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

S Ireland,1 J Gilchrist,2 I Maconochie3

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.3 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 2006.4 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.5 The Cochrane review has, however, fuelled the debate on the usefulness of CISD. In 1997, Mitchell and Everly6 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.
results were discussed to achieve consensus.

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individual. Common themes were:

Debriefing highlighted psychological or emotional issues in an
qualitative data using the framework approach. 2 Two authors indepen-
Data analysis
This study was a descriptive evaluation of debriefing systems in
developed 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 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,
including a teaching hospital and district general hospital
from each deanery across the United Kingdom. We attempted
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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 pro-
vided. 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.

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hospitals. The free text comments were analyzed as qualitative
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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. (3)
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 1  Response rate of different clinical groups

<table>
<thead>
<tr>
<th>Clinical group</th>
<th>Response rate n/N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric senior nurse</td>
<td>40/45 (89)</td>
</tr>
<tr>
<td>Paediatric consultant</td>
<td>32/45 (71)</td>
</tr>
<tr>
<td>ED senior nurse</td>
<td>36/45 (80)</td>
</tr>
<tr>
<td>ED consultant</td>
<td>36/45 (80)</td>
</tr>
</tbody>
</table>

ED, emergency department.
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.

Acknowledgements: The authors would like to thank Rob Ireland, Julie Woodhead, Chris Roberts and Josie Howard.

Table 2 Responses from clinicians to questionnaire about failed paediatric resuscitation

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer n (% responding)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a formal Trust policy for carrying out debriefs?</td>
<td>Yes (12) No (72)</td>
</tr>
<tr>
<td>Following a failed paediatric resuscitation would a debrief occur</td>
<td>Most of the time (62)</td>
</tr>
<tr>
<td>Is the aim of these debriefs to resolve or review Medical issues</td>
<td>4 (3)</td>
</tr>
<tr>
<td>Is the following questions with regard to what you think happens in your own trust following a failed paediatric resuscitation</td>
<td></td>
</tr>
<tr>
<td>When would a debrief occur?</td>
<td>Immediately (39)</td>
</tr>
<tr>
<td>Who would be invited to attend?</td>
<td>Doctors (88) Nurses (89)</td>
</tr>
<tr>
<td>Where would the debrief take place?</td>
<td>In the department/ward where event took place (69)</td>
</tr>
<tr>
<td>Would the session be led by someone involved in the resuscitation attempt?</td>
<td>Yes (76) No (35)</td>
</tr>
<tr>
<td>Who would this person be?</td>
<td>Doctor (80) Nurse (35)</td>
</tr>
<tr>
<td>Have you ever been involved in a debrief where a person specially trained in debriefs has lead the session?</td>
<td>Yes (18) No (76)</td>
</tr>
<tr>
<td>Have you ever had any training in leading a debriefing session?</td>
<td>Yes (13) No (81)</td>
</tr>
<tr>
<td>Total n = 144 unless specified.</td>
<td></td>
</tr>
</tbody>
</table>

*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.

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Competing interests: None.

Ethics approval: As this was a survey not involving patients, consent from the participants was inferred by their responding to the questionnaire.

REFERENCES