by letter. A questionnaire was included with each letter and all participants were given the opportunity to refuse to participate. Handwritten, white, stamped addressed envelopes were provided. A reminder letter was sent if there was no response within 2 weeks and a second questionnaire was sent 2 weeks thereafter if there was still no response.

Questions collected data about trust policy and events and also about individuals' own personal experience of debrief. The majority of questions required tick box answers but there was also space for free text comments.

The questionnaire was first piloted in 10 trusts to ensure that it covered the aims of this study. The results of these pilot questionnaires are included in the results.

Data analysis

This study was a descriptive evaluation of debriefing systems in hospitals. The free text comments were analyzed as qualitative data using the framework approach.⁵ Two authors independently reviewed the comments using this method and the results were discussed to achieve consensus.

RESULTS

The overall response rate was 80%.

Quantitative results

See table 2.

Qualitative data

The last few questions asked for free text comments regarding specific issues around debriefing (n = number of responses with this theme).

Participants were asked to indicate what would happen if debriefing highlighted psychological or emotional issues in an individual. Common themes were:

1. The problems would be discussed with that individual on a one-to-one basis, often via the line manager. (41)
2. The person would be directed for further help to areas such as occupational health, the trust counselling service, an

external counsellor, a psychologist or their own general practitioner. (92)

3. Consideration was given to the need for time off work or individual training needs. (9)

The next question asked what would happen if the debriefing identified strategic working problems. Here the issues raised included:

1. The necessary involvement of a senior member of staff at an early stage. (42)
2. Discussion with the trust resuscitation training officers. (8)
3. Problems could be highlighted by the use of incident forms and discussion at clinical governance or risk management meetings. An action plan would be drawn up that could involve the setting up of a working party if it was a complex issue. The problems would then be addressed with guideline review and training programmes. The issues would be re-evaluated or audited at a later date to assess the success of the plan. (34)

Participants were asked to comment about how they would deal with any practical issues that were highlighted:

1. Equipment issues should be dealt with urgently by the appropriate member of staff. (13)
2. As with the previous question, the need to review guidelines and training was considered important and would generally be dealt with in a manner similar to that outlined above. (49)

Finally, participants were invited to make general comments relating to the practice of debriefing staff after failed paediatric resuscitation:

1. Of the comments that were made, a large number were in support of the practice. (64)
2. Many felt it should be carried out early after the event but participants did acknowledge the practical difficulties of organising it in a way to accommodate shift patterns. (17)
3. There were several comments relating to it being on a voluntary basis and not too formal. (14)
4. Using trained personnel to address the psychological effects of failed resuscitation was important for some participants. (9)
5. A no-blame or non-judgemental atmosphere was perceived as important by several individuals. (8)

DISCUSSION

This study gives insight into the current UK practice of debriefing after failed paediatric resuscitation, which has been identified as one of the most stressful critical incidents for staff.⁶ The practice appears to be widespread and popular, despite the lack of evidence of benefit. In summary, it usually occurs within one week, is aimed mostly at the doctors and nurses involved and is led by a senior doctor or nurse who was present, but this person has usually had no special training for the task. It appears that most departments have ideas on how to deal with issues that may be generated by the debriefing, namely strategic working practice problems or psychological issues in individuals.

Recommendations

On the basis of these findings we make the following recommendations about debriefing after failed paediatric resuscitation.

Debriefing should occur within a few days of the event, all staff involved should be invited and it should ideally address both medical and psychological issues. A senior clinician should lead medical debrief and a trained individual should discuss

Table 2 Responses from clinicians to questionnaire about failed paediatric resuscitation

| Question | Answer n (% responding)* |
|--|-----------------------------|
| Answer the following questions with regard to what you think happens in your own trust following a failed paediatric resuscitation | |
| Is there a formal Trust policy for carrying out debriefs? | |
| Yes | 17 (12) |
| No | 104 (72) |
| Following a failed paediatric resuscitation would a debrief occur | |
| Most of the time | 89 (62) |
| Sometimes | 32 (22) |
| Rarely | 17 (12) |
| Is the aim of these debriefs to resolve or review | |
| Medical issues | 4 (3) |
| Emotional or psychological issues | 9 (6) |
| Both medical and emotional or psychological issues | 122 (85) |
| Answer the following questions with regard to your own personal experience of debriefs following a failed paediatric resuscitation | |
| When would a debrief occur? | |
| Immediately | 56 (39) |
| Soon (within 1 week) | 76 (53) |
| Never | 30 (21) |
| Who would be invited to attend? | |
| Doctors | 127 (88) |
| Nurses | 128 (89) |
| Others, eg, paramedics | 89 (62) |
| Where would the debrief take place? | |
| In the department/ward where event took place | 99 (69) |
| Somewhere else in the hospital | 39 (27) |
| Other, eg, seminar room | 12 (8) |
| Would the session be led by someone involved in the resuscitation attempt? | |
| Yes | 109 (76) |
| No | 50 (35) |
| Who would this person be? | |
| Doctor | 115 (80) |
| Nurse | 50 (35) |
| Other, eg, chaplain | 20 (14) |
| Have you ever been involved in a debrief where a person specially trained in debriefs has lead the session? | |
| Yes | 26 (18) |
| No | 109 (76) |
| Have you ever had any training in leading a debriefing session? | |
| Yes | 19 (13) |
| No | 116 (81) |

Total n = 144 unless specified.

*When n > 144, multiple responses given.

psychological issues. Debriefing should utilise clinical governance pathways to deal with medical issues and should highlight clear pathways of referral if psychological problems are discovered.

CONCLUSIONS

We have formulated some good practice guidelines based on the responses of 144 clinicians; the original intention when this survey was planned. It has, however, become clear that there is little formal research into the benefits of debriefing hospital staff after critical incidents such as failed resuscitation. Therefore, to show that the recommendations have value, further research needs to be conducted in this area. This would ideally be a multicentre study investigating the different techniques of debriefing in hospitals and measuring hard outcomes relating to the ability of staff to deliver patient care, rather than the subjective opinions of staff.

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