Debriefing after a crisis

What’s the best way to resolve moral distress? Don’t suffer in silence.

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Moral distress... It surfaces, especially in high-stakes, high-stress healthcare settings. Research shows that nurses who experience moral distress in their work setting without receiving situational support aren’t able to easily process the experience. Nurses who eventually resolve their moral distress alone may take longer than a year to do so.1

Whereas dramatic, “newsworthy” events trigger an outpouring of support for workgroups, the daily, less dramatic but morally draining events that nurses face often remain unacknowledged. Employees may benefit from brief interventions, called debriefing or critical incident stress debriefing (CISD), when exposed to a traumatic event.2 Leadership initiative is needed to bring together staff members to acknowledge shared distress, to accept responses to that distress, to affirm the group’s human suffering, and to help the group cope.4

The process
Debriefing is an information-sharing and event-processing session conducted as a conversation between peers. Group members become informants to each other about a situation or event that occurred to them as a group. The listener can be a therapist, counselor, or professional peer who helps the group process the information being shared. The person who conducts the session should have the professional skills to guide the established process that will help staff members recover from their distress. An important aspect of debriefing is that the leader will assess the need for individuals who might benefit from further individual counseling and will make recommendations for individual follow-up.2

How can a manager recognize the need for debriefing?
The staff’s mood can provide a clear indication about the type and level of distress being experienced. Whether the experience of distress is moral, emotional, psychological, or spiritual in nature, if it’s occurring within the group as a whole, the whole group needs affirmation and support.

First, there can be a somber mood with signs such as an unusual quietness, less conversation, less responsiveness to each other and to patients, less expressed interest in each other, and obvious signs of sadness such as frequent sighing or easy tearfulness. The event itself can be obvious, one in which the manager was directly involved. Rarely, it’s obscure, such as an external event about which the manager has no direct knowledge.

Keeping a finger on the pulse of the staff as a group is an important managerial responsibility. Whenever a critical incident has occurred, debriefing should follow as soon as possible. Yet, debriefing isn’t the answer to every problem, because not every problem that occurs in the workplace is a critical incident.

What’s a critical incident?
Events that would garner this kind of attention and intervention include episodes of workplace violence or terrorism, industrial accidents, or other events of a serious nature. Yet, the healthcare environment is replete with examples of critical incidents that aren’t newsworthy, as they’re protected from public disclosure by patient confidentiality. For example, adverse drug reactions that have led to the unanticipated death of patients must be reported to federal and state agencies. These agencies are responsible to safeguard public safety by releasing general information as warnings, but wouldn’t release specific details to the media that could compromise a particular patient’s right to confi-
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dentity about medical treatment. Yet, a healthcare worker who gave a fatal dose of properly prescribed and administered medication to a patient would be involved in a critical incident of great magnitude given the loss of life. In healthcare, there are additional examples of critical incidents that aren’t as serious as the actual loss of a patient’s life, but these are events that can disturb the sense of peace and purpose of healthcare workers. These lower-level critical incidents can accumulate and contribute to staff burnout, which ultimately detracts from care quality. Therefore, a critical incident could be an unusual event or unanticipated loss that negatively affects the staff as a group.

How it’s conducted

Once the nurse manager perceives the need for debriefing, a reliable professional peer skilled in CISD should be asked to assist with the process. Our psychiatric clinical nurse specialist (CNS) was the expert advanced practice nurse with the appropriate education and skill set able to facilitate this process. The nurse manager explained the crisis situation and her observations about the staff’s responses to the psychiatric CNS. A time that was convenient for debriefing was agreed upon by the manager, psychiatric CNS, and the affected staff.

Ideally, all individuals involved in the distressing situation should be invited to participate in the debriefing session. A single group session can last between 30 minutes to 3 hours, depending on the nature of the event. An event that results in one or more deaths requires more time and may warrant numerous group and one-on-one sessions. Events that are more ordinary, such as daily sources of distress, are less likely to receive managerial attention, yet they can
become more permanently dam-
aging to the workgroup and to
patient care if continuously unac-
knowledged.

Each session uses a clearly
defined set of counseling proce-
dures, developed in 2000 by
experts Lim, Childs, and Gon-
salves, that unfold in eight phases:

1. **Introduction:** The facilitator
establishes the group goals and
rules and reinforces the need for
confidentiality about anything that
transpires within the group.

2. **Fact gathering:** Each staff per-
son describes what happened and
facts are gathered.

3. **Reaction phase:** Led by the
facilitator, the group examines its
feelings, thoughts, and responses
to the event experienced. If the
debriefing session happens soon
after the event occurred, there
might not be any symptoms.

4. **Symptom phase:** If some time
has elapsed since the event, group
members may be experiencing symp-
toms. The facilitator helps the group
examine how these reactions have
affected personal and work lives.

5. **Stress response:** The facilitator
teaches group members about their
stress response.

6. **Suggestions:** The facilitator
offers guidance on how to cope
with stress related to the incident.

7. **Incident phase:** Group members
identify positive aspects of the event.

8. **Referral phase:** The facilitator
concludes with this phase, whereby
specific individuals who require
additional support are referred for
individual follow-up.

The following vignettes show
two types of events that led to staff
distress, and how each issue was
handled during debriefing sessions.

**Vignette 1: Conflicted family deci-
sion coupled with an unexpected
patient outcome**

A ventilator-dependent, terminally
ill patient from the intensive care
unit (ICU) arrived to a floor-care unit with an endotracheal tube in place. Due to the patient’s condition, physicians believed that the patient’s death was imminent. The patient’s healthcare proxy had signed a do-not-resuscitate (DNR) order, and comfort care was initiated prior to transfer out of the ICU. About a day after transfer to the floor-care unit, the patient’s condition changed suddenly and visibly, heralding the patient’s death. The patient’s healthcare proxy begged the staff to “Do something! Do something!” Recognizing the right of the healthcare proxy to reverse the DNR status at any time, staff members came to the immediate assistance of the patient. After their resuscitative efforts, the patient’s appearance was marred. The healthcare proxy began to accuse the staff of having harmed the patient. Within minutes, the behavior of the healthcare proxy escalated out of control. Together, the nurse manager, nursing supervisor, and the patient’s attending physician tried to intervene to calm the healthcare proxy. The unit felt “under siege” for approximately 2 to 3 hours afterward.

The staff present at the time of the event felt traumatized by the patient’s appearance and by the accusations of the healthcare proxy. The nurse manager was aware that the group was experiencing moral distress related to the attempt to intervene that had produced a dramatic change in the patient’s appearance in the final hours of life—disfigurement that wouldn’t have time to heal before the patient died.

Due to the social silence and altered sociability that can occur within a group experiencing moral distress, workgroups need leaders who will recognize their distress and initiate an acceptant group intervention. The reason that this type of distress is called moral distress and not psychological, emotional, or spiritual distress is that the harm to an objective good is perceived in the context of the values held by the person who experiences moral distress. In this case, the staff valued providing comfort care in the last hours of this patient’s life. Such care wouldn’t include the unexpected outcome of a disfigured appearance. Neither would it include ignoring the changing condition if the healthcare proxy wasn’t able to accept the moment of death. The “do something” command of the healthcare proxy in the context of a signed DNR order demonstrated the proxy’s ambivalence about the DNR decision and concurrently revoked the decision. The action taken by the staff was a good action that respected the proxy’s decisional conflict and right to revoke the DNR order, and yet, it produced a harm that no one expected to occur. The entire team, including staff nurses, other healthcare professionals, and the nurse manager needed to process this event in order to continue to provide care.

A single debriefing session occurred the next day. At the start of the session, the patient was still alive, and the proxy was still present in the patient’s room from the earlier evening. The staff worried about what would happen when the moment of death arrived. The group was led through the debriefing process in a stepwise manner (as previously explained) and as it pertained to the tenuous status of the clinical situation. At first, the staff identified the events of the critical incident, including the healthcare proxy’s request to “do something,” their response, the patient’s condition, and the proxy’s reaction. Teaching about this aspect of the critical incident was provided by the psychiatric CNS to enhance the staff’s understanding of the proxy’s reaction as part of the grieving process. The proxy’s reaction was identified as the shock or denial response. Salient features of that response included: loud protest and disbelief, followed by acute anguish and expressions of anger, blame, and agitation.

The staff then engaged in further discussion, which revealed that the proxy had been personally responsible for the patient’s care for the past 20 years, lived with the patient, and would have no other support or friends once the patient passed away. Not all of the staff members knew these details at the time of the proxy’s reaction. Given their shared understanding of the daunting loss that the proxy was experiencing, the staff members were able to resume working together as a team in a therapeutic manner, overcome their sense of having been traumatized, and develop a greater sense of compassion and sensitivity for the proxy. When the patient died, staff expressed their condolences in a sensitive manner and turned their attention to comforting the proxy at the moment of loss. The single debriefing session lasted approximately 30 minutes and benefited more than a dozen employees who had been exposed to the event.

The staff’s mood can provide a clear indication about the type and level of distress being experienced.

Vignette 2: Multiple losses by death and accident among the staff
The staff experienced the sudden loss of a coworker to a serious but nonfatal accident. As the extent of the nurse’s injuries became known among the staff, it became clear that the coworker wouldn’t return to work immediately. Staff schedules were rearranged to cover that nurse’s absence during the height of vacation season. Soon after, the staff received more bad news: another accident left a coworker’s family member permanently disabled. A few days later, the staff received news of the untimely death of a former coworker. The staff knew that she was leaving three young children behind.

The staff nurses were visibly upset by these serious, sudden losses in the short time span of a few weeks. Staff nurses tried to do their work, but became tearful at change-of-shift as they shared the bad news. The staff’s mood was generally somber, subdued, and sad.

Multiple supportive debriefing sessions were held to provide an opportunity for day and night staffs to participate. When staff nurses were unable to attend prescheduled debriefing sessions, the psychiatric CNS returned at a mutually agreeable time to work with those staff nurses.

The sessions allowed staff members an opportunity to grieve their losses and to identify the personal impact of these losses on their own lives. Staff identified sadness, fear, survivor guilt, and deep compassion for their coworkers during the sessions. The acknowledgement of their losses and grief validated their emotions and other responses. As they shared the personal impact that these losses represented in their own lives, they also shared their points of view about how they would want to help their coworkers and their families. The debriefing process gave them an open forum to discuss their thoughts, and the group devised a plan to support the needs of each other and their
injured peers. They communicated the plan to any others who hadn’t been able to attend the sessions.

**Speaking up**
Lack of experience, limited assessment skills, and poor timing can undermine the effectiveness of debriefing. Enlisting the help of a properly credentialed professional can reduce potential harm. Yet, what if no one debriefs after a distressing situation occurs? Staff members could process their responses individually in silence, which is depersonalizing, fail to acknowledge their dignity as workers who are suffering, and ultimately alienate themselves from each other. The resulting fragmentation of the workgroup reduces morale and makes it more difficult for workers to work with each other. Some staff members can experience a complicated response or a prolonged grief reaction, resulting in distance from their workgroup. Because the experience of moral distress involves the perception of harm to an objective good, the interior anguish can lead to a grieving process for the individual or the group that might not be acknowledged or addressed if debriefing isn’t initiated. With moral distress, the likelihood that the person who experiences it will initiate discussion is very low. Debriefing provides a safe forum for the group to discuss and process that type of experience.

A benefit of debriefing is that the healthy coping skills of some members of the group can be shared with other members, giving an example of healthy ways of coping for those who might cope in less effective ways. Debriefing was not mandatory. All staff nurses and others involved in the crises were invited to engage in the process, which was directed at support and affirmation of the staff. The debriefing sessions provided opportunities for acceptance of normal responses to a distressing situation and increased mutual understanding and empathy among members of the workgroup.

Debriefing has helped our units function in a more therapeutic manner overall. It has fostered the staff’s ability to work together by putting crisis situations, even mild ones, into proper perspective. The group’s work within this guided process supported staff cohesion, which is essential to healthy morale. The absence of this kind of acceptant and affirming managerial support could lead to staff burnout and increased turnover, which is more likely to occur in junior, inexperienced members of the team.7

**Relating to forces of Magnetism**
An interesting point about the process of debriefing is how it relates to six “forces of Magnetism.”8 First, the “quality of nursing leadership” at the executive level must demonstrate compassion for its staff and patients
by fostering a spirit of supportive collaboration. Second, managers who use the debriefing process appropriately will nurture their staff members with this acceptant intervention. This practice is evidence of a “managerial style” that’s open, malleable, collaborative, and responsive.

Third, the internal consultation provided by the psychiatric CNS to the staff provides evidence for the force of Magnetism called “consultation and resources.”

Fourth, since all members of the interdisciplinary team were involved in the critical incident, all members were invited to participate in the debriefing sessions. This collaboration supports the “interdisciplinary relationship” element of the force of Magnetism. Fifth, the psychiatric CNS became a teacher to her peers and others during the debriefing sessions about the proxy’s psychological responses, as well as about their own normal reactions. This perspective is evidence for the force of Magnetism, “nurses as teachers.” Finally, the force of Magnetism called “quality of care” depends on the success of the debriefing process because staff members can’t continue to provide high-quality care if they’re in a state of distress, especially a state of moral distress.

Freedom to cope
The process of debriefing helped staff members take time together to identify the personal impact of the traumas and losses they had experienced as a workgroup. By validating their experiences and responses, debriefing freed staff to return to their own work on behalf of others.

Debriefing isn’t meant to take the place of individual counseling where needed; it helps identify individuals who might need further assistance to cope. From the nurse manager’s view, this brief group intervention provided tangible support in an acceptant manner for staff members when they experienced a difficult time in their work environment. Such managerial support fostered group cohesion, which is the foundation of healthy morale and high-quality patient care. It can nurture the professional development and personal well-being of inexperienced staff members who are at higher risk for burnout if distressing events remain unacknowledged.

In our current healthcare climate, the expectations for excellent customer service and high productivity require managerial sensitivity to staff when work-related crises occur. Debriefing is one way that managers can help their staff rebalance after a clinical crisis.

REFERENCES

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