Guidelines for Critical Incident Stress Management

Certified Registered Nurse Anesthetists (CRNAs) provide high-quality anesthesia services and are personally invested in the continuing health, safety, and welfare of their patients. The Institute of Medicine report, *To Err is Human: Building a Safer Health System* sparked a nationwide call to design systems of care that decrease risk of error and enhance patient safety.[1] The American Association of Nurse Anesthetists (AANA) embraces patient and healthcare provider wellbeing and safety.

The AANA recognizes that the physical and emotional wellbeing of CRNAs and Student Registered Nurse Anesthetists (SRNAs) is the foundation for practice excellence. Critical incidents are inevitable in healthcare, possibly causing significant, long term health issues for patients and those who care for them. It is estimated that every anesthesia provider will experience at least one perioperative catastrophic event at some point in his or her career.[2] Therefore, the AANA is committed to supporting anesthesia professionals who may be impacted by critical incidents during the course of their careers. Appropriate early intervention may minimize the effects of stress and prevent long-term problems from occurring.

These guidelines are a resource for healthcare organizations, patients, families and caregivers to develop and integrate into facility policy and ongoing education programs to support essential dialogue during and more importantly, for as long as necessary, after a critical adverse event.[3]

Definitions	
The terms *critical incident* and *adverse event* are often used interchangeably. Other terms that may be used include *sentinel event* and *traumatic incident*. Each of these terms describes events that are unanticipated and may or may not be preventable.	
Critical incident	A powerful and overwhelming event that lies outside the range of usual human experience. It has the potential to exhaust one's usual coping mechanisms, resulting in psychological distress and disruption of normal adaptive functioning.[1] These events are typically related to a breakdown in the overall health system or process, rather than the negligence of one individual.[2]
Adverse event	An unintended injury, patient harm, or complication resulting in a prolonged hospital stay, disability at the time of discharge, or death and is typically caused by healthcare process management rather than by the patient's underlying disease process.[3]
Medical error	The failure to take a known and planned action or using the wrong plan of action to achieve an aim. The error may or may not lead to patient harm.[4]
Near miss	An event or situation that could have resulted in accident, injury, harm, or illness, but did not, either by chance or through timely intervention.[5]
Disclosure	Providing open and timely communication about adverse events to keep patients and family members informed, acknowledge suffering and grief, and help reduce feelings of abandonment, thereby supporting patients' recovery and health.[6]
Reporting	Providing information to the appropriate authorities regarding the adverse event or errors.[7]

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Second Victim	A healthcare provider involved in an unanticipated adverse patient event, medical error, and/or a patient related–injury who becomes traumatized by the event.[8]
First Victim	Patients who are directly impacted or harmed by an adverse event or medical error.[8]

Critical Incidents and Adverse Events

Critical Incident Impact

Severity of stress related to a critical incident is determined by personal interpretation of the event, perceived seriousness of the incident, length of exposure, pre-existing coping strategies, and available social support.[9] The factors that determine whether an incident is traumatic are subjective and variable. It is normal and acceptable for each person to interpret and cope with the same incident in a different manner.

When a critical incident occurs, a cascade of emotions may overwhelm an otherwise healthy individual's coping skills.[10] For this reason, healthcare providers involved in critical incidents are often termed "second victims."[11] Second victims are affected by the impact of the incident on the first victims[8] and may suffer from feelings of guilt, shame, distress, anger, and isolation in the workplace. They may also suffer adverse health effects.[11] These symptoms can result in reduction in work performance, burnout, poor sleeping habits, inability to concentrate, excessive alcohol consumption, and contemplation of a career change.[11,12]

Individual Effects

Acute Traumatic Stress

Acute traumatic stress occurs soon after the incident and negatively affects quality of life both at work and home.[1] Symptoms of acute traumatic stress can include sleep disturbance, withdrawal, poor concentration, changes in interactions with others, depression, anxiety, and excessive use of illegal substances or alcohol.[10,13,14]

Posttraumatic Stress Disorder (PTSD)

When traumatic stress is not appropriately addressed directly following a critical incident, individuals become at risk of PTSD (Figure 1).[13,15,16] PTSD is characterized by clinically significant distress symptoms that persist longer than one month and can result in permanent disability, further affecting the second victim's ability to assume optimal patient care responsibilities.[10]

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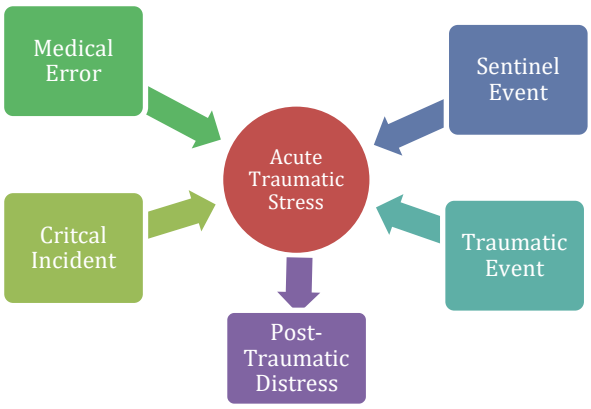
Figure 1. Relationship between acute stress and post-traumatic distress disorder following a critical incident.



Management of Traumatic Responses

The CRNA and SRNA have provided the supportive environment necessary for the patient's understanding and recovery, but as the second victim, the anesthesia professional may require the same support as they move through their personal coping process.[12] Crisis interventions support all victims impacted by a critical incident, and help second victims understand and normalize their emotional reactions and prevent long-term consequences, such as PTSD.[1,13,16,17] These interventions may include debriefing, counseling, screening for the need for longer-term therapy, and referrals for further mental health treatment. Several types of interventions may be implemented on a one-on-one basis or in small groups. The most commonly utilized interventions are briefly described below.

Intervention Strategies for Managing Critical Incident Stress

Critical Incident Stress Management (CISM) Model

The CISM model is a comprehensive, multicomponent program to maintain or restore the individual(s) involved to their usual state of health by alleviating the severe effects of traumatic stress.[17-19] The interventions are conducted throughout three stages of the model: pre-crisis, acute crisis, and post-crisis to address preparing for an incident, the reactions that immediately follow an incident, and the possible long-term effects from experiencing a critical incident. Critical incident stress management model may be used by individuals, families, and organizations and should be facilitated by trained personnel. The seven core components of CISM are briefly discussed below.[10]

Pre-Crisis Stage Intervention

Pre-crisis preparation

This phase of the model occurs prior to a critical incident. It includes stress management and stress resistance education, instruction in relaxation techniques, and developing and strengthening coping skills.

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Acute Crisis Stage Interventions

Demobilization and consultation

This intervention occurs immediately after the incident to assess immediate reactions to the event and provide information on next steps. This session typically lasts 10-15 minutes and is led by a person of authority. After the short session, all parties are encouraged to relax for approximately 20 minutes prior to returning to work. The goal of this brief session is to immediately assist individuals in understanding and managing their preliminary reactions to the event.

Defusing

A defusing session is an extension of the demobilization and consultation session and occurs after the work day, but before the involved parties depart for the day. This session is conducted by a person of authority and typically lasts an hour. The purpose of this intervention is to recount the details of the event, provide information about potential emotional reactions, offer support, and allow individuals to express his or her concerns surrounding the incident.

Critical Incident Stress Debriefing (CISD)

Critical incident stress debriefing was originally used for emergency service workers, but has been found to be useful in the healthcare field. It is highly recommended[1,9,10,12,15,20-25] and the most frequently used component of CISM.[17,25] CISD is designed to accompany the other components of this model and should not be used as a stand-alone intervention. Rather, facility policies should include CISD in the comprehensive CISM that incorporates the other important elements.

This intervention involves a structured group discussion that occurs one to three days after the critical incident. The debriefing session should include all staff from the same discipline and department who were involved in the critical incident.[12] The session is designed to provide closure, alleviate signs and symptoms of acute distress, and assess the need for individual follow-up. Emotional support, better mental health of the group, increased job retention, reduced symptoms, and increased productivity are reported benefits of CISD.[1,10,15,20,22,24] The seven phases of formal debriefing include introduction, fact phase, thought phase, reaction phase, symptom phase, teaching phase, and re-entry phase.[25]

One-on-one crisis intervention

Crisis intervention includes counseling or provision of psychological support throughout the full range of the crisis spectrum. The goal is to guide each person back to the level of functioning prior to the incident.

Family critical incident stress management

Critical incidents have a significant and devastating impact on families. Family crisis intervention supports the family, promotes patient-provider communication, and provides direction towards closure.

Post-Crisis Stage Intervention

Follow-up and referral for treatment

Critical incidents have overwhelming effects on all parties involved. There may be a need for long-term psychological treatment. Therefore, it is important that a follow-up and referral mechanism is established for anesthesia providers and their families.

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Resources

- A Primer on Critical Incident Stress Management by the International Critical Incident Stress Foundation
- Critical Incident Stress Management Peer Support Training Seminars

Briefing-Debriefing Model
The briefing-debriefing method is primarily used prior to and following surgical procedures, regardless of whether or not a critical incident occurred.[26,27] The goal of this process is to establish a platform for reducing communication barriers and encouraging openness among the healthcare team members.[26] Typically the lead surgeon acts as facilitator, employs a debriefing checklist, and opens the debriefing process by asking for introductions. The facilitator then asks an ice breaker question to create a sense of cohesion amongst the group. The team is encouraged to share any concerns that could impact patient care. Once the briefing is complete, the surgery commences.

Following surgery, the debriefing stage allows all healthcare staff to reflect and voice concerns regarding the procedure. The debriefing stage has an educational tone and may include encouraging remarks regarding the procedure. It may also be problem-solving focused, aimed at identifying and discussing near misses, equipment deficiencies, and/or patient safety issues. The entire process is brief, approximately three minutes for each session. This method has been reported to improve interdisciplinary communication and teamwork in the operating room,[27] which is essential in the event that a critical incident occurs.

Resources

- "Briefings, debriefings: Path to safer care" article
- "Implementing Standardized Operating Room Briefings and Debriefings at a Large Regional Medical Center" article

Considerations for Critical Incident Stress Management Program Development
Currently, few facilities have established CISM policies,[28-30] and many CRNAs report feeling underprepared to cope with the after-effects of a critical incident.[30] Professional interventions in the workplace are beneficial to both healthcare providers and patients and are essential to ensure quality healthcare.[14,31,32] Critical incident stress management programs support development of healthy coping mechanisms and may improve work engagement with associated reduction in stress-related illness absences.[31]

Key elements to consider in establishing a CISM program or policy:

- Preparation Component: To provide education regarding critical incident stress and what to expect when an incident occurs.
- Prevention Component: Training in relaxation techniques that may provide comfort to prevent the coping system from being overwhelmed.[31,32]
- Debriefing Sessions: These are strongly encouraged for healthcare providers involved in a critical incident, but not be mandatory.[31] They should also be available on request by any member of the healthcare team.[29]
- Interventions: Led by mental health professionals who are experienced in the debriefing process and not directly involved in the critical incident.[22,28,31]

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- Confidential and Non-judgmental: All intervention participants should be assured that all discussions are confidential and non-judgmental.[31]
- Evaluation Process: Evaluation of the CISM program following the event provides staff with the opportunity to reflect, assess the effectiveness of the program and contribute to the ongoing improvement and engagement with the program.[9,17,22,31]

Strategies for implementing a CISM program or policy:

- Management support of a CISM program is vital for the program's success.[29] Management and supervisory staff should be trained prior to implementing the CISM program facility-wide.
- When educating staff, emphasize that management fully supports the policy.
- Develop a robust policy communication plan that includes how to access support resources for those who are experiencing traumatic stress or have been involved in a critical incident.
- Extensively communicate through vehicles such as staff meetings and notices posted throughout the facility.
- Seek employee feedback so questions and concerns may be addressed.
- Provide continuous educational opportunities after the policy has been implemented to support employees and encourage use of services.

Disclosure

Communication is a key factor in both preventing and coping with critical incidents. It is imperative to establish open and effective communication with patients and their families. A growing number of institutions and providers have embraced the concept of disclosure. However, challenges regarding disclosure still exist as organizations struggle with issues of when, what, how, and why to disclose. There are three types of disclosure:[33] clinical, institutional, and large-scale disclosure. This document discusses clinical disclosure, which addresses the provider-patient relationship.

History of Disclosure

Historically, disclosure of critical incidents to patients was rare due to concerns about professional preservation and fear of litigation.[33,34] In recent years, national and international governments, accrediting bodies, and healthcare institutions have taken measures to address acts of disclosure. Federal and state governments have increasingly enacted legislation to address the use of disclosure in litigation. More legislation is necessary in order for providers to feel comfortable with disclosure.[35]

Why disclose a critical incident or adverse event?

There are several reasons why a healthcare provider may disclose an unanticipated event or adverse outcome to the patient. Patients have reported a desire and expectation to be informed of the outcomes of their care.[6,33,34,36,37] Patients are unable to make informed decisions and consent to subsequent treatment if they are not completely aware of the adverse event.[33,36] In addition to serving the patient, disclosure creates an opportunity for the provider to validate the patient's concerns and to offer empathy which may emotionally benefit the healthcare provider as well.[36]

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Some accrediting organizations, such as The Joint Commission, have added language to their standards requiring licensed practitioners to disclose unanticipated outcomes to patient and families.[38] In addition, ethical and professional codes of conduct encourage the disclosure of unanticipated outcomes to patients.[6,33,36,37,39] The AANA *Code of Ethics for the Certified Registered Nurse Anesthetist* provides language that supports protecting patients and attending to their needs, "The CRNA protects the patient from harm and is an advocate for the patient's welfare."[30]

Is disclosure always appropriate?

Research suggests that disclosure may not always be in the patient's best interest. Situations in which a provider may wish to refrain from disclosing an unanticipated outcome include: if the patient's safety will be at risk, if there is potential for abuse or neglect by the patient's family member, or if there is a police investigation of the incident.[40] In addition, both patients and healthcare providers agree minor medical errors that pose no harm do not warrant disclosure.[34]

Disclosure and systems improvement

Disclosure may benefit systems improvement because issues that contributed to the critical incident may be revealed.[33] Incident or root cause analysis led by the facility performance improvement or risk management team is vital for systems improvement and prevention of future occurrences.[6] Without incident analysis, incident reporting is ineffective. When disclosure is integrated with patient safety and risk management activities, it supports a culture of patient safety and quality improvement.[41,42]

Barriers to disclosure

The most commonly identified barrier to disclosure is fear.[33,36,37] Healthcare providers often equate disclosure with liability, and have eschewed disclosure due to an inherent fear of professional sanctions[36] and litigation.[37] An additional perceived barrier to disclosure has been uncertainty regarding the quantity of information that should be shared with patients.[41] Due to the lack of transparency in prior decades, healthcare providers are also often not aware of what information is appropriate for inclusion in disclosure.[41] The culture within an institution can be a barrier to adopting new policies and practices. Therefore, organizations must assess and alter the facility culture among healthcare providers and afford them the support needed to embrace disclosure practices.[33]

Considerations for disclosure policy development

The 2013 AANA Critical Incidents and Adverse Events Open Forum Evaluation Results[30] revealed that 70.6 percent of respondents were unaware of a disclosure process or policy within their organization. Although healthcare professionals are concerned about addressing patients' requests for transparency, limited information exists on effective disclosure strategies.[41] An institutional disclosure and apology policy should include staff training on adverse events, disclosure, apology, and a protocol for reporting critical incidents. The policy should also include a provision for an analysis of the investigation findings after a critical incident occurs and is reported. These components will contribute to the learning process and potentially decrease the frequency of adverse events.

The AANA encourages healthcare organizations to develop a policy for anesthesia providers and all healthcare professionals to use as a guide to navigate through the disclosure process. The CRNA, the facility, and their respective liability carriers should align their strategy and process for the disclosure of adverse events. This policy will foster public confidence in the healthcare system by emphasizing transparency and future prevention strategies.

The disclosure process should be promoted and outlined in an institution's critical incident stress management policy or program and encompass the following:[34,36,40]

- Establish an internal system for reporting adverse events, including the method for analyzing the reports, which serves to improve systems processes.
- Identify the situations in which disclosure and reporting are appropriate within the facility and externally to particular regulatory agencies.
- Provide a process for investigating the unanticipated event, which may include a disclosure team of key healthcare professionals (i.e., a high-level administrator, a patient care liaison assigned to address patient concerns, and a clinically-trained individual possessing skill in adverse events management).
- Encourage disclosure practices with an emphasis on prevention and patient safety rather than punitive sanctions.
- Provide an outline of possible information and timeline that may be considered when developing the patient and family disclosure meeting(s).
- Indicate the information to be documented in the provider's record of disclosure (e.g., objective details of the incident, all parties involved in the disclosure meeting).
- Emphasize the importance of communication between the patient care liaison and the patient. The patient care liaison may support the patient to access additional services and be the main point of contact for future concerns.[42]

Conclusion

In order for critical incident stress management and the disclosure process to become an organizational norm, organizational leadership and administrative support are essential. Educational training programs for staff should aim to promote and enhance the disclosure process by offering guidance on managing crucial conversations with patients and their families while allowing the provider to exhibit empathy regarding the incident. Coping skills and empathy to enhance patient communication skills should be addressed in the training program. Transparent and caring healthcare organizations that provide the healthcare team, patients, and their families with the resources and emotional support after an adverse event are more likely to be trusted in the future. Anesthesia professionals will be most successful in managing adverse events if they are supported through the disclosure and coping process by organizational leadership, colleagues, and facility policy. Anesthesia professionals are encouraged to investigate alternative resources and counseling opportunities if they do not exist at their institution.

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