Debriefing for Emergency Room Nurses

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Nursing 420

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It was 0700 and I had just got to the hospital. I was walking down the hall towards my patient’s room when blue lights started flashing above his door, code blue! Doctors, nurses, and CNAs came running to the room. The patient’s chest was opened with a scalpel. While I was doing compressions blood began running down the patient’s neck and chest. This was my first code, and first time doing CPR. Emergency room (ER) nurses are faced with inherently stressful situations like this, and are confronted at some point with death. Post-traumatic stress disorder (PTSD) is very common among nurses that deal with critical incidents. “Such critical incidents can have devastating effects on the physical and mental health of ED staff” (Healy & Tyrell, 2013, pg. 32).

Encouraging new research has shown that post-incident debriefing can decrease PTSD among nurses following a stressful event. “Having a supportive social network and being able to talk things over with colleagues, was found to have a strong preventive effect on the development of PTSD” (Adriaenssens & Maes, 2012, pg. 1413).

Unfortunately the literature also reports that the debriefing practice is poorly established in emergency departments (ED). After my first code, not one staff member in the department asked me if I needed to talk to anyone. Yet, research shows the importance of debriefing after a traumatic event (Sandstrom, Nilsson, Juuso, 2016). Does debriefing decrease the chance of PTSD after a traumatic event?

**Method**

It is not uncommon for nurses to experience PTSD in the course of their work. Is it possible that interventions like post event debriefings can reduce the effects of PTDS? The objective of this study is to research the current evidence that supports ER nurses
who participate in debriefing sessions following a traumatic emergency room event, experience fewer signs of PTSD than nurses who do not.

Comparative descriptive design is best for this research because I will be comparing the differences between two or more groups in a natural setting (Grove, 2014). Population sampling will be done through cluster sampling. Recruitment pool will be two randomly selected hospitals in the state of Oregon, in which debriefing is practiced, and in which the Emergency Department sees over 110-patients/day. Trauma will be defined as emotional or mental stress in which nurses are having flashbacks or replaying the incident in their mind. All nurses in each Emergency Department will be interviewed. This will give me a baseline for nurses who have not experienced a traumatic event in the last six months. An advertisement will be posted on the bulletin boards near the Emergency Room. Five dollars will be given to each participant to reimburse them for time spent.

Based on the subject’s responses to the PCL-M questionnaire, the ER nursing staff will be placed in one of three groups, based on 1) trauma with debriefing; 2) trauma without debriefing; and 3) no trauma. The PCL-M questionnaire is used in the military and validated through at least two studies in 2002 in U.S. Veterans Administration hospitals (Dobie, Kivlahan, Walker, Newman, 2002). This questionnaire will be available as an online survey for the nurses to fill out. There will be a question at the top of the survey that states: “Have you experienced a traumatic event in the last six months?” If they answer yes it will prompt them to complete the survey, if they answer no, they will still be asked to complete the survey. This will provide a baseline for where nurses fall
who have not experienced a traumatic event. Example questions from the PCLM questionnaire are located below. I will then be able to compare the means from my three different groups.

<table>
<thead>
<tr>
<th></th>
<th>Not At All</th>
<th>A Little Bit</th>
<th>Moderately</th>
<th>Quite A Bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Repeated, disturbing memories, thoughts or images of a stressful traumatic experience?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Repeated, disturbing dreams of a stressful traumatic experience?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Feeling very upset when something reminded you of stressful traumatic experience?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Avoid thinking about or talking about a traumatic experience or avoiding having feelings related to it?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>


This research will compare three independent groups. In order to determine whether there are any significant differences, a one-way analysis of variance (ANOVA) will be used to determine any differences between the means of the groups (Grove, 2014). Participants will sign an informed consent that provides them with the risks and
benefits of in the study. One high risk, is that participants may re-experience traumatic feelings when taking the questionnaire. Therefore, I will provide each participant an opportunity for three free counseling sessions for the month following their participation. To ensure that the research is conducted in accordance with all federal, institutional, and ethical guidelines, the proposal will be reviewed and sought to be approved by the Institutional Review Board (IRB).

**Theoretical Model**

The proposed research theory is based on Pam Reed’s Theory of Self-Transcendence, which she created in 2003. Reed explains that her theory is based on two assumptions: 1) that human beings are integral to their environment 2) Self-Transcendence is a developmental imperative (Espana & Mamengo, 2012). Reed theorized that when a person faces a traumatic experience, this opens up opportunity for awareness of self and environment. Expanding this awareness can create self-transcendence spiritually, physically, or emotionally (Espana & Mamengo, 2012). Self-transcendence is defined as “Inherent, gradual, non-linear developmental process, resulting in increased awareness of dimensions greater than the self and the expansions of personal boundaries” (Espana & Mamengo, 2012, pg.1).

Reed then goes on to explain the importance of well-being and vulnerability. The concept of well-being is broadly interpreted as a state of wholeness and health. It is fluid and defined in large part by each individual according to his or her particular value system. A person’s religious, environment, cultural, and societal influences all play a significant role in shaping the concept. Vulnerability is defined as one’s own challenging
life events or sense of personal mortality. Reed described self-transcendence as a “survival mechanism” which comes naturally when confronted with a traumatic event (Espana & Mamengo, 2012). This proposed study will build off the idea that a person can respond either positively or negatively to a traumatic event. Reed stated that this idea “will either expand or crush his inner boundaries” (Espana & Mamengo, 2012, pg.1). If this research finds that debriefing after a traumatic event decreases the chance of responding negatively; then it will be vital to implement debriefing within 48 hours of the incident (Davis, 2013). Doing so will promote a supportive social network, that will hopefully prevent the development of PTSD. The concept of well-being is broadly interpreted as a state of wholeness and health. It is fluid and defined in large part by each individual according to his or her own value system. A person’s religious, environment, cultural, and societal influences all play a significant role in shaping the concept.
Conceptual Framework


Adapted from Pam Reed's Theoretical Model of Associations.
Annotated Bibliography


African Journal of Emergency Medicine, 5(1)

Lee Wallis is a professor at Stellenbosch University and is over the department of Emergency Medicine. Suki Goodman and Llizane Minnie are both professors at the University of Cape Town (Minnie, Goodman, & Wallis, 2014). This article is appropriate for emergency room nurses; however, it also provides research evidence for administration and those conducting debriefings. This primary qualitative study evaluated coping mechanisms of EMS personnel in Cape Town following a traumatic event. A questionnaire was given to 189 EMS responders asking them to reflect on emotional reactions and symptoms following trauma (Minnie, Goodman, Wallis, 2014). One possible weakness was the lack of random sampling, which could potentially lead to bias. According to the authors, the sample size was sufficient, and all participants had experienced a traumatic incident. Researchers found that EMS personnel experience avoidance symptoms and used emotion-focused coping after a traumatic event. A major finding of the study was that participants all agreed that their company debriefings were inadequate and that debriefing practice was poorly established. It is important for the psychological wellbeing of nurses to express feelings about the traumatic experience (Minnie, Goodman, Wallis, 2014). However, they will not have this opportunity if debriefings are not taking place. This study provides a baseline for my research proposal by demonstrating inadequacy of debriefing after trauma among EMS personnel.

Linda Sandstrom is a law professor at the Suffolk University in Boston. Carina Nilsson and Paivi Juuso are professors at Lulea University of Technology; and Asa Engstrom is over Anaesthetics and Emergency Medical Care at the Lulea University of Technology (Sandstrom, Nilsson, Juuso, & Engstrom, 2016). This study is particularly appropriate for nurses caring for patients after a traumatic event. This primary qualitative study was conducted in a Swedish hospital, in a ten-bed intensive care unit. Four group discussions were held with fifteen critical care nurses who had cared for patients suffering from trauma (Sandstrom et al., 2016). Eight discussion questions were asked, focusing on reflection and debriefing. The questions asked, and methods for collecting data were relevant to the study. One potential weakness was that there were no male participants, only female, limiting a fuller understanding of gender response to trauma. The results support my research proposal because the authors found it vital to implement follow-up debriefing to allow critical care nurses the opportunity to express feelings (Sandstrom et al., 2016). Caring for trauma patients can have a devastating effect on the emotional and mental health of staff. The staff in this study often felt at fault when not fulfilling the family’s wishes in times of emotional stress (Sandstrom et al., 2016). Being able to discuss these feelings will help decrease the chance for developing PTSD.

Margaret J. Pack is a professor at Charles Darwin University in Northern Australia. She is over Social Work and Humanitarian Studies (Pack, 2014). This study is applicable to nurse managers in the ER or trauma setting. Thirteen social workers in New Zealand who had experienced a critical incidence within the last five years participated. Critical incidence was defined as experiencing trauma. In-depth interviews were audiotaped and analyzed in order to obtain qualitative data (Pack, 2014). A potential weakness of this study is that only women 40 and older were surveyed. This may have lead to a loss of valuable data regarding responses of younger women. One interesting finding, was that over half the sample had left their previous job to find a new one after experiencing a critical incident (Pack, 2014).

Researchers found the importance of support from colleagues and line manager. Participants stated that a pre-existing healthy relationship with the manager and colleagues had the most influence on the post-debriefing process itself. Debriefing was most successful when their manager was trustworthy and emotionally aware of their feelings (Pack, 2014). This study relates to my research because it shows the importance of understanding that a traumatic event can be painful to talk about; however, it is crucial to reach out to supportive people. This study showed that the quality and type of relationship had a major impact on the actual debriefing process. Belief that emotional support from co-workers would be available if needed, improved the nature of the discussions (Pack, 2014).

David N. Sattler works in the Psychology Department at Western Washington University. Bill Boyd works in the Fire Department in Bellingham Washington, and Julie Kirsch works in the Psychology Department, at the University of Wisconsin (Sattler, Boyd, & Kirsch, 2014). The audience for this article could include all nurses, in particular those who have never participated in a posttraumatic debriefing session. This was a qualitative descriptive design, in which 286 firefighters in Washington were given a survey that asked questions based on posttraumatic symptoms, coping, and debriefing. One potential flaw in this research was that participants were not asked to frame their traumatic event within a certain time period (Sattler et al., 2014). Therefore, the longer time since the event or debriefing process, the lesser the influence on their perception of the experience. Researchers found firefighters had experienced a traumatic event sometime in their career; however; only half participated in debriefing following the exposure. A significant finding was that of those firefighters who participated in debriefing, only 64% reported their stress decreased after two weeks; some even mentioned debriefing had no impact (Sattler et al., 2014). This study is valuable because it provides an opposing viewpoint to my research question about the impact debriefing plays on PTSD. Some participants stated that debriefing would actually increase their stress level, which contrasts with my hypothesis.
Implications

This study will review and provide current evidence that supports debriefing decreasing the effects of PTSD among ER nurses after a traumatic event. The research already done creates a baseline demonstrating that although debriefing has been shown to be affective, it is poorly established (Minnie, Goodman, & Wallis, 2014). The state of well-being is fluid and defined by each individual’s unique experiences. This research can potentially revision the future of nursing by changing each individual nurse’s perception of the debriefing process. Integrating post-debriefing after a traumatic event will not only be valuable to the mental health of nurses, but for the patients as well. Nurses will have the opportunity to educate patients who have experienced trauma, on the importance of expressing feelings and finding support.

As nurses are able to reflect on the impact of their decisions, teamwork can be strengthened, and modifications implemented if necessary. Not only will debriefing improve the psychological health of nurses; it can improve the quality of the nurse’s care for their patient. The devastating effects of PTSD can have a negative outcome on the patients care; therefore implementing debriefing is vital after a traumatic event. If nurses feel they have established a mental coping system, they are less likely to avoid patients of trauma. Potential consequences that oppose my research is the possibility of debriefing causing more stress (Sattler, Boyd, & Kirsch, 2014). If early intervention following a traumatic event is not initiated within a certain time period, this could also potentially change the effect of the debriefing process.
Recommendation

Debriefing has positive effects, yet there is still inadequate implementation of this process. Due to opposing views, and potential consequences of the debriefing process, further research is needed (Sattler, Boyd, & Kirsch, 2014). I recommend at least two replications of my study with an increasingly larger number of participants so that we can better apply the results to the population. Greater in-depth interviews and questionnaires, as well as expanding the study to more than one state can provide nurses with more exact evidence on the effectiveness of debriefing decreasing PTSD. Not only should the psychological well-being of nurses be studied, but the effects of debriefing on burn out, and career changes. More education within the clinical environment is also needed; such as training programs that identify the importance of debriefing and signs of PTSD. I recommend that hospitals implement policies that require that nurses are given the opportunity to debrief after each traumatic experience.

Insights

Death can be a traumatic event for anyone. I was first intrigued with this topic after my first code at the hospital. My patient had passed, and not one member of the team asked me how I was doing. I wasn’t offended, but I was very surprised. I had been educated multiple times on the importance of post-debriefing, yet I did not see it practiced. I hypothesize that my research will show evidence that ER nurses who
participate in debriefing sessions following a traumatic event, will experience fewer signs of PTSD than nurses who do not.

The most meaningful thing I have taken away from this research is that debriefing is not only for nurses. Debriefing describes a process of talking about traumatic events. Whether that be in your home, church, community, classroom, or nursing program; expressing your feelings and finding support can expand your inner boundaries. Psalms 44:15 says, “My confusion is continually before me, and the shame of my face hath covered me.” PTSD can cause confusion, and nurses might replay the incident over and over while trying to take care of the next patient. I would feel so ashamed if I made a mistake or missed a clue because I was not mentally there when caring for my patient. Psalms 46:1 “God is our refuge and strength, a very present help in trouble.” Sometimes that “help” is debriefing or support from another. In this life we are God’s hands, he uses us as tools or instruments to bare one another’s burdens.
References


