



RD 05 (2011)

WELFARE OF ANAESTHETISTS SPECIAL INTEREST GROUP

CRITICAL INCIDENT SUPPORT (CIS)

AFTER AN ADVERSE EVENT OR CRITICAL INCIDENT

Following an incident with a serious adverse outcome, or a “near miss” (or any other critical incident such as a sudden death of a staff member), the **needs of all parties** must be considered.

Patient and/or relatives

- The bad news has to be conveyed to the **patient and/or relative** (see Breaking Bad News Resource Document (RD) 10).
- RD 10 states that it is appropriate to apologise, but not to admit fault, eg: you can say “I regret that this has happened...” but not “I am sorry I did this to you / this is my fault...”
- Many hospitals have implemented an **Open Disclosure** policy, with strict guidelines regarding **apologies and truthful disclosure of events**. Guidelines may differ in each hospital / state.

The individual and the team involved

- Personnel involved with the adverse event will almost certainly need to discuss it, and take part in a debriefing process.
- **Confidential information** should not be disclosed to those unconnected to the incident, despite the curiosity aroused and emotions generated in hospital staff by an adverse event.
- Support must be **customised to the individual and the situation**. The debriefing process must allow individuals to discuss individual and team-level performances, identify errors made, and develop a plan to improve subsequent performance.
- Approach the relevant department (eg legal services or patient liaison officers) to receive guidance before approaching the patient, if you need assistance.
- Record the facts of the case and contact your medical defence organisation (see RD 14 Medico-legal Issues).

The adverse event

- **Root Cause Analysis** should be conducted, and any findings addressed.

The **anaesthetic department** has to deal with the results of any anaesthetic mishap (see After a Major Mishap RD 11).



INDIVIDUAL SUPPORT

- Finding a private room for discussion is essential
- The professional directly involved with the critical incident is known as the “second victim”. He or she may need intensive support. This support should be offered, (and hopefully accepted) in a timely manner, ie offered as soon as possible after the incident.
- It is important that empathetic and/or trained colleagues provide this support, since the “second victim” will usually display a significant emotional response to the adverse event. Professional psychological support may be necessary.
- The subjective response to an incident depends on a number of factors. The impact on the individual may vary depending on his or her level of training, resilience, past experience, personal support networks and coping skills.
- Debriefing and support should be offered on an individual basis, and should reinforce an individual’s natural recuperative processes. It may need to be offered on more than one occasion.
- Debriefing should be offered to individuals in a manner customised to their needs, eg via a mentor, colleague, and/or psychologist.
- Distress should be acknowledged. The emotional response following a critical incident varies over time (similar to the grieving process) and need for support may similarly evolve. There is the potential for the individual(s) to develop an adjustment disorder or post traumatic stress disorder (PTSD)
- Further contact should be offered; even after an initial refusal (the policy is to maintain an open door).
- Formal counselling, when necessary, should be provided by a recognised and trained psychologist, psychotherapist, psychiatrist or professional counsellor. General practitioners and senior clinicians with relevant training may also be consulted,
- It may also be valuable for the person to draw on the support of peers, supervisors, mentors, family members, friends, or even the person directly involved himself/herself, as well as any combination of these resources.
- The ability to function adequately or to concentrate on work is compromised by the stress response following a mishap, and time out to recover is appropriate.
- There should be relief from further duties until he/she feels able to return to work, with appropriate support and supervision. The amount of time required will vary depending on the individual / event involved and should be flexible.
- Single session debriefing has been shown to be ineffective in preventing PTSD, and may have a negative effect on those with pre-existing psychological disorders. Thus a formal and/or mandatory process may be harmful.
- It will be necessary to allow time and support for the individual to complete paperwork, and/or other legal formalities. This non-clinical “downtime” will also allow further ‘unofficial’ debriefing, with the affected person enabled to interact with colleagues and mentors at his or her discretion.
- Medical defence organisations (MDOs) should be notified of any event that may lead to legal proceedings. A colleague chosen as a mentor may assist the person directly involved with compiling



the necessary documents. A document about the incident, with only the facts recorded, should be composed; a copy inserted into the patient's chart, a copy sent to the relevant MDO, and the person directly involved should keep a copy (see RD 14 Medico-legal Issues).

- If there is a possibility of medico-legal action following the incident, there will be even greater need for long term support (months – years) of the doctor involved.
- Inadequate support may contribute to the following consequences for the anaesthetist (adjustment disorder or post-traumatic stress disorder):
 - Guilt
 - Constant internal repetition of events
 - Dysfunctional behavior
 - Insomnia
 - Substance abuse
 - Early retirement
 - Suicide
- The debriefing/support interview should be documented.
- Despite the critical incident being apparently due to “error” on the part of the person directly involved, human error theory requires that hospitals develop and initiate a process of root cause analysis (RCA) after an adverse event. This process will uncover system problems, which can then be addressed.
- The person directly involved may be helped by the results of the RCA, which may show many factors were involved in precipitating the incident.
- There may be a perceived stigma associated with accessing support services. This barrier may be lessened by departmental education regarding the expected process for follow up after a mishap (eg confidential access to individual debriefing by a psychologist, with the option for ongoing review if desired by the individual).
- If there is a possibility of medico-legal action following the incident, there will be even greater need for long term support (months-years) of the doctor(s) involved.
- The efficacy of critical incident support has not been sufficiently studied in emergency workers

GROUP SUPPORT

- Group “debriefing” may be worthwhile. Debriefing is likely to be more effective with teams which work together regularly, rather than if the team involved in the incident is an ad hoc one (ie hasn't worked together before the incident)
- Support personnel need specific training to offer group support.
- Groups deal better with guilt issues
- A psychologist could be introduced to the group (by including him or her in a group debriefing session) if it is likely that individuals may desire personal single session follow up.



HOSPITALS, DEPARTMENTS, GROUPS

- Personnel conducting debriefing need adequate training in all the CIS issues to allow appropriate intervention.
- All members need to know who the facility/department support person(s) is/are.
- Careful consideration will need to be given as to whether or not the individual directly concerned in an adverse incident should directly interact with the patient's family members. Eventually this interaction may need to occur for the family's "closure" process.
- If an incident involves a registrar and a consultant, then both should be able to acknowledge each other's distress - to each other, and/or to a third (support) person.
- Anxiety concerning the debriefing process may be alleviated by repeated exposure to this process; eg regular participation in the debriefing/feedback sessions after simulator sessions, both for participants and instructors.
- Pervasive culture depends on the attitudes of those in charge/line managers; where this is negative, there should be steps taken to align attitudes with current practice.
- No one attends work deliberately intending to cause harm. An appropriate response to a mishap (whether caused by error or not) encourages ongoing learning by the individuals and colleagues involved, with the potential to improve the outcome if circumstances leading to that mishap are ever repeated.
- Members of a department or group should be encouraged to identify those whom they trust, in anticipation that they may need to "debrief" with a trustworthy person or persons (mentors) after a critical incident. Individuals should identify and develop more than one mentor (in case the only one is away).
- Confidentiality is of supreme importance – support for a registrar after a critical incident must NOT jeopardise future career prospects.
- Mandatory "debriefing" after each emergency department shift came to be favourably anticipated in a department in which it was instituted. Other departments could adopt this practice.
- There is less stigma associated with accessing services that are expected and supported by departments, as a follow up after mishaps, (such as regular debriefing), rather than such a process being an exceptional event. All departments could practise post-sessional "debriefing".
- The department should ensure that Root Cause Analysis is conducted for all major incidents or near misses, and any findings arising therefrom should be addressed.

CIS PERSONNEL

- Hospitals should employ appropriate personnel as CIS personnel/liaison psychologists, with contact details available after hours in the anaesthetic department
- Each department should designate a support person/welfare person.



- An appropriate person may not always be immediately available – delegation may be necessary, or a list of suitable personnel may be kept by the department, including information for contact after hours
- A psychologist could be available for large operating theatre complexes.
- CIS personnel should undertake PRO-ACTIVE strategies as well as acting reactively.
- Consider the characteristics of a suitable support person when appointing this person.
- Support/debrief personnel should have their own supervisors.

WHO CAN YOU CALL ON ?

Trusted colleague and/or peer
 Mentor (s)
 General Practitioner
 Supervisor of Training or College Tutor
 Employee Assistance Program in your hospital
 Doctors Health Advisory Service (DHAS) Australia and New Zealand
 British Medical Association (BMA) Counselling and Doctor Advice Service (UK 08459 200 169)
 Departmental/divisional support person
 Psychologist
 Psychiatrist
 WOA SIG representative
 Medical Board/Council
 Lifeline (Samaritans UK)

Further Reading

- Australian Council for Safety and Quality in Health Care.
 Open Disclosure Standard: A National Standard for Open Communication in Public and Private Hospitals, July 2003. www.safetyandquality.org/articles/Action/opendisclfact.pdf
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- Welfare of Anaesthetists Special Interest Group Resource Documents 2011
RD 08 Mentoring and Peer Support Programs
RD 10 Breaking Bad News
RD 11 After a major mishap
RD 14 Medico-legal Issues
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Older references which may be useful

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- Fisher M. The Anaesthetic Crisis. Clinical Anesthesiology June 1993
- McNab F. After the catastrophe. Australasian Anaesthesia 1988.
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