College of Intensive Care Medicine
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CICM WELFARE

Critical Incident Support

Critical incidents are common in the ICU environment. **Support** after a critical incident is important, for patients and families, but also for the ICU team. Support will need to be **customised** and appropriate for the situation and the individuals or team involved.

What is a critical incident?

A critical incident is an event that *may* cause harm to a patient or staff member (a 'near miss') or an event in which harm *occurs* to a patient or a staff member (a 'serious adverse event'). Critical events are often stressful for those involved. When a critical incident occurs, the needs of all involved parties (e.g. patients, families, staff members, the individual department and hospital) are important to consider.

Patients and families

After a critical incident, patients and families must be informed. Communication should be timely and occur in a private space for the patient and/or family. A support person should be present for individual relatives or patients. The facts should be explained accurately, and **sensitively**. Delivering sensitive or distressing news well may help patients and families with acceptance, and may minimise short and long-term distress, as well as reduce complaints or litigation later. Stress for staff members involved may also be reduced.

Not all practitioners are experienced and comfortable with breaking bad news. **Planning and practicing** what will be said, and how, may be helpful prior to the meeting. It is important that patients and families understand that the team cares about the event(s) and outcome(s). Allow uninterrupted **time** for reactions and questions. Offer patients and families further meetings and contact.

Many institutions have guidelines regarding breaking bad news and **open disclosure**, including guidelines around apologies. Institutions may also have personnel to offer guidance in specific situations (e.g. legal department, patient liaison officers). **Check your institution's guidelines, policies, and resources**. In some circumstances, referral to the Coroner will be necessary, and should also be discussed with the family.

The individual and team involved

Usually, a discussion of the events with a **team debrief** should occur. Debriefing should allow clarification of events, discussion of individual and team performances, may identify errors, and may help in improving future performance. Debriefing may also be helpful in correcting any misconceptions or misunderstandings experienced by team members. Debriefing should occur in a timely fashion, and ideally all those involved in the incident will be able to attend. Group debriefing may be more effective for teams that regularly work together, versus those that do not. Any debriefing process or interviews should be documented.

Remember it is vital to **maintain confidentiality,** and therefore discussion of confidential information should be limited to those involved with the event.

Documentation is essential. Ensure a record in the patient notes is kept of the facts (rather than opinions) of the event. It may be helpful to compose a document specifically recording the event, with review of this by senior colleagues and the practitioners' medical defence organisations. A copy of this document should be kept in the patient's notes, as well as kept by the practitioners involved. The documentation should be legible, dated, timed and signed. Documentation with an institutional critical incident form may also be necessary.

Individual support will need to be tailored to the individual and the situation. The individual response depends on many factors including level of training and experience, resilience, previous experiences, individual coping skills and support networks, levels of fatigue and stress.

Once again, a **private space** and **timely** offer for discussion is essential. The individual(s) involved may need significant support. It is important that this is offered by empathetic, and preferably experienced, or even trained colleagues or mentors, who are able to listen to the individual, and remain non-judgemental. The person may also benefit over time from support from peers, friends, or family members. Additional **professional psychological support** may be required and should be offered. Professional support and counselling should be by trained and qualified practitioners, such as psychologists, psychiatrists, general practitioners, or professional counsellors. Many institutions have confidential psychological support available for employees (such as employee assistance programs).

Support may need to be offered more than once, and for some individuals, may need to be **ongoing** (particularly if medico-legal actions occur following the incident). The level and type of support required may change over time, as the individual's response to stress evolves. **Distress** should be openly acknowledged, and it is important to recognise that the psychological response to the event may change over time. In the event of an individual declining support initially, it is important to emphasise that support is available on an **ongoing** basis.

Immediately after the critical incident, the individual(s) involved may need to be **relieved from further clinical duties**, and given a time period to have support, attend to essential tasks (such as documentation, and contact with medical defence organisations for incidents that may lead to legal processes), and then a time period to recover. The time required will vary between individuals. The individual may need assistance to complete documentation, from a trusted colleague or mentor.

The department and hospital

Remember, individuals do not attend work intending to cause harm. Appropriate individual, departmental, and institutional responses allow for ongoing learning from the incident, with the aim to improve the outcome in subsequent similar circumstances. A critical incident may benefit from a case review or **root cause analysis**, so that contributing system problems may be identified and addressed. Discussion at a morbidity and mortality meeting may also be useful later, to allow for learning and improvement.

Departments should ideally have **well established processes** for critical events, so that individuals and teams understand and are prepared for both the **group debrief** process, and the need for **confidential individual discussion** +/- debrief, with the option for ongoing professional support as required. Having well established and expected processes *may* help reduce the potential stigma for individuals in accessing support.

Individuals conducting debriefing should have **adequate training**. A psychologist may be useful for group debriefing as well as individual support. There is some evidence that participation in regular

debriefing (such as in simulation sessions, as well as after near-miss events, and adverse events, and even after regular 'shifts') reduces anxiety concerning the debrief process and is viewed positively by participants.

Remember **confidentiality** is essential. Support for individuals should not compromise that individual's ongoing training, or career progress.

Resources after a Critical Incident

1. Departmental Welfare Advocate or Support Person
2. Clinical Director or Head of Department
3. Supervisor of Training
4. Mentor(s)
5. Trusted colleagues or peers
6. Doctors Health Advisory Service (DHAS) Australia and New Zealand
7. Institutional Employee Assistance Program
8. General Practitioner
9. Trained psychologist, psychotherapist, counsellor, or psychiatrist
10. Converge International Member Assistance Program via CICM
11. Medical Council of New Zealand, Australian Medical Council
12. Medical defence or indemnity organisation

With thanks to the ANZCA Welfare SIG Resource Documents referenced below, from which this document is largely derived.

References

1. Anaesthesia Continuing Education and Welfare of Anaesthetists Special Interest Group, Australian and New Zealand College of Anaesthetists Resource Documents **RD 05** (Critical Incident Support), **RD 08** (Mentoring and Peer Support Programs), **RD 10** (Breaking Bad News), **RD 11** (After a Major Mishap) and **RD 14** (Medico-Legal Issues).

2. Catastrophes in Anaesthetic Practice – dealing with the aftermath. The Association of Anaesthetists of Great Britain and Ireland. 2005.