Immediate Debriefing after Pediatric Critical Incidents

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Abstract

Background: Critical incidents are described as events that induce strong emotional responses that can increase stress levels thereby impeding a nurse's ability to provide good care. Nurses working in the pediatric environment are frequently exposed to critical incidents that affect their well-being. This repeated exposure may result in burnout and eventually leading to compassion fatigue.

Local Problem: Nurses working in a community hospital expressed a need for immediate debriefings after pediatric critical incidents. Debriefings were occurring days to weeks after the critical incident. The purpose of this quality improvement project was to implement an immediate debriefing program for the interprofessional care team, after pediatric critical incidents to decrease stress associated with critical incidents and increase overall staff satisfaction. Examples of critical incidents include resuscitation of patients after cardiac or respiratory arrest, patient death, sudden or acute clinical changes requiring transfer to the Pediatric Intensive Care Unit (PICU), and conflicts with patients' and/or their family members.

Interventions: The quality improvement project was implemented on the pediatric unit at a community hospital in Baltimore, Maryland. Project implementation was conducted over a 14-week period. During the first two weeks, charge nurses who served as project champions attended a 30-minute training session led by the project leader on critical incident stress debriefing and conducted debriefings on the unit. Participants completed a pre- and post-implementation critical incident debriefing survey. All debriefing sessions were identified by the charge nurse and held during the same shift as the critical event. After each debriefing session, staff completed a post critical incident debriefing survey. Data collection included elements from the post critical incident debriefing survey. Responses to pre- and post-implementation surveys were compared to assess the impact of the debriefing sessions in decreasing staff stress and increasing satisfaction following a critical incident.

Results: Eleven critical incidents occurred, with a debriefing session conducted after each incident. A total of 51 team

members participated in these sessions, of which 13 participated in more than one session. Critical incidents included patients with sudden or acute clinical changes requiring transfer to the PICU, conflicts with patients, and patients at end of life. Post critical incident debriefing survey results revealed 94% of staff strongly agreed or agreed the debriefing session was held at an appropriate time, 81% strongly agreed or agreed debriefings helped decrease feelings of stress and unease, 77% strongly agreed or agreed debriefings were meaningful, and 81% strongly agreed or agreed debriefings improved satisfaction with debriefing session. Post-implementation survey results revealed the implementation of debriefing sessions immediately post-critical incidents decreased staff stress associated with critical incidents most of the time (74%) and increased overall staff satisfaction most of the time (61%).

Conclusion: Critical incidents in Pediatrics/PICU can cause a significant amount of staff stress. Implementation of a debriefing process was found to be helpful in decreasing stress associated with critical incidents and increasing overall staff satisfaction with the debriefing process. The debriefing process also helped identify barriers to patient care, discuss patient and staff safety concerns, and identify potential solutions.

Background

Critical incidents are described as events that induce strong emotional responses that can increase stress levels and impacts a nurse's ability to provide good care (Healy & Tyrrell, 2013). Nurses working in the pediatric environment are exposed to critical incidents that effect their well-being and repeated exposure can cause burnout, which eventually can lead to compassion fatigue (Maloney, 2012). Nurse retention is greatly affected by nurses experiencing burnout and compassion fatigue, especially with younger generation and novice nurses, leading to approximately 20% leaving within the first year of employment (Kelly, Baker, & Horton, 2017). Maloney (2012), assessed secondary traumatic stress among emergency room nurses and found 46% had disturbing thoughts of their patients after traumatic events, 52% avoided certain types of patients, and 43% reported having emotional numbing. Pediatric nurses are frequently exposed to patients suffering from physical and sexual traumas, resuscitation of patients in cardiac or respiratory arrest, patients that decompensate due to sepsis or severe respiratory ailments, and conflicts with patient's family members which can be emotionally draining to the nurse caring for the patient (Hammerle, Devendorf, Murray & McGhee, 2017).

Compassion fatigue is defined as having high levels of secondary traumatic stress and burnout which can eventually cause caregivers to be incapable of having compassionate and caring connections with their patients. Nurses deal with stressful situations every day (Kelly, Baker & Horton, 2017). This stress can lead to increased absenteeism; approximately 54% of call-outs are due to stress-related disorders such as headaches, hypertension, and chronic pain (Maloney, 2012). Stress can lead to diminished job satisfaction, increased sick leave, and higher turnover rates (Healy & Tyrell, 2013). Debriefing after critical incidents has been proven to decrease stress, improve concentration, improve morale, and improve work engagement (Schmidt & Haglund, 2017). Debriefing allows staff to have the support needed to balance the negative impact of stressful situations and contribute to improved patient outcomes, boost morale, and identify training needs of staff involved in critical incidents (Hammerle, et al., 2017).

The practice problem took place in a 450 bed, community hospital in the inner city of Baltimore. The hospital has a twenty-six-bed pediatric unit with twenty designated pediatric beds and six designated pediatric intensive care unit (PICU) beds. The unit did not have a debriefing program in place after critical incidents. Occasionally a debriefing took place after a pediatric death of an oncology patient or a pediatric resuscitation that resulted in a death, but usually occurred weeks after the event. This made it difficult for staff affected by the event to attend the session. On the unit, a need was expressed for more immediate debriefing after pediatric critical incidents to prevent compassion fatigue and provide staff the support needed after participating in these events. Nurses expressed that new staff, new nurse graduates, and experienced nurses need debriefing sessions to feel support from peers and leadership, as well as, provide a safe place where they are able to discuss events that transpired without judgement. The nurses also stated that when debriefings are conducted, they occur weeks after an event and are scheduled around the availability of social work and chaplain services, rather than the availability of the staff who were involved in the critical incident.

Purpose and Goals

The purpose of this DNP project was to implement an immediate debriefing program after all pediatric critical incidents that occur on the pediatric unit or PICU to decrease compassion fatigue associated with exposure to these events. Critical incidents included resuscitation of patients after cardiac or respiratory arrest, patient death, patients on the pediatric unit that decompensated due to sepsis or respiratory distress and required transfer to the PICU, and conflicts with patient's and family members. The short-term goals of the DNP project were that 100% of staff would participate in the debriefing program and would utilize the checklist post critical incidents in the pediatric unit and pediatric intensive care unit. Appropriate use of the debriefing program was assessed from debriefing log documentation; barriers were evaluated; and staff feedback was used to modify timing of debriefing sessions if indicated. The long-term goal of the DNP project was to ensure that a debriefing occurred after each critical incident with participation of all staff involved in the incident. At the completion of the project implementation, staff would report satisfaction with the debriefing process and decreased stress associated with discussion of critical incidents.

Theoretical Framework

Lewin's Change Model is a model for understanding organizational change and is known as the 'unfreeze, change, and refreeze' model (Mind Tools Content Team, n.d.). The model has a three-stage process to implementing a change, a) unfreeze, b) change, and c) refreeze. The first stage of the change process, 'unfreeze,' includes preparing the organization to recognize a change is needed and modifying current practice in order to establish an improved standard of practice. The debriefing process was not a standard practice on the unit, it did not occur with every critical incident, and the nursing staff was dissatisfied with the lack of a debriefing after each critical event. An email was sent to nursing leadership, the pediatric hospitalists and pediatric intensivists, the advanced practice nurse, and education specialist for the children's hospital division, and several nurses from the pediatric and PICU about the desired change in current practice in regard to debriefing after pediatric critical incidents. The response from all recipients was unanimous in agreement for implementation of a debriefing process after pediatric critical events. One physician responded that the debriefings took too long to coordinate and were not beneficial to staff affected by the event.

The second stage of the process, 'change,' occurs when individuals start to believe in the need for a change in practice and embrace and support the change. The strong recommendation in support of a debriefing program found in the review of literature, administration of a pre-implementation survey on the current practice of debriefings after critical events, and administration of a compassion fatigue survey to the staff are activities that help identify the need for the debriefing program and gain staff support for practice change. Staff buy-in allows for implementation of the debriefing program to be accepted, promoted, and sustained as the new standard of practice of debriefing after critical incidents.

The final stage of the change process, 'refreeze,' is acceptance of the practice change, including the change being adopted by the organization and the new standard of practice. Once the debriefing program is accepted by the staff and organization as the new standard of practice after pediatric critical incidents, the change process will be at the level of refreeze. Program sustainability and improvement of staff well-being after critical incidents are the final stage of the change process.

Literature Review

The need to implement a standardized debriefing program after pediatric critical incidents was the focus of this literature review. The review began broadly with the evidence supporting the use of standardized debriefing after critical incidents. The discussion was followed by a review of the effects critical incidents have on staff well-being causing compassion fatigue. Finally, the review concluded with the current evidence supporting a standardized debriefing program to improve staff well-being and decrease compassion fatigue.

Analysis

Edrees, Connors, Paine, Taylor, and Wu (2016) described a Resilience In Stressful Events (RISE) organizational support program, developed and implemented at Johns Hopkins Hospital to provide support to the staff after adverse patient events. A pre-implementation survey revealed that most staff had experienced an unexpected adverse event and desired peer support. Prior to the implementation of the Rise program, 70% of staff had been directly involved in unexpected adverse event, 57.9% reported experiencing anxiety or inability to perform their job, and 70.3% reached out for support. Peer responders reported 88% of encounters as successful, 66.7% of peer responders rated success of the interaction as excellent and 22.8% as neutral, and 83.3% reported meeting caller's needs. A total of 84.3% of callers were offered additional support by the peer responder.

Copeland and Liska (2016) implemented a post-code pause (PCP) with the intent to standardize a debriefing process, encourage a supportive culture, improve transition back to normal activities, and allow staff to express reverence for patients involved in code or trauma event. Pre and post implementation data comparison demonstrated improvement in the following: support from peers 4% (96% vs. 100%), support by leaders 3% (91% vs. 94%), ability to pay homage 25% (36% vs. 61%), having enough time to regroup 18% (43% vs. 61%), and not feeling pressured to return to work too quickly 11% (59% vs. 70%). Over the one-year pilot period, 84 code events occurred, and a PCP occurred after 47 events with a utilization rate of 56%. Post implementation, 79% of respondents felt the PCP was valued at least half the time or more, 76% of respondents felt the PCP was somewhat helpful in paying homage to the patient, and 71% of respondents were able to return to work with a sense of focus.

Hammerle et al., (2017) described the importance of debriefing programs as tools to diminish stress brought on after critical incidents in the emergency department. The authors further described how debriefing programs are important in improving patient outcomes, identifying training gaps, and improving staff morale. A debriefing program is important in providing staff support and can be beneficial in protecting and preserving the staff well-being.

A literature review and survey conducted by Healy and Tyrrell (2013) assessed nurses' and doctors' apparent need for debriefing after critical incidents and provided recommendations on ways to improve debriefings. An anonymous survey implemented in three emergency departments (ED) in Ireland (N= 103/150 respondents, 69% [90 nurses and 13 doctors]), demonstrated 84% of respondents rated debriefing after stressful incidents in the ED as "important" and "very important." Of those surveyed, 62% had never been offered the opportunity to take part in a debriefing, 15% were unsure if debriefing participation was available at work place, and only 37% had taken part in a debriefing session. Three main purposes of debriefing emerged from the survey: provide emotional and psychological support, improve clinical practice after critical events, and foster team spirit.

Kelly, Baker, and Horton (2017) conducted a literature review and evidence-based intervention project, Code Compassion, to reduce compassion fatigue in acute care nurses. The project outcomes were to reduce immediate burnout with a Code Compassion cart, to address secondary trauma with Critical Incident Stress Debriefing (CISD) and promote compassion satisfaction with meaningful peer recognition. The Code Compassion cart is a mobile cart that contained self-renewing offerings. The CISD was deployed with the Code Compassion cart and performed by trained staff in CISD to provide staff that needed a debriefing session immediately post traumatic event. Meaningful recognition was achieved by peer recognition, with quarterly nominee breakfasts and Exemplary Nurse Award Honoree. A similar qualitative study by Maloney (2012) examined the use of a CISD to support staff in the healing process after a critical incident. Evidence supports that CISD has positive emotional and cognitive impact on participants.

A case study by Schmidt and Haglund (2017) describe the signs and symptoms of compassion fatigue using one nurses' experience and present the process of Personal Reflective Debrief (PRD) to prevent compassion fatigue. Debriefing is presented as a non-threatening and low-cost way to discuss unexpected critical incidents and help with the group healing process.

A randomized control trial (RCT) by Tuckey & Scott (2014) evaluated the efficacy of group CISD at preventing post-traumatic stress and promoting return to normal functioning. Sixty-seven fire fighters were randomly placed into three different treatment conditions: 1) CISD, 2) stress management education, or 3) screening (without treatment). The outcomes measured post intervention were: 1) post-traumatic stress, 2) overall psychological distress, 3) quality of life, and 4) alcohol use. Post-intervention results showed no significant contribution to levels of post-traumatic stress and psychological distress after either intervention. However, post-intervention results showed a change in alcohol consumption and self-rated quality of life results. CISD group showed significantly less alcohol consumption compared to the screening group. CISD group had higher self-rated quality of life scores post-intervention in comparison with the education group.

Synthesis

The studies by Hammerle et al. (2017), Healy and Tyrrell (2013), and Schmidt and Haglund (2017) all found that a debriefing program can provide staff support and improve staff well-being. Hammerle et al. (2017) and Healy and Tyrrell (2013) describe how debriefing improves staff morale and fosters team spirit. Maloney (2012) and Kelly et al. (2017) describe the use of Critical Incident Stress Debriefing (CISD) as a way to support staff in the healing process. Schmidt and Haglund (2017) present debriefing as a non-threatening and low-cost way to deal with unexpected critical incidents and help with the group healing process. An RCT by Tuckey & Scott (2014) found that participants in the CISD group had decreased alcohol consumption and increased self-rated quality of life post-intervention.

Some limitations to the literature were small sample sizes and limited evidenced based literature found. The literature search demonstrated lack of systematic reviews and RCTs. One RCT was limited to male fire fighters placed in three intervention groups (Tuckey & Scott, 2014). The results demonstrated decreased alcohol consumption and increased quality of life but discussed that a higher percentage of men reported high alcohol consumption and dependency than women and a larger percentage of women reported mental health concerns.

Based on the above evidence, the recommendation for practice is to implement a debriefing program after critical incidents. By doing so, nurses will have a standardized way to discuss emotional and psychological feelings encountered after experiencing critical events with the support of peers in a non-judgmental environment thereby minimizing compassion fatigue, promoting mental well-being, and improving self-rated quality of life.

Implementation Plan

A quality improvement (QI) project focused on immediate debriefing after pediatric critical incidents was implemented with a sample of critical incidents and staff participants in pediatric critical incidents. Inclusion criteria for the critical incidents included cardiac/respiratory arrests, patient death, patients that decompensated due to sepsis or respiratory distress requiring transfer to the PICU, and conflicts with patients' and family members. The estimated number of critical incidents during the implementation phase (n= 10). Was estimated using the average number of transfers to the PICU from the pediatric unit over a three-month period. Inclusion criteria for the staff participants sample included the pediatric unit and PICU

Registered Nurses, pediatric Residents, Patient Care Associates (PCA), and pediatric respiratory therapists. The estimated sample size (n= 87) was based on the number of current staff working on the units. The project was carried out on the pediatric units of a community hospital in the inner city of Baltimore.

Procedures and Timelines

The QI project was implemented over a 14-week period. Three weeks prior to implementation, the DNP project leader distributed a journal club article on compassion fatigue via email and administered the Professional Quality of Life Scale (ProQOL) (see Appendix B) to assess staff compassion satisfaction and compassion fatigue. The ProQOL is a self-scored tool that allows any individual to measure the quality one feels, positive and negative aspects, in helping and caring for others (Hudnall Stamm, 2019). This can be health care providers, teachers, social workers, and other professions who help those in need (Hudnall Stamm, 2019). The ProQOL has three subscales, compassion fatigue, burnout, and compassion satisfaction (Hudnall Stamm, 2019). Staff were required to submit the ProQOL assessment and sign a participant sheet that was kept in the PICU. During the first week, the DNP project leader presented the DNP project to the nursing staff in a PowerPoint presentation during the monthly staff meeting and to the physician staff during noon conference. During the second week, the DNP project leader trained a team of 10 to 12 permanent charge nurses who served as project champions and leaders of the debriefing sessions. The team champions attended a 30-minute training session (Appendix C, teaching plan) led by the project leader on the use of a critical incident stress debriefing checklist (see Appendix D). The champions promoted and conducted debriefings after critical incidents to guarantee project sustainability. The pre-implementation survey (Appendix E) was distributed to the staff to complete prior to implementation during week two, to assess staff need for debriefing sessions after critical incidents.

During weeks three through twelve immediate debriefings were conducted for all critical incidents on the pediatric unit and PICU utilizing the debriefing session checklist. The project leader or a champion was present during each immediate debriefing after a critical incident to observe, conduct, and support the practice change. After each debriefing staff completed a post critical incident debriefing survey (Appendix

F) and the project leader or champion completed a debriefing data collection sheet (Appendix G).

During weeks thirteen and fourteen, the staff completed the post-implementation debriefing survey (Appendix H) to assess nursing satisfaction with debriefing program and assess if there was a decrease in stress after critical incidents.

Data Collection

The ProQOL was used to assess staff compassion satisfaction and compassion fatigue of the participants in the project. The ProQOL is a 30-item Likert scale questionnaire that is separated into assessing compassion satisfaction, burnout, and secondary traumatic stress. The total number of responses and the score for each question is tallied to provide a score for each section of the tool. The results are then compared to a chart that assigns a low, average, or high level of compassion satisfaction, burnout, and secondary traumatic stress.

The pre-implementation and post-implementation surveys and the debriefing data collection sheet included participant demographics along with information on number of debriefings, type of critical incidents, barriers to implementing debriefing sessions, and impact of debriefings on decreasing stress associated with critical incidents and improving staff satisfaction with debriefing sessions.

Data Analysis

From the post critical incident debriefing survey data was analyzed using descriptive statistics and frequencies tabulated from the data collected. Responses to pre- and post-implementation surveys were compared to assess the impact of the debriefing sessions on decreasing staff stress and increasing satisfaction following a critical incident. Themes were generated from the open-ended survey question responses and common themes were placed in pivot table. Participant privacy was maintained with the use of a participant code, mother's maiden name. The data was collected via survey monkey prior to implementation and post implementation. The post debriefing session survey was collected via paper and was later entered into survey monkey by DNP project leader. This data was later entered into an Excel spreadsheet in order to conduct statistical analysis.

A project description was submitted to University of Maryland Baltimore (UMB) Institutional Review Board (IRB) for a Non-Human Subjects Research (NHSR) determination. Approval to implement the DNP project was also sought from the host organization IRB.

Results

Modifications were made during implementation of the QI project. Initially debriefings were conducted by the project leader until the project champions comfort level in conducting debriefings improved. Another modification involved increasing the frequency of calling the unit to twice daily to verify with the charge nurses if there was a patient incident that qualified for a debriefing. One final modification was extending the implementation phase until the fourteenth week to ensure the predicted number of debriefings were completed.

The pre-implementation survey was completed by 61% (53/87) of the staff, which included nursing, respiratory therapy, and physicians. Demographic data for the sample of respondents (n=53) is presented in Table 2. The majority of the respondents were nurses with greater than 10 years of experience, and 94.3% were female. Pre-implementation survey responses revealed that most of the respondents experienced critical incidents at work sometimes or occasionally. Those that responded stated employers helped them cope with stress associated with critical incidents at work sometimes or occasionally. Respondents reported that employers offered debriefing sessions after critical incidents most of the time (33%) or sometimes (33%). The majority of staff that responded to the survey stated that debriefing sessions after critical incidents were either very important (53%) or important (30%) to them. The majority of respondents stated debriefing sessions were mainly held 1-3 days (40%) or 1 week (31%) after a critical incident. The majority of respondents stated debriefing sessions after a critical incident should be held immediately (52%), at the end of shift (15%), or 1-3 days later (29%). Common themes from the pre-implementation survey in regard to barriers preventing a debriefing after a critical incident were: time constraints, patient care, scheduling of debriefing, and staff availability (Figure 1).

Of the 83 staff members, 32 (38.5%) completed the post-implementation survey. Four nurses who completed the pre-implementation survey resigned during the implementation period. Demographic data for the sample of respondents (n=32) are presented in Table 4. The majority of the respondents were nurses with greater than 10 years of experience, and 93.8% were female. The majority of respondents stated that a debriefing session was held immediately after a critical incident (Table 5). All respondents agreed that debriefing sessions after critical events were very important (59%) and important (34%). This was an increase from the pre-implementation survey, very important 6% increase and important 4% increase. The majority of respondents stated that an immediate debriefing after critical incidents decreases stress associated with participation in critical incidents most of the time. The majority of respondents stated that immediate debriefing after critical incidents improve satisfaction with debriefing experience most of the time. Common themes regarding barriers to a debriefing after a critical incident pre and post implementation were: patient care, time constraints, and staff availability, and compared see Figure 1.

Eleven debriefing sessions were conducted with a total of 51 staff members, of which 13 participated in more than one debriefing session. Each staff member completed a post critical incident debriefing survey after participation in the debriefing session (see Table 6 and Figure 2). The majority of the participants were nurses (82%). The majority of staff (95%) strongly agreed or agreed that debriefing was held at an appropriate time for them. 79% of staff surveyed strongly agreed or agreed that debriefings helped decrease feelings of stress and unease. 78% of staff also strongly agreed or agreed that debriefings were meaningful to them. 82% of staff surveyed strongly agreed or agreed that debriefings improved their satisfaction with debriefing sessions.

An overall increase of 10% of staff agreed debriefing sessions after critical incidents were important. An increase of 20% of staff agreed debriefing sessions should be held immediately after a critical incident. Post-implementation survey results demonstrated that immediate debriefing after critical incidents decreased stress associated with participation in critical incidents most of the time (74.2%) or sometimes (22.6%). Also, immediate debriefings after critical incidents improved satisfaction with the debriefing experience all the time (19.4%), most of the time (61.3%), and sometimes (19.35%). The post critical incident debriefing survey results showed 52.9% of staff strongly agreed and 29.4% agreed debriefings helped decrease feelings of stress and unease. 58.8% of staff strongly agreed and 23.5% agreed that debriefings improved their satisfaction with debriefing sessions.

Discussion

This QI project provides support regarding feasibility of implementing a debriefing program after pediatric critical incidents. The debriefing sessions assisted in decreasing the staff's feelings of stress and unease associated with critical incidents. Exposure to critical incidents in health care has been known to cause anxiety, absenteeism, and burnout (Edrees et al., 2016). Debriefing after critical incidents has been used to support staff during the healing process and provide emotional support (Maloney, 2012). The findings of QI project are consistent with the findings of Hammerle et al & Copeland et al., debriefing programs provide staff support and protect and preserve staff well-being, and a standardized debriefing program allows staff to pay homage to the patient and allowed staff to return to work with a sense of focus.

Some staff felt that not all the debriefings were necessary. Staff stated that a patient who was being transferred to the PICU from the pediatric unit for increasing respiratory support did not warrant a debriefing. However, the majority of the staff feedback was quite positive. For example, a debriefing was held by the project leader after a 4-month infant presented in cardiac arrest and required resuscitation most of the day. The project leader also held a debriefing for the nurses on night shift after the patient was withdrawn from respiratory and cardiac support. The debriefing was attended by all disciplines involved in the care of the patient. A nurse sent the project leader a text message that read, "I really liked our debriefing last night! And I really liked how our PICU attending was there for it too. We definitely need to continue these debriefings even after your project."

One strength of the project was the availability of the project leader to conduct initial debriefings until champions comfort level in conducting debriefings improved. The champions and leadership buy-in was crucial to the implementation of the QI project. Another strength of the debriefing program was the Debriefing Session Checklist (Appendix C) which provided insight on barriers to patient care due to lack of equipment, broken equipment, and delay in medication administration due to accessibility. The checklist also helped to identify patient and staff safety concerns secondary to delays in security response with a combative patient, quick access to emergent medications, and delays related to ancillary staff.

Limitations to the project were that the project was implemented during a low census timeframe, during the fall season which is a time of low patient census, limiting the number of debriefings that could have been conducted. This also impacted the number of participants involved in a debriefing due to lower staffing needs. Other limitations were low acuity of the patient population limiting the number of debriefings and staff uncertainty regarding what qualified as a critical incident requiring a debriefing.

Including the permanent charge nurse group as the unit champions ensured project sustainability because there was always one permanent charge nurse scheduled for each unit. Having two nurses available during each shift trained to conduct debriefing sessions ensured a debriefing was held after each critical incident which in turn contributed to sustainability. Now that the program has been successfully sustained in the pediatric unit and PICU, further dissemination of the program will be attempted in the pediatric emergency department as a long-term goal. Key elements for successful sustainability and spread of this program, included the support of nursing leadership, engaged unit champions, and the perceived value of the practice change by the multidisciplinary staff.

Conclusion

The results of this QI project demonstrate that a debriefing session after pediatric critical incidents can decrease staff's feelings of stress and unease as well as improve staff satisfaction with debriefings. The project also provides an example of development and implementation of a debriefing program that was successful in conducting debriefing sessions immediately after critical incidents. The permanent charge nurse group serving as unit champions contributed to project success and sustainability. Support of nursing leadership, identifying unit champions who are leaders in the unit, and validating a need for the practice change were key elements to the success and sustainability of the program and will guarantee the spread of the program to other units. Future research should take place in a large self-standing pediatric hospital during the winter season when patient acuity is higher or in a high acuity pediatric intensive care unit or cardiac intensive care unit to provide a better sample size. Recommendations for future research would be to conduct debriefings on patients after cardiac or respiratory arrest, shock, and other life-threatening episodes rather than patients who require transfer to the PICU as was done in this QI project.

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Table 1. Evidence Review Table

Author, year	Study objective/intervention or exposures compared	Design	Sample (N)	Outcomes studied (how measured)	Results	*Level and Quality Rating
Copeland & Liska, (2016)	Implementation of a post-code pause with aim to standardize debriefing process, encourage a supportive culture, improve transition back to normal activities, and allow staff to express reverence for patients involved in code or trauma event.	A one-year pilot project. Pre-implementation, mid-implementation, and post-implementation of Post-Code Pause (PCP)	Implemented at a suburban Level 1 shock trauma center.	Project goals: -standardize debriefing process -encourage supportive team-based culture -improve transition back to normal activities after responding to a code/trauma -provide responders opportunity to express reverence to patient involved in code or trauma event.	- 46/155 respondents to pre-implementation survey - 37/192 respondents to mid-implementation survey -33/173 respondents to post-implementation survey - Pre and post implementation data comparison demonstrated improvement in the following: -support from peers 4% (96% vs 100%) -supported by leaders 3% (91% vs 94%) -ability to pay homage 25% (36% vs 61%) -having enough time to regroup 18% (43% vs 61%) -not feeling pressured to return to work too quickly 11% (59% vs 70%) - 84 code events occurred over one-year pilot and a PCP occurred after 47 with a utilization rate of 56%, due to high acuity and not a lack of desire to conduct. - Post implementation 79% of respondents felt pause was valued at least half the time or more, 76% felt pause was somewhat helpful in paying homage to patient, and 71% were able to return to work with a sense of focus.	6 C
Edrees, Connors, Paine, Norvell, Taylor, & Wu, (2016)	Describe the development of Resilience in Stressful Events (RISE) program at Johns Hopkins Hospital in providing support to second victims who experience emotional distress after patient adverse events.	Case study with mixed methodology: frequency encounter counts, staff surveys, and peer responder self-evaluations.	Implemented at a urban area hospital. (N= 80 Rise calls)	data on need for support of healthcare workers; Peer Responder Encounter Form: peer responder gave de-identified information on event and nature of RISE call;	- Pre-Rise, 70% directly involved in unexpected adverse event. 57.9% reported experiencing anxiety, or inability to perform their job, 70.3% reached out for support. - A total of 119 calls over a 5-year period. -Majority of incidents were adverse events. -80 encounters, 45% included death of a	6 C

				Peer Responder Assessment Form: peer responder evaluated each interaction with call; and Peer responder focus group: assessed peer responder perception, confidence level, and self-assessed competence on RISE training.	patient, 21.3% involved an adverse event. -The mean length of interaction was 49 minutes -43% one-to-one interactions -56% group interactions -84.3% of callers were offered additional support by peer responder -88% of peer responders reported encounter as successful (66.7% of peer responders rated success of interaction as excellent -22.8% as neutral) -83.3% reported meeting caller's needs.	
Hammerle, Devendorf, Murray, & McGhee, (2017)	Discussion on the importance of debriefing programs as tools to diminish stress brought on after critical incidents in the ED.	Discussion on the development, implementation, and barriers to implementation of a debriefing program.	N/A	N/A	- Importance of debriefing programs in improving patient outcomes, identifying training gaps, and improve staff morale. - Development of debriefing program, barriers to implementation, and example session format presented. - A debriefing program is important to providing staff support and if developed can protect and preserve the staff well-being.	7 D
Kelly, Baker, & Horton, (2017)	Implementation of Code Compassion project to reduce compassion fatigue in acute care nurses.	Literature review and a multifaceted evidence-based intervention project development.	Implemented at one academic medical center in the Southwest United States.	The three themes chosen: reducing burnout, addressing secondary trauma, and promoting compassion satisfaction. A three-pronged multifaceted approach to reducing compassion fatigue with the development of the project Code Compassion.	- Project outcomes: reduce immediate burnout with a Code Compassion Cart, address secondary trauma with CISD, and promote compassion satisfaction with meaningful recognition (DAISY Award). - The Code Compassion Cart a mobile cart that contained self-renewing offerings such as snacks, hot beverages, stress balls, aromatherapy, relaxation CDs, portable massage chair, yoga breathing techniques, inspirational cards, and journals. - Code Compassion Cart and CISD were deployed and performed by trained staff to provide debriefing sessions immediately post traumatic event based on staff need. - Meaningful recognition achieved through DAISY award.	6 C

Healy & Tyrrell, (2013)	Assess nurses' and doctors' apparent need for debriefing after critical incidents and recommendations on ways to improve in this area.	Literature review and descriptive opinion survey on need for debriefing after stressful events.	Anonymous survey implemented in 3 Emergency Departments in Ireland. (N= 103/150 respondents, 69% [90 nurses and 13 doctors]).	Participants perception on the importance of debriefing answered in own words, by choosing number of possible answers, and choosing numbers on a sliding scale.	- 84% rated debriefing after stressful incidents in ED as "important" and "very important." - 62% had never been offered the opportunity to take part in a debriefing. - 15% unsure if debriefing participation was available at work place. - 37% had taken part in debriefing sessions. 3 purposes for debriefing emerged: -Provide emotional or psychological support. -Help staff improve or renew clinical practice after critical events. -Foster team spirit.	6 C
Maloney (2012)	Discussion on the benefits of Critical Incident Stress Debriefing (CISD) along with other modalities as a way to support staff healing after a critical incident.	Qualitative study	N/A	No intervention evaluated.	Response to critical incident and use of CISD as a way to support staff in the healing process after a critical incident.	6 D
Schmidt & Haglund, (2017)	Describe compassion fatigue using one nurses' experience and present the process of Personal Reflective Debrief (PRD) as a way to prevent compassion fatigue.	Case Study	N/A	Signs and symptoms of compassion fatigue. Use of debriefing as a way to prevent compassion fatigue.	Use of PRD as a way to promote resilience in ED nurses where compassion fatigue is unavoidable. Debriefing is presented as a non-threatening and low-cost way to discuss unexpected critical incidents and help with the group healing process.	6 D
Tuckey & Scott, (2014)	Evaluate the efficacy of group CISD at preventing post-traumatic stress and promoting return to normal functioning.	Randomized control trial	N=67 (volunteer fire-fighters)	Three treatment conditions were used: 1) CISD, 2) stress management education, 3) Screening (without treatment). Outcomes measured: 1) post-traumatic stress, 2) overall psychological distress, 3) quality of life, and 4) alcohol use.	Fire fighter brigades were randomly allocated to three intervention conditions. Post-intervention results showed: -no significant contribution to levels of post-traumatic stress and psychological distress after either intervention -post-intervention results showed a change in alcohol consumption and quality of life results -CISD group had significantly less alcohol consumption compared to Screening group. -CISD group had higher self-rated quality of life scores compared to the education group.	2 B

Table 2. Pre-Implementation Survey Demographics (n=53)

Category	No. (%)
Gender	
Female	
Male	50 (94.3%)
	3 (5.7%)
Discipline	
Registered Nurse	
Physician	31 (58.5%)
Respiratory Therapist	18 (34%)
	7 (7.5%)
RN experience	
0-5 years	
5-10 years	4 (7.5%)
11-15 years	6 (11.3%)
>15 years	9 (17%)
	12 (22.6%)
MD experience	
PGY-1	
PGY-2	5 (9.4%)
PGY-3	10 (18.9%)
PGY-4	2 (3.8%)
	1 (2%)
RT experience	
0-5 years	
5-10 years	1 (2%)
11-15 years	0
>15 years	0
	3 (5.7%)

Table 3. Pre-Implementation Survey Question Results (n=53)

Question	Answer Choices	Responses
How important is a debriefing session after critical incidents?	Very important	28 (52.8%)
	Important	16 (30.2%)
	Somewhat important	7 (13.2%)

	Slightly important	2 (3.8%)
	Not important	0
How soon after a critical incident is a debriefing session held?	Immediately	4 (8.9%)
	At the end of the shift	4 (8.9%)
	1-3 days	18 (40%)
	1 week	14 (31.1%)
	2 weeks	5 (11.1%)
How soon should debriefing sessions be held after critical incidents?	Immediately	27 (51.9%)
	At the end of the shift	8 (15.4%)
	1-3 days	15 (28.9%)
	1 week	2 (3.9%)
	2 weeks	0

Table 4. Post-Implementation Survey Demographics (n=32)

Category	No. (%)
Gender	
Female	
Male	30 (93.8%)
	2 (6.2%)
Discipline	
Registered Nurse	
Physician	22 (68.8%)
Respiratory Therapist	9 (28%)
	1 (3.1%)
RN experience	
0-5 years	
5-10 years	4 (12.5%)
11-15 years	5 (15.6%)
>15 years	4 (12.5%)
	9 (28.1%)
MD experience	
PGY-1	
PGY-2	2 (6.3%)
PGY-3	4 (12.5%)

PGY-4	2 (6.3%)
	1 (3.1%)
RT experience	
0-5 years	
5-10 years	0
11-15 years	0
>15 years	0
	1 (3.1%)

Table 5. Post-Implementation Survey Question Results (n=32)

Question	Answer Choices	Responses
How important is a debriefing session after critical incidents?	Very important	19 (59.4%)
	Important	11 (34.4%)
	Somewhat important	2 (6.3%)
	Slightly important	0
	Not important	0
How soon after a critical incident was a debriefing session held?	Immediately	16 (61.5%)
	At the end of the shift	2 (7.7%)
	1 day later	3 (11.5%)
	One was not held	5 (19.2%)
How soon should debriefing sessions be held after critical incidents?	Immediately	20 (71.4%)
	At the end of the shift	4 (14.3%)
	1 day later	3 (10.7%)
	One was not held	1 (3.6%)
Does immediate debriefing after critical incidents decrease stress associated with participation in critical incidents?	All the time	1 (3.2%)
	Most of the time	23 (74.2%)
	Sometimes	7 (22.6%)
	Occasionally	0
	Never	0
Does immediate debriefing		

after critical incidents improve satisfaction with debriefing experience?	All the time	6 (19.4%)
	Most of the time	19 (61.3%)
	Sometimes	6 (19.4%)
	Occasionally	0
	Never	0

Table 6. Post Critical Incident Debriefing Survey Results (n=51)

Question	Answer Choices	Responses
Discipline		
	RN	36 (82.4%) (13 participated in 2 debriefings)
	Resident	4 (7.8%)
	Attending Physician	3 (5.9%)
	RT	2 (3.9%)
	Other (social worker, child life specialist, chaplain, unit secretary, etc.)	6 (11.8%)
Was the debriefing held at an appropriate time for you?		
	Strongly agree	35 (68.6%)
	Agree	13 (25.5%)
	Neutral	2 (3.9%)
	Disagree	1 (2%)
	Strongly Disagree	0
Did the debriefing help decrease feelings of stress and unease?		
	Strongly agree	27 (52.9%)
	Agree	15 (29.4%)
	Neutral	8 (15.7%)
	Disagree	1 (2%)
	Strongly Disagree	0
Was the debriefing meaningful to you?		
	Strongly agree	28 (54.9%)
	Agree	12 (23.5%)
	Neutral	11 (21.6%)
	Disagree	0

	Strongly Disagree	0
Did the debriefing improve your satisfaction with debriefing sessions?	Strongly agree	30 (58.8%)
	Agree	12 (23.5%)
	Neutral	9 (17.7%)
	Disagree	0
	Strongly Disagree	0

Figure1. Comparison of Pre-implementation and Post-implementation survey open ended question common themes.

Figure 2. Post Debriefing Survey results.

Appendix A: Part 1

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (2009)

When you *[care for]* people you have direct contact with their lives. As you may have found, your compassion for those you *[care for]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[care provider]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often

1. _____ I am happy.
2. _____ I am preoccupied with more than one person I *[care for]*.
3. _____ I get satisfaction from being able to *[take care of]* people.
4. _____ I feel connected to others.
5. _____ I jump or am startled by unexpected sounds.
6. _____ I feel invigorated after working with those I *[care for]*.
7. _____ I find it difficult to separate my personal life from my life as a *[care provider]*.
8. _____ I am not as productive at work because I am losing

sleep over traumatic experiences of a person I *[cared for]*.

9. _____ I think that I might have been affected by the traumatic stress of those I *[care for]*.
10. _____ I feel trapped by my job as a *[care provider]*.
11. _____ Because of my *[caring]*, I have felt "on edge" about various things.
12. _____ I like my work as a *[care provider]*.
13. _____ I feel depressed because of the traumatic experiences of the people I *[care for]*.
14. _____ I feel as though I am experiencing the trauma of someone I have *[cared for]*.
15. _____ I have beliefs that sustain me.
16. _____ I am pleased with how I am able to keep up with *[caring]* techniques and protocols.
17. _____ I am the person I always wanted to be.
18. _____ My work makes me feel satisfied.
19. _____ I feel worn out because of my work as a *[care provider]*.
20. _____ I have happy thoughts and feelings about those I *[care for]* and how I could help them.
21. _____ I feel overwhelmed because my case [work] load seems endless.
22. _____ I believe I can make a difference through my work.
23. _____ I avoid certain activities or situations because they remind me of frightening experiences of the people I *[care for]*.
24. _____ I am proud of what I can do to *[care for others]*.
25. _____ As a result of my *[caring]*, I have intrusive, frightening thoughts.
26. _____ I feel "bogged down" by the system.
27. _____ I have thoughts that I am a "success" as a *[care provider]*.
28. _____ I can't recall important parts of my work with trauma victims.
29. _____ I am a very caring person.
30. _____ I am happy that I chose to do this work.

Appendix A: Part 2

Compassion Fatigue Survey Demographics Information

Participant Code (Mother's Maiden Name):

____

Female ÿ Male ÿ

1. Circle which applies:
   Nurse Resident (year) _____
   Respiratory therapist
   Attending Physician (which unit) _______ PCA
   Other (position)____________________

2. Years in Nursing ___________ Years as a Physician _______________

3. Years as Respiratory Therapist __________ Years as a PCA ______________

4. Compassion Fatigue Score ______________

5. Compassion Satisfaction Score _____________

Appendix B: Debriefing Session Education

Learning Objectives	Content Outline	Method of Instruction	Time Spent	Method of Evaluation
At the end of the of this teaching session, unit champions will: 1. comprehend the definition of critical incidents and how they affect individuals caring for the patient.	Critical Incidents 1. Definition 2. Effects of critical incidents on health care providers. a. Emotional b. Physical c. Psychological	PowerPoint presentation and discussion	10 minutes	Discussion with question and answer
2. comprehend the importance of debriefing sessions after critical incidents.	Debriefing session 1. Importance of debriefing sessions. a. Support of individual b. Promote emotional well-being c. Decrease stress associated with participation in	PowerPoint presentation and discussion	10 minutes	Discussion with question and answer

	critical incidents			
3. comprehend the process of conducting a debriefing session after critical incidents.	Debriefing process 1. Overview of debriefing session 2. Demonstrate a debriefing session 3. Review debriefing tool	PowerPoint presentation, video on debriefing session, and debriefing tool.	15 minutes	Discussion with question and answer
4. facilitate a debriefing session after critical incidents.	Debriefing session 1. Conduct a pediatric critical incident (cardiac resuscitation) 2. Conduct a debriefing session post critical incident (participants) 3. Review debriefing session outcomes	Mock cardiac resuscitation, debriefing session, and discussion	30 minutes	Hands on scenario and discussion.

Appendix C:

Debriefing Session Checklist

Date: ______________________ Time: _______________

Reason for Debriefing: ________________________________

Present for debriefing: # Nurses _______ Charge Nurse ___________

Physician Provider _____________ Respiratory Therapist _________ PCA___________

Other ____________________

1. Debriefing held in separate area: Yes No
2. Debriefing was led by debriefer: Yes No
3. Staff given a moment to regroup: Yes No

Debriefing discussion structure: Comments:

1. Done well as a team
_________________________ __________
2. Interventions were not offered
______________________________ _____
3. Equipment and medications available.
____
4. Growth and improvement from this experience.
____
5. Support each other? Yes No
______________________________ ____

6. Support the family? Yes No ______________________________

____

7. Feelings Expressed ________________________

____

8. Able to successfully return to work? Yes No ________________________________

9. If a team member expressed inability to return to work, what other support was provided? ____________________ ____________________________

Appendix D:

Pre-Implementation Debriefing Survey

Participant Code (Mother's Maiden Name): ________________________ Female ÿ Male ÿ

1. Circle which applies:
   Nurse Resident (year) ______ Respiratory therapist
   Attending Physician (which unit) _______ PCA
   Other (position) ____________________

2. Years in Nursing _____________ Years as a Physician _______________

3. Years as Respiratory Therapist __________ Years as a PCA ______________

4. Critical Incidents are defined as: resuscitation of patients after cardiac or respiratory arrest, oncology patients at end of life stage, patients on the pediatric unit that decompensate due to sepsis or respiratory distress requiring transfer to the PICU, or conflicts with patient's family members.

Question	All the time	Most of the time	Sometimes	Occasionally	Never
How often do you experience critical incidents at work?					
Does your employer help you					

cope with stress associated with these critical incidents at work?					
Does your employer offer debriefing sessions after critical incidents at work?					
In your opinion, how important is a debriefing session after critical incidents?	**Very Important**	**Important**	**Somewhat Important**	**Slightly Important**	**Not Important**
Have you ever taken part in a debriefing session after a critical incident?	**Yes**	**No**			
Question	**Immediately**	**At the end of the shift**	**1-3 days**	**1-week**	**2-weeks**
If so, how soon after a critical incident is a debriefing session held?					
In your opinion, how soon should debriefing sessions be held after a critical incident?					
What barriers do you believe prevent debriefings from occurring after critical incidents?					

Appendix E:
Post Critical Incident Debriefing Survey

Participant Code (Mother's Maiden Name)
____

1. Date _________________
2. Circle which applies:

Nurse Resident (year) ______ Respiratory therapist

Attending Physician (which unit) _______ PCA

Other (position) ______________________

3. Years in Nursing ______________ Years as a Physician _________________
4. Years as Respiratory Therapist ___________ Years as a PCA _______________

Questions	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Was the debriefing held at an appropriate time for you?					
Did the debriefing help decrease feelings of stress and unease?					
Was the debriefing meaningful to you?					

Did the debriefing improve your satisfaction
with debriefing sessions?

Appendix F:
Data Collection Sheet

Date: ______________________

Type of critical incident:

a. Cardiac/respiratory arrest
b. Oncology patient end of life
c. Pediatric transfer to PICU for sepsis decompensation
d. Pediatric transfer to PICU for respiratory decompensation
e. Conflict with patient or family member

Number of participants: _______________

a. # Nurses ______ b. # Physicians __________ c. # Respiratory therapist ________
d. PCA _____ e. Other _________

Debriefing conducted by: ____________________

Debriefing conducted:

a. immediately after incident
b. at end of shift
c. 1 day later
d. Not conducted and why?
____

Did participants express feeling supported after debriefing? Yes ÿ No ÿ

Did participants express decrease level of stress after debriefing? Yes ÿ No ÿ

Did participants express inability to return to work after critical incident and debriefing session?

Yes ÿ No ÿ

Was a referral made for further support interventions? Yes ÿ No ÿ

Appendix G:

Post-Implementation Debriefing Survey

Participant Code (Mother's Maiden Name) ________________________

1. Circle which applies:
   Nurse Resident (year) _____
   Respiratory therapist PCA
   Attending Physician (which unit) _______ Other (position) ____________________

2. Years in Nursing ___________ Years as a Physician/Resident _______________

3. Years as Respiratory Therapist __________ Years as a PCA ______________

4. Critical Incidents are defined as: resuscitation of patients after cardiac or respiratory arrest, oncology patients at end of life stage, patients on the pediatric unit that decompensate due to sepsis or severe respiratory ailments and require transfer to the PICU, and conflicts with patient's family members.

Question	**None**	**1**	**2**	**3**	**4+**
How many critical incidents did you experience at work during the implementation period?					
Of these critical incidents, how many had post immediate debriefing sessions?					
Question	**Immediately**	**At the end of the shift**	**1 day later**	**One was not held**	
How soon after a critical incident was a debriefing session held?					
In your opinion, how soon should debriefing sessions be					

held after a critical incident?	
What barriers do you believe prevent debriefings from occurring after critical incidents?	

Question	Very Important	Important	Somewhat Important	Slightly Important	Not Important
In your opinion, how important is a debriefing session after critical incidents?					

Question	All the time	Most of the time	Sometimes	Occasionally	Never
Does immediate debriefing after critical incidents decrease stress associated with participation in critical incidents?					
Does immediate debriefing after critical incidents improve satisfaction with debriefing experience?					

Appendix H
Project Proposal Summary

Background

Critical incidents are described as events that induce strong emotional responses that can increase stress levels thereby impeding nurse's ability to provide good care (Healy & Tyrrell, 2013). Nurses working in the pediatric environment are exposed to critical incidents that effect their well-being and repeated exposure can cause burnout, eventually can lead to compassion fatigue (Maloney, 2012). The practice problem took place on a twenty-six-bed pediatric unit with twenty pediatric beds and six pediatric intensive care unit (PICU) beds in a community hospital in the inner city of Baltimore. The unit did not have a debriefing program after critical incidents. Nurses expressed a need for immediate debriefings after pediatric critical incidents to prevent compassion fatigue and provide staff needed support after participating in these events.

Purpose

The purpose of this DNP project was to implement an immediate debriefing program after pediatric critical incidents on the pediatric unit and PICU to decrease compassion fatigue associated with exposure to these events. These incidents included resuscitation of patients after cardiac or respiratory arrest, patient death, patients that decompensate due to sepsis or respiratory distress requiring transfer to the PICU, and conflicts with patients' family members.

Implementation Plan

The quality improvement project took place over a 14-week period. The first week, the DNP project leader educated nurses about project during monthly staff meeting and physicians during noon conference. The second week, the project leader trained a group of 12 permanent charge nurses who served as project champions and debriefers. The team champions attended a 30-minute training session led by project leader on critical incident stress debriefing and all staff completed a pre-implementation survey. Weeks three through fourteen, immediate debriefings were conducted for all critical incidents in the pediatric unit and PICU. A champion was present after each critical incident to perform the debriefing. After each debriefing session, staff completed a post critical incident debriefing survey. Weeks thirteen and fourteen, staff completed the post-implementation debriefing survey to assess if there was a decrease in stress and an increase in staff satisfaction.

Data Collection

The ProQOL was used to assess staff compassion satisfaction and compassion fatigue of the participants in the project. The pre-implementation and post-implementation surveys and the debriefing data collection sheet provided participant demographics along with information on number of debriefings, what kind of critical incidents, barriers to implementing debriefing sessions, and whether debriefings were instrumental in decreasing stress associated with critical incidents and improving staff satisfaction with debriefing sessions.

Data Analysis

Data was analyzed from data collected from debriefing checklist and the post critical incident debriefing survey. Responses to pre- and post-implementation surveys were compared to assess the impact of the debriefing sessions in decreasing staff stress and increasing satisfaction following a critical incident.

Participant privacy was maintained with the use of a participant code, mother's maiden name. The data was collected and entered into an Excel spreadsheet in order to conduct statistical analysis. All information was stored in a password protected computer.