May 2016 Article of the Month

This month's article selection is by Chaplain John Ehman,
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Copeland, D. and Liska, H. "**Implementation of a Post-Code Pause: extending post-event debriefing to include silence**." *Journal of Trauma Nursing* 23, no. 2 (March-April 2016): 58-64.

SUMMARY and COMMENT: This month's article presents an assessment of a brief intervention developed by nurses and originally led by a chaplain, for hospital staff after a resuscitation/trauma response. As such, it models a debriefing strategy that *could* be led by or supported by a chaplain to "address the psychological and spiritual effects of repetitive job-related exposure to codes and other traumatic events" [p. 59]. It focuses on Emergency Department staff but shows promise for wider hospital application.

The project was carried out through a unit-based council (UBC) in light of staff needs identified at a 32-bed suburban Level 1 shock trauma center with an average of 6.6 "code" events a month. The overall goals were to "(1) standardize a debriefing process, (2) encourage a supportive team-based culture, (3) improve transition back to 'normal' activities after responding to code/trauma events, and (4) provide responders an opportunity to express reverence for patients involved in code and trauma events" [p. 59]. Formalizing a Post-Code Pause (PCP) was a way to "frame" [p. 59] a process for these ends.

> Initially, the chaplain, who responds to all code events, facilitated the pause, but after code events, they were busy attending to the needs of family members. Unit-based council members took responsibility for facilitating the pauses until all RNs were trained. Ensuring that a PCP occurs is now the primary RN's responsibility. If he or she is too busy to facilitate, the RN is to delegate it to an available chaplain or UBC member. ...It is intended to occur as soon after the event as is feasible. Pauses are conducted in the patient room or wherever space allows. All team members involved in the case are invited to attend, and at times, family members have attended. [p. 59]

The PCP is well outlined by the authors, but it involves particularly "a 10- to 15-s moment of silence, or pause, to honor the life of the patient if he or she died or to celebrate the life-saving work of the team if the patient survived" [pp. 59-60]. This is followed by a set of debriefing questions [p. 60] in which five operational items are supplemented by two personal items (italicized below):

1. What did the team do well?
2. What intervention(s) do you wish had or had not been offered?
3. Are you satisfied with the equipment and medications available?
4. Where can we grow and improve?
5. How did we support family (if present)?
6. *How are you doing after the event?*
7. *What do you need to be able to be successful in returning to work right now?*

An information pamphlet on the signs and symptoms of caregiver distress is also provided, and special arrangements for additional time are made for staff who do not feel they can return immediately to their work.

Data were collected from questionnaires distributed prior to the PCP implementation and at both six months and one year after the implementation. During the year, there were 84 code events, 47 of which were followed by a PCP. Perception of the intervention was positive overall, and results from the quantitative (Likert-scored) and qualitative (open-ended) questions are presented in tables as well as the text [pp. 60-62]. Staff reported feeling more support from peers/leaders, more opportunity to regroup personally before returning to normal duties, and greater opportunity to pay homage to the patient. Regarding the latter, the percentage of staff who said they always or most of the time had opportunity to pay homage to patient rose from 36% at pre-implementation to 61% at one year after implementation (though notably at six months, it was 68%) [--see p. 60 and Table 2, p. 61]. There was also a "dramatic decrease in respondents reporting that they think about these events after leaving work" [p. 63], from 61% to 40% [--see Figure 1, p. 61]. The authors observe that "[b]usy ED staff members were willing and able to find time to pause and debrief and found benefit in doing so; therefore, the feasibility of implementing PCPs throughout the hospital with beneficial effects is probably high" [p. 63]. However, one paradoxical finding stands out: "Postimplementation, respondents feeling they were given adequate time to regroup before returning to their assignments and feeling pressure to return to work too quickly both increased" [p. 62]; and the authors speculate on the complex dynamics of time pressure in a hospital setting.

Also, chaplains may be especially interested in the staff's answers to a question about their most common thoughts or feelings after responding to a trauma: "(1) What was done/what was not done, including could/should things have been done differently and could outcomes have been different, (2) Sadness for the patient and/or family members, (3) Sense of responsibility, including responses such as 'it is my job' and 'I need to keep working,' (4) Anger/frustration, and (5) Fortune, including what an unfortunate event that was or reflecting on how fortunate they are" [p. 60].

Though longitudinal, this is a limited pilot study, and its results must be considered modest. An analysis of statistical significance of change is especially lacking. Yet, this project makes some headway where "[t]he literature related to debriefing code and resuscitation events is virtually silent with respect to the psychological impact or feelings associated with responding to these events" [pp. 58-59; and see Items of Related Interest, §I, below]. The study seems most promising as an intervention proof-of-concept, and it holds out the potential for a process of formal involvement of chaplains in a post-resuscitation debriefing process. And, though the intervention is not explicitly spiritual, it is one that the authors characterize as reminding providers of our common "humanness" -- an "attempt to shift an entire team to acknowledging that fact collectively" [p. 63]. Surely it would not be too much of a leap to see how such an acknowledgement may open up pastoral interactions.

Suggestions for the Use of the Article for Student Discussion:

This should be a very accessible article for any CPE group, with the text well paired with tables and figures, and with a practical emphasis. It may be that before a group discusses the particulars, students will want to think about the very idea of a Post-Code Pause and the possibility of a chaplain's involvement, as well as how chaplains might help staff after a resuscitation even if a formal process like this one isn't in place. Since many hospitals have more code events on inpatient units than in the ED of the hospital for the study, there is plenty of potential for envisioning the adaptation of this model. Moving to the article itself, do students think the two personal questions to staff capture the right information? Would students want to ask something different? The group might consider picking apart the concept of *paying homage*. Sometimes family members attended the PCP [p. 59]. How might that affect the debriefing session? In terms of methodology, this article could be an entree to discussion of how to measure effectiveness of an intervention. What does the group make of the discussion of time pressures [--see pp. 62-63]? The article focuses on the problem of the "psychological and spiritual effects of repetitive job-related exposure to codes and other traumatic events" [p. 59]. What of the

cumulative effect for *chaplains*? The group could muse about the final quote in the article: "We restock our rooms and we restock our code carts. Now we take time to restock ourselves" [p. 63].

Related Items of Interest:

I. A note about how little the issue of the psychological effects of participating in resuscitation events is addressed in the literature: our article's leading reference [p. 58] of the European Resuscitation Council Guidelines for Resuscitation [Baskett, P., Steen P., & Bossaert, L., "European Resuscitation Council Guidelines for Resuscitation 2005 Section 8. The ethics of resuscitation and end-of-life decisions," *Resuscitation* 67, suppl. 1 (December 2005): S171–S180], includes a paragraph-length section on Staff Debrief. However, in the 2010 revision of those guidelines [Lippert, F. K., Raffay, V., Georgiou, M., Steen, P. A. and Bossaert, L., "European Resuscitation Council Guidelines for Resuscitation 2010 Section 10. The ethics of resuscitation and end-of-life decisions," *Resuscitation* 81, no. 10 (October 2010): 1445-1451], that section has disappeared, and there is only a passing reference to debriefing in the last sentence of the text. In neither case is the mention of debriefing given a source footnote.

II. Our authors note Critical Incident Stress Debriefings (CISD): a model of debriefing that is relatively widespread but nevertheless somewhat contested. Indeed the developers of the intervention in our article believed CISD to be insufficient for the goals of the present project [--see p. 59]. However, for chaplains wishing to delve into the literature about CISD, the following recent articles may provide points of departure:

> Healy, S. and Tyrrell, M. "**Importance of debriefing following critical incidents**." *Emergency Nurse* 20, no. 10 (March 2013): 32-37. [(Abstract:) Working in emergency departments (EDs) is inherently stressful, and stress caused by events such as witnessed death, elder or child abuse, and aggression and violence can have profound effects on staff. One strategy that can be effective in helping staff deal with such events is critical incident stress debriefing but, as the literature suggests, this is poorly established in ED settings. This article reports the results of a study in three EDs in Ireland of nurses' and doctors' perceived needs for debriefing and makes recommendations to improve this area of practice.]
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> Tuckey, M. R. and Scott, J. E. "**Group critical incident stress debriefing with emergency services personnel: a randomized controlled trial**." *Anxiety, Stress, & Coping* 27, no. 1 (Jan 2014): 38-54. [(Abstract:) Although single-session individual debriefing is contraindicated, the efficacy of group psychological debriefing remains unresolved. We conducted the first randomized controlled trial of critical incident stress debriefing (CISD) with emergency workers (67 volunteer fire-fighters) following shared exposure to an occupational potentially traumatic event (PTE). The goals of group CISD are to prevent post-traumatic stress and promote return to normal functioning following a PTE. To assess both goals we measured four outcomes, before and after the intervention: post-traumatic stress, psychological distress, quality of life, and alcohol use. Fire brigades were randomly assigned to one of three treatment conditions: (1) CISD, (2) Screening (i.e., no-treatment), or (3) stress management Education. Controlling for pre-intervention scores, CISD was associated with significantly less alcohol use post-intervention relative to Screening, and significantly greater post-intervention quality of life relative to Education. There were no significant effects on post-traumatic stress or psychological distress. Overall, CISD may benefit broader functioning following exposure to work-related PTEs. Future research should focus on individual, group, and organizational factors and processes that can promote recovery from operational stressors. Ultimately, an occupational health (rather than victim-based) approach will provide the best framework for understanding and combating potential threats to the health and well-being of workers at high risk for PTE exposure.]

III. Our authors remark that the developers of the Post-Code Pause were "fortunate to begin the project with full support and buy-in from hospital and departmental leadership, which was crucial to its success" [p. 59]. The following recent article may be helpful to spur further thinking about practical aspects of implementing post-resuscitation debriefings.

> Berg, G. M., Hervey, A. M., Basham-Saif, A., Parsons, D., Acuna, D. L. and Lippoldt, D. "**Acceptability and implementation of debriefings after trauma resuscitation**." *Journal of Trauma Nursing* 21, no. 5 (September-October 2014): 201-208. [(Abstract:) Postresuscitation debriefings allow team members to reflect on performance and discuss areas for improvement. Pre-/postsurveys of trauma team members (physicians, mid-level practitioners, technicians, pharmacists, and nurses) were administered to evaluate the acceptability of debriefings and self-perceptions after multidisciplinary trauma resuscitations. After a 3-month trial period, improvements were observed in perceptions of psychological and patient safety, role on team, team communication, and acceptability of the debriefing initiative. Regrouping for a debriefing requires organizational change, which may be more easily assimilated if team members recognize the potential for process improvement and feel confident about success.]

IV. Chaplains may wish to consider this month's article in the wider context of *burnout*. See the October 2011Article-of-the-Month on burnout, secondary traumatic stress, and social support in a sample of chaplains.
