Critical Incidents

Bob Wright, R.G.N., R.M.N.
Senior Charge Nurse, Accident and Emergency Department, Leeds General Infirmary, England

Reproduced by kind permission of *Nursing Times* where this article first appeared on 10th May, 1989, Vol. 85 No. 19.



When I saw a firefighter being interviewed on a television news bulletin, he actually said very little. He had just returned from Armenia where he had been helping to rescue earthquake victims. When asked what it was like out there, he said: 'It was unbelievable, I have never seen and experienced so much pain.'

The interviewer asked no more. The obvious anguish and distress in that man's short answer were enough. He said it all. I wondered later who was going to care for him and how he was.

Over the years in A&E I have studied how we care for our patients in crisis[1] and how we structure our interventions. We become more and more aware of encountering the whole of our patients, and recognise that alongside the trauma and health care issues are the patients' psychological needs.

As we are dealing with patients with serious and often mutilating injuries, their distressed relatives also arrive with needs and care requirements that take their toll on health care staff. The commitment and sensitivity required by staff, as described by Ashdown[2], when dealing with a sudden death can leave staff feeling drained and ineffective.

Many of the workshops I have conducted on coping with sudden death and the emotional cost of caring to us, the nurses, have highlighted our feelings of deficiency. Such workshops can highlight areas of vulnerability and remove some of the fears. I have, for example, been able to identify which emotional responses in relatives are likely to leave us feeling incapacitated[3]. This knowledge will, to some extent, prepare nurses and others for some of the difficulties by reducing the overwhelming nature of these feelings.

We pay lip service to caring for each other but often fail to give space or structures for this to happen. Our response to some of the distress in the incidents staff have to deal with may well be 'they can always come and talk to us'. And many nurses do describe unspoken, non-confronting ways of caring for colleagues: taking some of the burden of work away from colleagues, or manipulating the situation so that difficult or painful issues were avoided. When asked if they had discussed this with colleagues, they said they had not but had simply done it quietly.

This response is a clear reflection of our attitude to our own emotional needs. This attitude seems to be: 'Do not ask to have them (needs) met but hope they will be, in some passive way.' There is, of course, that well worn statement of 'I am always here if you want me'. The anxiety with this is that if you do state your need, you will be labelled as abnormal or weak.

In the wake of recent disasters, and because of the enormity of these tragedies, we have allowed ourselves to acknowledge some of the pain and distress and seek help for it. However, there are as many other serious if smaller disastrous events daily in our hospitals and health care settings that should receive attention because of the stress they produce. For example, the road traffic accident where two or three family members are killed. The children and maybe a parent from a house fire—dead or dying on arrival, and caring for the remaining family member.

In 1988 I spent some time working with, and hearing how, professionals in Australia and the US have frameworks for confronting the stress of these critical incidents. Since then I have had the opportunity to look at how these can be used in critical care nursing areas in hospitals. One reason why the frameworks are so valuable is that they take a much more assertive approach to the incident. We do not wait for some magic kind of catharsis to take place. We actively give time, space, structure and validity to the stress. By providing a structure to deal with the stress of the incident, recognition is given to the fact that workers can become victims.

A critical incident is any situation faced by emergency and critical care personnel that causes them to experience unusually strong emotional reactions. These feelings have the potential to interfere with their ability to function either at the time, or later. Critical incidents produce some characteristic physical and psychological symptoms. It is very common and, in fact, quite normal for this to happen when they have experienced a horrible event.

Some stress reactions appear immediately after the event or within a few hours or days. In some cases it is weeks or months before the reaction appears. The signs and symptoms of a stress reaction may last for a few days or months depending on the severity of the event. With understanding and support the stress may pass quickly. In other cases, the event is so painful that a more structured assistance is required. This works more effectively if a peer group member has been taught some of the skills. In critical incident stress debriefing (CISD) the facilitator needs a good working knowledge of stress and counselling. Mitchell[4] states that its value should not be underestimated as it can extend the careers of personnel, and thus prevent resources having to be used to replace skilled staff. He describes how staff may have just seen too much human misery and broken bodies, but their expertise is a valuable commodity which is worth preserving.

Debriefing

The three frameworks used to alleviate stress of critical incidents are defusing, demobilisation and debriefing.

Defusing is a short type of crisis intervention for critical care and emergency personnel. Harris[5] feels it is particularly appropriate for such people, who are especially oriented to act and control the situation. The defusing is designed to make the incident less harmful by providing immediate support and assistance. It aims to reduce tension, regain emotional control

and to focus on strengths and skills. The ensuing return to normal functioning begins the recovery process.

The focus on cognitive functioning (or thinking) enables the person to think rather than react. A low profile should be maintained by the interventionist. Those involved should be allowed to take the lead and do the talking. As defusing is short term, the parameters are set by the people themselves. They are in charge of the level of emotional ventilation. This will allow them to take it where they want and to return to normal functioning.

You may remember how this has happened, for example, at report or handover time for nurses. Although the whole shift will need to be reported on, a critical incident will receive immediate attention and be of paramount importance. Until all the details of this event have been shared, the nurse talking is unable to discuss other events. If attempts are made to curtail the disclosure it will re-emerge later

Most nurses working with critical incidents will realise that time and attention will have to be given to the incident to allow it to be laid to rest. When all facts and feelings about it have been shared it can be concluded satisfactorily. It is put away or given a rest and the goal of returning to normal functioning is achieved.

Other activities connected with defusing include providing factual information. Some key information may have been missed by the nurse which prevents her concluding the event.

Denial is at its most powerful within the first 24 hours. We often describe denial as being unhealthy but it may be a necessary form of insulation. Be gentle with the nurse if denial is apparent. It may be the safety valve she needs for the moment. This can be clarified later.

Try to assess who needs more than defusing and make a mental note to catch them later and offer more. Thank people for doing some good work. Give them the credit they deserve. Reassure them that reactions to such events are normal. It is not they who are abnormal, but the event itself. The defusing may be facilitated by asking some simple questions (see Fig. 1). On hearing the answers, re-emphasise how they sound pretty normal. Question five brings the span of duty to an end. It arrives at termination of the event.

Demobilisation is the act of discharge from service. It provides personnel with some structured end to their span of duty and should obviously only be used at the end of a shift. Demobilisations are mostly done for large scale incidents only, so a room is needed to hold large numbers of personnel.

Figure 1—Questions to ask

1 What happened there?
The facts of the incident

2 What did you think about it?
Are there any particular thoughts that are uppermost in your mind?
What are your first thoughts?

3 WITH MORE CAUTION
What made this different?
What was the worst part for you?

4 What would help you most right now?
What signs are there that this was more powerful than usual?

5 What will you do when you get home?
Who will be there?

When people enter the room they should be able to obtain a drink and, as they will be tired, will expect to be detained in the room for 15 minutes at the most. The designated leader, who will conduct the demobilisation, should have accurate factual information available. Everyone involved must attend. It is not just for those who need it, or the especially sensitive or vulnerable. The message will be that we all need it, that it is for the whole team. It is to facilitate an end to a stressful working period for all personnel.

The aims of demobilisation are to:

- Focus on strengths and skills, to re-evaluate the work and receive some factual information
- Acquire some emotional control and cognitive functioning and reduce tension
- Begin the recovery process and leave behind some of the stress
- Begin to be educated by it by saying 'We have learned that . . .'

The goals, and some of the comments, may seem similar to those of defusing. The difference is that demobilisation has a more definite time limit. The leader is more clearly designated and participation by staff is limited, though they are told that further help is to be given later. The focus is, therefore, more on cognitive functioning and not emotional ventilation.

You will, at this stage, want staff to focus ultimately on their own resources. If demobilisation is a positive experience, staff are more likely to return for defusing or debriefing. While the leader will be more directive at this stage he or she will need to be available later. Large scale events involve many people and you want to provide useful information in a short time to the maximum number of people. Again thank them for a job well done, assure them that they were fine but that the event is abnormal and further help may be needed.

Common responses include fatigue or exhaustion, feeling overwhelmed, grief, guilt, anger, denial or numbness or withdrawal, and anxiety.

Critical Incident Stress Debriefing

Critical incident stress debriefing (CISD) is the more formal type of debriefing that should be done by someone with a knowledge of counselling stress and (if possible) the working procedure in the emergency situation. If the person needing CISD is a critical care nurse, for example, someone with the aforementioned skills who is also a critical care nurse would be the most appropriate. Formal CISDs take place 24-48 hours after the event. Mitchell[4] says that a group meeting is most useful first, followed by individual, more formal, debriefings. Mitchell also states the debriefings should be mandatory for all personnel who were involved.

Most nurses working with critical incidents will realise that time and attention will have to be given to the incident to allow it to be laid to rest. When all facts and feelings about it have been shared it can be concluded satisfactorily. It is put away or given a rest and the goal of returning to normal functioning is achieved.

The formal CISD has six phases. In total, it takes three to five hours.

Phase 1. After introduction, the rules about confidentiality are explained. The nurse or other client needs absolute reassurance that no details of the briefing will be divulged.

Phase 2. The facilitators ask the person to give some personal details. After this they go on to describe their role in the incident, what they did, what they saw, what they heard, what they may have smelled.

Phase 3. When all this factual information has emerged, you can go on to ask how they as an individual felt about what happened. The questions 'How did you feel when this happened', 'how are you feeling now?' and 'have you felt like this before?' are then put. It is often at this stage that the facilitator has very little to do, as a great outpouring of the whole event and attendant feelings takes place. Feelings of frustration, fears, guilt, anger and ambivalence are common. Some will apologise that the feelings are about some trivial as-

pect of the event. They are important to them and need to be expressed and listened to.

Phase 4. This phase concerns what changes have occurred at the event and since, the impact it has had on their lives and how they feel it will alter their future. This discussion should focus not only on their work but also on what difference it has made at home. You will hear, in the staff's own words, their own unique stress response syndrome. Useful questions include 'what did you experience?' and 'has your life changed since this?'

Phase 5. This is used to teach something about stress and how individuals respond. Information about common physical symptoms, sleep patterns and emotional reactions can be described. Again, the emphasis is on what happens to normal people and that it was the event they were involved in that was abnormal and distressing.

Phase 6. This phase brings the debriefing to an end. It is aptly called the re-entry phase because, if the debriefing has been effective, people will return to work effectively. Hopefully, they will have discharged any distress and learned something about themselves, and been finally reassured. When all outstanding issues are finally dealt with, the debriefing is clearly ended. The aim of this phase is to wrap up loose ends, deal with outstanding issues, provide final reassurance and a plan of action.

A follow-up CISD may be useful as a group six months after the event but is not always necessary. There may be some issue or problem that has emerged or re-emerged as a result of the event.

Some staff may be identified as having longer term problems because the incident allowed some past conflict to resurface and compound the difficulties. This may need further professional expertise or advice.

Many nurses and other emergency workers face incidents which are connected to disastrous events. Other incidents, while not part of a major disaster, are unusual or seem like an exacerbation of a daily event. For example, nurses may often deal with a death by trauma from a road accident. Two or three deaths in the same accident or family, and a nurse mobilising all her physical, emotional and working resources to handle this, may be described as facing a critical incident. It has the potential to leave the nurse feeling damaged and ineffective.

If our staff can be freed from frustration, anxiety and guilt as well as other physical symptoms, that is good. It is good for them and for their families, and they deserve our care. It is good for our work, our efficiency and our effectiveness. Having to replace good personnel is a waste of resources and time.

Waiting for some debriefing to happen may result in a long wait—with shortages in resources, time and personnel it may never happen. Stress debriefing must be planned into our work schedules. Some of the principles are so simple that you may be saying that you knew it already. Do not let its simplicity cause you to underestimate its value. Done well, there is every likelihood that some overwhelming and potentially destructive feelings will assume manageable proportions.

References

1. Wright B. Caring in Crisis. Edinburgh: Churchill Livngstone, 1986.
2. Ashdown M. Sudden death. *Nursing Mirror* 1985; 161: 18, 22-24.
3. Wright B. Sudden death: aspects that incapacitate the carer. *Nursing* 1988; 3: 31, 12-15.
4. Mitchell JT. When disaster strikes—the critical incident stress debriefing process. *Journal of Emergency Medical Services* January 1983, Baltimore.
5. Harris V. Post-scene intervention strategies for emergency workers. Proceedings of 'Stress and Trauma in Emergency Workers' conference, Melbourne, Australia, 1988.

GCT

GROUPWORK CONSULTATION & TRAINING

The only specialist organisation offering a full range of groupwork courses, both in-house and in-service in the U.K.

GROUPWORK WITH CARERS (NEW)

Aims to provide a forum for professionals and carers involved in running groups for people caring for friends and relatives with a variety of needs and disabilities to meet with others who are involved in facilitating this type of group.

2-day non-residential workshop, £70 + VAT per person. 13-14 Feb., 2-3 July, 12-13 Nov., 1990.

ENDINGS & BEGINNINGS— A GROUPWORK APPROACH

Aims to provide a greater understanding of the endings and new beginnings process so that professionals can develop a more positive, sensitive and creative approach.

2-day non-residential workshop, £70 + VAT per person. 15-16 Feb., 18-19 June, 15-16 Nov., 1990.

For more information, phone 01-858 6627 or write to GCT, Greenwich College, Meridian House, Royal Hill, Greenwich SE10 8RT.

Editor: Hannelore Wass

Educational Psychology, University of Florida, 1418 Norman Hall, Gainesville, Florida 32611, USA

This acclaimed journal publishes refereed papers on significant concerns and practical approaches in the ever-growing field of death education and counselling. It provides an international, interdisciplinary forum in which a variety of professionals share experiences, techniques, successes, failures and ideas with the aim of helping those who work with the dying and their families.

DEATH STUDIES

Recent Selected Contents

Organization and defense in health care: death and the health professional, Alison Holman (USA) • Stability of social support networks following later life spousal bereavement, Dale Lund (USA) • Sex differences in death anxiety: a test of the emotional expressiveness hypothesis, Andrew R. Dattel and Robert A. Neimeyer (USA) • Informing a patient of malignant illness, Yoshitomo Takahashi (Japan) • Fathers experiencing a perinatal loss, Cynthia Bach Hughes and Judith Paige-Liebermann (USA) • A moral dilemma: to kill — allowing to die, John Cole (Canada)

SUBSCRIPTION INFORMATION

Vol 14 (1990), Bimonthly, ISSN 0748-1187

Institutional: £65, Personal: £33

Free sample copies and information available from Annabel Jelley, Taylor & Francis, Rankine Road, Basingstoke, Hants, RG24 OPR, Tel. 0256-840366

Taylor & Francis

London • New York • Philadelphia