Resuscitation Council UK

Responder Wellbeing

A resource developed by Resuscitation Council UK (RCUK), for you.
July 2023

Executive summary

This resource is written for all responders.

It aims to:

- provide an overview of responder wellbeing
- de-stigmatise common experiences to encourage seeking help if needed
- highlight opportunities for individual responders, teams and leaders at all levels to improve responder wellbeing.

The effects of resuscitation exposure are described. Resuscitation exposure can affect responder wellbeing in different ways. It might make you feel good, neutral or bad, and all of these feelings are common. There are also mental health conditions associated with resuscitation exposure such as Post Traumatic Stress Disorder (PTSD), depression and anxiety. Knowing about these conditions allows you to recognise them more readily and to access early support.

A 'post-resuscitation procedure' is suggested for use after resuscitation exposure.

This consists of:

1) Conducting an Operational Debrief (OD). An OD is led by the clinical team and primarily focuses on the performance and learning of the team. It also represents an opportunity to psychologically support responders.
2) Actively monitoring responders for the development of resuscitation-associated mental health conditions for an extended time period.
3) Referring responders for further assessment and support if required.
4) Periodic team reflection sessions to share experiences that may otherwise go unspoken and process emotional challenges together.

This resource will provide information about organisational factors that can influence responder wellbeing and empower individuals, teams and leaders wishing to effectively address responder wellbeing.

Organisational factors include shift work, resourcing, staffing, rest provision, bullying, infection risk, support, autonomy and supervision.

All interventions should be designed with stakeholder involvement. Preventative interventions are most effective when followed by mitigation and targeted support for responders who become unwell.

Team leaders can influence wellbeing as well as colleagues by modelling self-care and post-resuscitation procedures, checking up on colleagues and signposting support when it is required.

As an individual, you should nurture adaptive coping mechanisms and seek help if required. Most importantly, please speak to someone if you are struggling.

All images are reconstructed, and no identifiable patient information is used.

Contents

Collaborators

Thank you to all those who have given their time and expertise to help create this resource so that others may benefit.

Written by

Dr Matthew Walton, Professor Neil Greenberg & Dr Mike Christian.

Peer reviewed by

Dr Esther Murray, Dr Kevin Teoh & Professor Richard Williams.

Edited by

Resuscitation Council UK members Dr Jasmeet Soar & Adam Benson Clarke.

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Dr Craig Walker and the team at Edinburgh Emergency Medicine and the Scottish Centre for Simulation and Clinical Human Factors for permission to use an adapted version of the STOP5 Hot Debrief Model.

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Introduction

Most healthcare workers undergo resuscitation training in order to prepare to provide emergency life support for patients. During your work as a responder, it's likely that you will put this training into practice. Unfortunately, for patients in cardiac arrest, most are likely to still die, despite our best efforts to resuscitate them.[1]

In most cases, the reality is that attempting resuscitation means being present for the moments around the death of another human being whose life you are directly trying to save. Therefore, Resuscitation Council UK (RCUK) considers it a duty to prepare all responders for the possible negative impact of a resuscitation event on their mental health and wellbeing.

This resource will help you gain a deeper understanding of:

- your own wellbeing and how it may be affected by exposure to resuscitation events
- how your wellbeing is affected by the team, leadership and organisation around you
- the opportunities at every level to influence your wellbeing and the wellbeing of those around you for the better.

Educating ourselves is the first step to ensuring better wellbeing for responders.[2] No matter what your role, this resource is for you.

Matt (Student), Tony (Paramedic) and Mike (Doctor) make their way towards a paediatric patient in traumatic cardiac arrest. Unfortunately, the patient did not survive.

[1] **Cardiac arrest - out of hospital care: What is the prognosis? (NICE, 2018)**
https://cks.nice.org.uk/topics/cardiac-arrest-out-of-hospital-care/background-information/prognosis/

[2] **Mental health and help seeking among trauma-exposed emergency service staff: a qualitative evidence synthesis (BMJ Open, 2022)**
https://www.proquest.com/docview/2624835797?pq-origsite=primo

The psychological impact of resuscitation

How might exposure to a resuscitation event affect you?

At the beginning, you might feel great.

Involvement in a resuscitation event can be an incredibly positive and profoundly meaningful experience. It might even be why you first chose to work in healthcare – resuscitating a patient is one of the most immediate and rewarding ways to (literally) save a life and it is an aspect that makes it truly unique from other occupations.

You may gain satisfaction from many elements of being involved in resuscitation, for example through:

- a good patient outcome
- a good performance by you and your colleagues, or,
- gratitude from patients and their families.

Sometimes your feelings might not be affected by exposure to a resuscitation event. For example:

- the case may not resonate deeply with you on a personal level
- you might be focused on your job ('in the zone'), or,
- you might simply feel neutral about the events of that day.

In a job where you see such events regularly, you may feel this way on a more frequent basis – but it is hard to predict.

Resuscitation can however of course, be, at times, shocking, upsetting and disturbing. It might make you feel bad, just as well as it might make you feel good. It might also make you feel so upset that you question your choice of career.

Any immediate distress you experience may be because, for example:

- the outcome for the patient is bad, e.g. pain or disability
- the mechanism may be especially distressing, e.g. trauma
- you felt that you and your team could have done something different
- the person reminded you of someone you know
- something about the case was particularly tragic, e.g. a paediatric patient with safeguarding concerns
- there may be overt anger or frustration expressed by relatives or colleagues. resuscitation can be emotive
- the profound responsibility for human life may also weigh heavily on you during a single event or over a prolonged period of time.

There are many elements of being involved in resuscitation that may make you feel bad.

But the important thing to know is that feeling good, neutral, or bad after a resuscitation event is common. The complexity of human beings and the dynamic environments in which we operate means that we cannot currently predict at what time, in what event and why we might react in a given way. For example, different people attending the same resuscitation event may have completely different reactions from each other. Junior staff members might be unaffected by a case, while a senior staff member might be profoundly affected; someone might be affected by one case but not the next one, and so on.

What we do know is that exposure to resuscitation has the potential to be a profoundly impactful event for anyone, healthcare worker or otherwise.

Mostly, we are concerned with the negative psychological effects of resuscitation exposure and how to mitigate them. This is because some negative reactions can be severe and serious and may benefit from some further action. In order to be able to look after our colleagues and ourselves effectively, we need to be familiar with the spectrum of negative reactions we might experience after exposure to resuscitation.

Tony (Paramedic) "It was visually disturbing, horrible to see."

Matt (Student) "Little reminders would trigger flashbacks to the event itself and make me feel physically sick."

Common distress

What are some of the negative reactions you might have?

Some negative reactions are considered to be 'non-pathological' and do not require any specialist treatment. Distress (feeling upset) after a resuscitation event is common, and there are many ways in which you can feel distressed. The effects of the distress may be categorised as physical, behavioural, emotional, or cognitive (TABLE 1). Acute stress reaction is a commonly described pattern of distress. Simply put, you might not feel yourself for a little while.

TABLE 1: Acute stress reactions (adapted from Walton, Murray & Christian 2020)

Indicators of acute stress reactions			
Physical	**Behavioural**	**Emotional**	**Cognitive**
Palpitations	Avoidance	Numbness	Poor concentration
Nausea, low appetite	Recklessness	Anxiety	Intrusive thoughts
Chest pain	Detachment	Low mood	Flashbacks
Headaches	Withdrawal	Anger, fear	Poor memory
Abdominal pains	Irritability	Mood swings	Confusion
Insomnia	Drug or alcohol use	Loss of pleasure	Hyper vigilance
Hyperarousal	Conflicts with others	Low confidence	Rumination

These feelings should start to subside after a few days but it is worth seeking further advice and help when:

- symptoms persist beyond four weeks[3], or, importantly,
- at any time if symptoms are severe and significantly impacting your life; especially if they are getting worse over time.

[3] **Overview - Post-traumatic stress disorder (NHS, 2022)**
https://www.nhs.uk/mental-health/conditions/post-traumatic-stress-disorder-ptsd/overview/

Talk to someone you trust about it, and consider involving your supervisor, staff wellbeing support service and/or GP so they can keep an eye on you.

A lot of the distress we experience surrounding these negative reactions is actually from the guilt, embarrassment or shame about reacting in the first place. It is, therefore, crucial to be aware that feeling like this is common for a while after a resuscitation exposure. It is also common to have a few lingering symptoms, particularly when triggered to recall the event.

However, when distress is severe and persistent it may crossover into pathology or more serious mental health conditions. You need to be aware of the signs and symptoms of these conditions in order to seek help if this happens to you or your colleagues.[4]

Tony (Paramedic) pictured sitting at home on his sofa thinking about the paediatric patient in traumatic cardiac arrest.

[4] **QE84 Acute stress reaction (ICD, 2023)** https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/505909942

Mental health conditions

These negative reactions are considered to be pathological, and they have specific diagnostic criteria and treatments. You need to be aware of these conditions in order to seek help if you suspect you or your colleagues are suffering from them. Note that some, but certainly not all, people who appear distressed may have a mental health condition.

Depression

Depression usually consists of lowered mood, sadness and inability to gain pleasure from ordinarily enjoyable aspects of your life that lasts longer than two weeks and significantly impacts your life. Depression can present in different ways and may involve physical symptoms, such as tiredness, loss of appetite, loss of sex drive, or aches and pains in the body. It may also involve anxiety (which is covered in the next section). It can range from mild (persistently low in spirit) to severe, where you feel that life is no longer worth living (suicidal). Unfortunately, depression and suicidal thoughts are not uncommon in healthcare workers.

Many of us wait a long time before seeking help, so the crucial message is:
Talk to someone you trust about how you feel sooner rather than later.

Your GP will also be able to assess your symptoms and decide if there are any treatments that you might benefit from or if there are any adaptations to your work that can help you recover. Sometimes this simply involves watchful waiting; other times, it might involve self-help resources, talking therapies or medication. In some cases, a specialist psychological team may become involved in your care to provide you with additional support.[5]

Suicidal thoughts

You do not need to be depressed to be suicidal.

As healthcare professionals, we often feel shame for having these thoughts or for bothering our colleagues with them. However, these thoughts are surprisingly common.[6] We carry a lot of assumptions about the systems in which we work, which may form a barrier to us seeking help. If you talk to someone about how you are feeling, you can expect they will listen and help you.

If you are thinking about hurting or killing yourself, please tell somebody or call:

- **111** - NHS
- **116123** – Samaritans
  Text "SHOUT" to **85258** – SHOUT crisis line
- Call **999** or come to the nearest Emergency Department if you do not feel safe by yourself.[7]

[5] **Overview - Clinical depression (NHS, 2019)** https://www.nhs.uk/mental-health/conditions/clinical-depression/overview/

[6] **Preventing suicide in England: Fifth progress report of the cross- government outcomes strategy to save lives (HM Government, 2020)** https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973935/fifth-suicide-prevention-strategy-progress-report.pdf

[7] **Where to get urgent help for mental health (NHS, 2023)** https://www.nhs.uk/nhs-services/mental-health-services/where-to-get-urgent-help-for-mental-health/

Generalised anxiety disorder (GAD)

Feelings of anxiety are common in day-to-day healthcare work and are part of our body's natural response to life-threatening situations. Undoubtedly, you will understand that anxiety comes with the pressure of trying to save a life. A degree of anxiety about performing resuscitation is common and helps us perform at our best.

There are some tools you may find helpful to use in these circumstances:

- mental rehearsal (think through the steps of what you might need to do next in advance of having to do them)[8]
- box breathing (fear is sometimes called 'excitement without breath' and responding to it by slowing down your breathing can be helpful)[9, 10]
- mindfulness (for example, focussing your mind on your breathing and shutting out the 'noise' around you, or visiting a 'happy place' in your head).[11]

Most of these techniques can be done without others even knowing that you are doing them, or in a brief moment such as on a break or in the lavatory!

However, sometimes anxiety becomes hard to control and starts to become more constant, significantly affecting our lives and job performance.

You may struggle to remember the last time you felt relaxed and be unable to keep your mind from racing thoughts.

Mike (Doctor) "I visualise, sometimes several times, the procedures I might be expected to do."

[8] **Effect of mental rehearsal on team performance and non-technical skills in surgical teams: systematic review (BJS Open, 2020)** https://academic.oup.com/bjsopen/article/4/6/1062/6136130

[9] **Psychological Skills to Improve Emergency Care Providers' Performance Under Stress (American College of Emergency Physicians, 2017)** https://emcrit.org/wp-content/uploads/2017/05/PEP-under-Stress.pdf

[10] **What Is Box Breathing? (Web MD, 2023)** https://www.webmd.com/balance/what-is-box-breathing

[11] **Mindfulness Meditation and Interprofessional Cardiopulmonary Resuscitation: A Mixed Methods Pilot Study (Teaching and Learning in Medicine, 2018)** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6240489/

Just like depression, anxiety is often accompanied by physical symptoms, such as restlessness, palpitations, dizziness, nausea, poor concentration, poor appetite and poor sleep. Anxiety is incredibly common in healthcare workers, with 5% of the UK general population estimated to have General Anxiety Disorder[12], and it can co-exist with depression. Talking to someone you trust and involving your GP can help. They will assess your needs and support you towards recovery so that you can feel more like yourself again.

Post Traumatic Stress Disorder (PTSD)

Any situation that you find traumatic, including resuscitation events, can cause Post Traumatic Stress Disorder (PTSD), a condition that is frequently referenced by the media. PTSD is an anxiety-based condition and anxiety is a key symptom.

As well as this, you may experience nightmares and intrusive re-living of the traumatic event. Some people also see, hear, and smell the incident as if it is happening again. This is known as a flashback. You may experience feelings of isolation, guilt and irritability. PTSD can develop shortly after a traumatic event, or less commonly, it can develop much later (months or years).

It is not completely clear what causes some people to develop PTSD after a traumatic event, but up to 1/3 of people who experience severe trauma will develop the condition.[13]

However, the way the trauma is experienced is important; for instance, someone who has been assaulted on the street will experience trauma very differently from a healthcare professional involved in a resuscitation.

Evidence suggests that around 10% of healthcare workers in acute settings exhibit symptoms of PTSD, according to a recent study.[14]

You should seek help for these symptoms if they last longer than four weeks or if they start significantly impacting on your life. As well as understanding that PTSD is common, it is also important to know that there are successful treatments available for it. Watchful waiting is the right initial approach, and psychological therapies (e.g. in some cases, antidepressant medicines) have been shown to be effective treatments for PTSD. Your GP will be helpful in making the diagnosis and determining what recovery plan will be most appropriate for you.

As always, if you are struggling, talk to someone you trust.

[12] **Overview - Generalised anxiety disorder in adults (NHS 2022)**
https://www.nhs.uk/mental-health/conditions/generalised-anxiety-disorder/overview/

[13] **Overview - Post-traumatic stress disorder (NHS, 2022)**
https://www.nhs.uk/mental-health/conditions/post-traumatic-stress-disorder-ptsd/overview/

[14] **The presence of psychological trauma symptoms in resuscitation providers and an exploration of debriefing practices (Resuscitation, 2019)**
https://pubmed.ncbi.nlm.nih.gov/31251894/

Other clinically relevant syndromes

There are some other syndromes that are worth being aware of because they are also common in resuscitation providers. Note that none are mental health conditions, but they can be profoundly impactful.

Burnout

Burnout describes the cumulative sense of fatigue or dissatisfaction that comes from chronic workplace stress. Regular exposure to stressful situations such as resuscitation is a risk factor. You may notice feeling cynical about your job, low on energy and have trouble performing to the same level as usual. The most common cause of burnout in healthcare is the demands of the job not being met by the personal or organisational resources available, e.g. working overtime in an understaffed environment. This is all too common in healthcare. It is important to recognise this and try to look after yourself before looking after others.

If you are struggling, talk to someone you trust, consider seeing your GP and employer, who will offer support. Sometimes, taking time away from work, reducing your hours or working conditions can be helpful to address burnout.[15]

Compassion fatigue

Compassion fatigue describes the 'wearing thin' of your ability to cope and remain caring in the face of repeated exposure to others' trauma.

Each time you are exposed to resuscitation, high levels of emotional labour are required.

Because you, as a healthcare worker, are likely to be good at empathising and showing compassion for others, you are at high risk of compassion fatigue. Compassion fatigue is linked to burnout but describes a more specific syndrome, sometimes termed a 'secondary stress reaction'. Feelings of numbness, helplessness and irritability can develop towards situations where you would have previously found satisfaction in being the caregiver. Physical symptoms such as poor sleep, poor concentration, aches, pains and social symptoms such as withdrawal can follow. It is a contributor to poor job satisfaction and absenteeism.

If you feel this way, talk to a trusted person and know that there is support available. Often recognising the issue and the impact that it is having is the most important step, after which you can begin self-help by seeking support from your GP or mental health services or your employer, who may be able to alter your work pattern in order to reset the balance.[16,17,18]

Moral injury

Moral injury is a relatively new concept to transfer into the world of medicine,[19] you may not have even heard of it before now, but it is worth being familiar with. It describes an act or omission that transgresses deeply held beliefs or moral code, either by yourself or witnessing it in others. It may be a betrayal of what is right by someone in a position of authority in a high-stakes situation.[20] Often it can be summarised by you not feeling able to provide the level of care you would like to give.

For example, this might be:

- ✓ end-of-life care issues
- ✓ exclusion of family during the resuscitation of an infectious patient
- ✓ lack of resources in a resuscitation
- ✓ non-accidental injury and safeguarding concerns

[15] **Occupational burnout (Wikipedia, 2023)** https://en.wikipedia.org/wiki/Occupational_burnout

[16] **Compassion Fatigue among Healthcare, Emergency and Community Service Workers: A Systematic Review (International Journal of Environmental Research and Public Health, 2016)** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4924075/

[17] **Compassion fatigue (Wikipedia, 2023)** https://en.wikipedia.org/wiki/Compassion_fatigue

[18] **Compassion Fatigue: Symptoms to Look For (Web MD, 2022)** https://www.webmd.com/mental-health/signs-compassion-fatigue

[19] **The Mental Health and Wellbeing of Healthcare Practitioners: Research and Practice (Murray & Brown, 2021)**

[20] **Moral injury: the effect on mental health and implications for treatment (The Lancet, 2021)** https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(21)00113-9/fulltext

There are also more systemic issues, such as:

- understaffing affecting patient care
- lack of time for patients
- national policies that fall short of the gold standard.

These matters and many more can trigger moral injury.[21]

The main symptoms of a moral injury are guilt, anger, disgust and shame.

Although moral injury is not a mental health condition (and, as yet, has no clear diagnostic criteria or treatment), the emotional, behavioural, somatic and cognitive impact can be profound. Additionally, moral injury is significantly associated with depression, PTSD and suicidal thoughts.

Often the shame or guilt that is felt is so strong that you might not want to talk to anyone about it, e.g. you may feel ashamed about what you did or what someone else did.

However, it is crucial that you do talk to someone you trust about these symptoms if they are persistent and impairing.

Practicing self-compassion, acceptance and forgiveness may help and you can also access support from your employer, your GP and other mental health services.

Peer-to-peer reflection is important, too. Schwartz rounds, for example, create a space to process such experiences.[22] Sharing your experiences with peers allows collective learning, and where appropriate, an issue may be raised and addressed to bring about positive change.

Matt (Student) "Sometimes seeing suffering regularly can take its toll and you feel like you need some time to reset".

[21] **Moral distress in the NHS and other organisations (BMA, 2021)** https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/creating-a-healthy-workplace/moral-distress-in-the-nhs-and-other-organisations

[22] **Schwartz Rounds (General Medical Council, 2019)** https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/reflective-practice/schwartz-rounds

Post-resuscitation procedure

What should you do after attending a resuscitation event?

Matt (Student), Tony (Paramedic) and Mike (Doctor) walk back to base to begin an operational debrief.

There are some things that should be routinely done after each resuscitation event, especially if the outcome is unsuccessful.

While currently, there is no conclusive evidence that post-resuscitation interventions prevent the development of serious mental health problems, we do know a lot about how to identify and support people who are negatively impacted as early as possible.

FIGURE 1 - Post-resuscitation procedure

	Consider referral for further support ↑	
Operational debrief →	Active monitoring →	Reflection

Operational Debriefing

Operational debriefing (OD) is a post-resuscitation debrief that focuses on the team's performance, i.e. how can we learn from this event and improve on our performance for next time? It also provides an opportunity for those people involved to try and make sense of the incident, which can help to clarify misperceptions or misunderstandings and prevent moral injuries.

Meta-analysis[23] shows that an OD can improve performance by 20-25%, and some studies show improved CPR performance and patient outcomes[24]; the positive mental health impact of an OD is likely to be at least part of the reason for this positive outcome. Note that there is little evidence for ODs formally preventing the onset of mental health conditions[25]; however, responders report feeling psychologically supported after ODs[26], and evidence that is currently available does indicate that well conducted ODs are unlikely to cause psychological harm[27].

Possible indirect benefits of OD on responder wellbeing may include:

- identifying distressed responders and signposting them to support or follow up
- opportunistic education for responders on possible psychological reactions
- reassurance on performance limits, futility and diffusing individual guilt for a poor outcome.

STOP5 Operational Debrief model

There are many methods of OD and a lot of variation between organisations. We have selected a model called 'STOP5' as an example produced by NHS Lothian.[28] This OD can be completed in five minutes immediately after a resuscitation event. This is sometimes termed a 'hot debrief', but note that an OD can be done after some time has passed (sometimes termed a 'cold debrief').[29]

To perform this debrief:

First, gather the team around for **five** minutes and read aloud the introductory statements.

Summarise the case (create a shared narrative of what happened)
Things that went well – ask the team
Opportunities to improve – ask the team
Points to action and who will be responsible, for example:

- Equipment that needs restocking. Who can do this?
- Should we share what we have learned? Who will send an email?
- A team member is distressed. Who will check on them? Time out?

[23] **Do team and individual debriefs enhance performance? A meta-analysis (Human Factors, 2013)**
https://pubmed.ncbi.nlm.nih.gov/23516804/

[24] **Debriefing of Resuscitation Performance (EIT #645): Systematic Review (ILCOR, 2021)**
https://costr.ilcor.org/document/debriefing-of-resuscitation-performance-eit-645-systematic-review

[25] **Single session debriefing after psychological trauma: a meta-analysis (The Lancet, 2022)**
https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(02)09897-5/fulltext

[26] **The presence of psychological trauma symptoms in resuscitation providers and an exploration of debriefing practices (Resuscitation, 2019)**
https://pubmed.ncbi.nlm.nih.gov/31251894/

[27] **The presence of psychological trauma symptoms in resuscitation providers and an exploration of debriefing practices (Resuscitation, 2019)**
https://pubmed.ncbi.nlm.nih.gov/31251894/

[28] **STOP5: a hot debrief model for resuscitation cases in the emergency department (Clinical and Experimental Emergency Medicine, 2020)**
https://pubmed.ncbi.nlm.nih.gov/33440103/

[29] **Debriefing of Resuscitation Performance (EIT #645): Systematic Review (ILCOR, 2021)**
https://costr.ilcor.org/document/debriefing-of-resuscitation-performance-eit-645-systematic-review

FIGURE 2: STOP5 OD proforma

Finally, consider opportunistic psychological support for team members.

STOP for 5 minutes

Thank the full team and ask **"Is everyone ok?"**

If **YES** then continue as below and **STATE FIRST:**

- ✓ We are going to have a five minute team debrief
- ✓ Purpose is to improve quality of patient care, it is not a blaming session
- ✓ Your participation is welcomed but not compulsory
- ✓ All information discussed during this debrief is confidential

HOT DEBRIEF	**Type of Case (tick)**	**Please list all staff members present**
Date:	☐ **Cardiac Arrest**	
Time:	☐ **Other**	
Location:	☐ **Staff Triggered**	**This form completed by:** _____

Summarise the case

Things that went well

E.g.: Preparation
- ✓ Equipment
- ✓ Roles
- ✓ Communication
- ✓ Protocol Adherence
- ✓ Timing

Opportunities to improve

As above

Points to action and responsibilities

A staff member shoud be assigned to follow up on any issues identified e.g., restocking equipment, sharing learning

Please note this form does not replace usual error reporting (e.g.) DATIX - if required you must do one

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☐ **HOT DEBRIEF not completed**

Reason: _____

Is a COLD DEBRIEF required?

YES ☐ **NO** ☐

Adapted from the STOPS Hot Debrief Model created by Edinburgh EM and the Scottish Centre of Simulation and Clinical Human Factors: bit.ly/STOP5ceem

Matt (Student) "The debrief allowed me the opportunity to ask and learn about what was a common psychological reaction. It prepared me for the days ahead. I felt reassured and more able to talk openly when I did actually experience distressing flashbacks."

How can I support my team during the Operational Debriefing (OD)?

There are opportunities to offer psychological support to team members (and bystanders) during the OD:

1. **Reassurance that their immediate reactions (thoughts, feelings, behaviours and somatic symptoms) are common.**
   Whether people feel good, neutral, or bad, it is all part of a common psychological reaction to a resuscitation event. Sometimes the stigma of having a reaction may be more distressing than the reaction itself, so knowing it is common (and culturally accepted) helps.

2. **Education on possible negative psychological reactions in the coming days, weeks, and months.**
   Even if people do not experience any negative post-resuscitation reactions, they need to know that it is not unusual to experience strong reactions related to the resuscitation event days, weeks, or months afterwards. Knowing this means that team members can anticipate reactions and may feel more able to speak up about them if they occur. Explain that these feelings should reduce over time, but if they persist over four weeks or if they start to significantly impact their life – they should seek help.

3. **Signpost to appropriate support services.**
   If team members need to seek help, they can reach out to:

   - Trusted friends, colleagues and family members
   - Supervisors
   - Mental Health charity resources (e.g. MIND, Samaritans, Lifelines)
   - Their GP
   - Occupational health
   - Staff counselling or employee assistance programmes (EAPs)

Explain that it is important not to suffer in silence. Sometimes we all attempt to be 'too strong for too long', and we need to look after ourselves. Looking after our mind is just the same as seeing a physiotherapist for a sports injury or going to the dentist to look after our teeth.

4. **Offer a break from the shift to reset**
   A cup of tea, a snack, or a pause to have a breather can make all the difference and is a gesture of care towards team members. In some cases, team members may be acutely affected by the resuscitation event to the extent that they are no longer able to or safe to work – if this is recognised, then it is sensible to take them off clinical duties until they recover sufficiently. However, people should not be simply sent home. It is much better to temporarily increase their access to collegial support and reassign them to less stressful duties.

5. **Assign a 'buddy' to check up on each other**
   To make sure nobody falls through the cracks, you might be able to assign 'buddies' in the team to check up on one another after the event. Peer support training can also be delivered (e.g. Trauma Risk Injury Management "TRiM" training[30, 47] to empower individuals to check in on their colleagues after a few weeks (see the section on "Active Monitoring").

6. **Check the understanding of performance limits and futility**
   It is common to ruminate on the event 'if only I did something differently, they might have survived'. Sometimes we may feel that our actions, or omissions, during the resuscitation caused the poor outcome. It is important to ensure that all team members have a shared understanding of the limits of their performance (which can be influenced by the situation) and, where appropriate, the futility of the resuscitation event so that they do not overestimate their personal influence on the poor outcome.

   Without this reassurance, they might walk away believing, for example, that they were responsible for the patient's death when that is not the case. Having the perspective of the bigger picture allows responders to contextualise their role and avoids undue self-blame and distress. However, it is important to nurture and support the responder's intent to strive for quality and self-improvement. Focus on positive and constructive learning when possible.

> **'The only real mistake is one we learn nothing from'** – Henry Ford

Data-driven Operational Debriefing (OD)

The International Liaison Committee On Resuscitation (ILCOR) recommend the use of data (performance metrics) to drive OD. For example:

- Defibrillator impedance signal recording to feedback on CPR effectiveness.[31]
- The use of video recording in some centres has also been suggested to enhance the OD.[32] Where available, data can be incorporated into the STOP5 debrief format. When using identifiable patient data, ensure that all relevant patient privacy and medico-legal requirements have been met.

Documentation

Note that you should seek advice from your organisation as to what should be recorded from the OD itself. It is suggested that the detailed content of the OD should not be recorded; however, the fact that an OD happened and who was present, should be recorded in order to achieve a reasonable balance of honest reflection and learning. If errors or safety issues have happened, they should be reported via usual and established routes.[33]

[30] **The Mental Health and Wellbeing of Nurses and Midwives in the United Kingdom (Journal of Occupational Medicine, 2020)**
https://www.som.org.uk/sites/som.org.uk/files/The_Mental_Health_and_Wellbeing_of_Nurses_and_Midwives_in_the_United_Kingdom.pdf

[31] **Debriefing of Resuscitation Performance (EIT #645): Systematic Review (ILCOR, 2021)**
https://costr.ilcor.org/document/debriefing-of-resuscitation-performance-eit-645-systematic-review

[32] **Use of briefing and debriefing in neonatal resuscitation, a scoping review (Resuscitation Plus, 2020)**
https://pubmed.ncbi.nlm.nih.gov/34223331/

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[47] **Psychological peer support for staff: implementing the Trauma Risk Management model in a hospital setting (Nursing Management, 2021)**
https://journals.rcni.com/nursing-management/evidence-and-practice/psychological-peer-support-for-staff-implementing-the-trauma-risk-management-model-in-a-hospital-setting-nm.2021.e1977/abs

Opt-Out

Please also be aware that 1:1 psychologically focused debriefing is not recommended and there is no role for mental health professionals to be 'flown in' to provide immediate psychological assistance for people who have been involved in a resuscitation.

For this reason, it should be possible for a person to opt-out of OD if they are concerned about suffering undue distress. But those who opt-out should always be checked upon later.

Active monitoring

Active monitoring means keeping a close eye on someone who was involved in a resuscitation event, usually for the first month but potentially for up to three months after more complex resuscitation incidents.

In practice, this can take many forms:

- the buddy system (as discussed, includes assigning buddies to check up on each other by text or by phone in the OD)
- formal peer supporters who can be trained (e.g. TRiM) with additional skills to facilitate and empower a 'check in' on their colleagues after a few weeks
- team leaders or supervisors doing an informal or formal team check-in either in person or by email
- logging exposures to resuscitation events with a contingency to target formal follow-up for affected individuals by appropriately experienced colleagues
- regular check-ins with a trusted colleague if resuscitation events are frequent, i.e. if there are multiple events each month.

The important aim is to give each person involved in a resuscitation event the opportunity to talk about how they are feeling and to offer more support to them if it is needed.

Matt "Receiving a text asking how I was meant so much to me. It made me feel cared for and it opened up the opportunity for me to talk if I wanted to, which I did. It helped a lot."

Remember, a resuscitation event may also affect people who are non-clinicians or who were not physically present, for example, in the pre-hospital environment it would be sensible to actively monitor the call handler who took the call as well as the individuals on scene.

Reception and housekeeping staff in the hospital environment are other examples of such personnel who are at risk of being overlooked and may need due care and attention.

Referral

If an individual is suffering severe and/or persistent psychological distress after a resuscitation event, then it may be appropriate to refer them for further help. Usually, even severe reactions reduce over a period of days to weeks; such reactions are not considered to be pathological.

There are many avenues to discuss what support is most effective for a given situation, and many services offer confidential advice if in doubt:

- Samaritans
- Lifelines
- Mind
- NHS 111
- NHS 999 if in crisis
- NHS wellbeing hubs and Resources (see the list at the end)
- GP
- Occupational health (OH) and Employee Assistance Programs (EAPs).

Some people may not wish to be referred to services, and it is important to respect their wishes, provided they are not at immediate risk of harm to themselves or others.

Referral support may include:

- continuation of active monitoring
- self-help, e.g., lifestyle adjustments, addressing work-life balance, relaxation, healthy eating, exercise
- GP or occupational health appointment for assessment
- talking therapies
- CBT (cognitive behavioural therapy)
- medications
- work adjustments
- specialist input (e.g. psychiatrist).

It is usually a good idea to make a supervisor or at least a trusted colleague at work aware of the situation so that they can help with active monitoring, developing a recovery plan and further support if required.

Reflection

Periodic whole-team reflective practice sessions (talking about the emotional, cognitive, behavioural and somatic impact of the work rather than what went right or wrong), ideally led by a supervisor (and not necessarily tied to one event), can be helpful. This way, peers can share experiences that may otherwise go unspoken and process emotional challenges together. It also creates an opportunity to check in with and support each other.

An example of this is a Schwartz round.[34]

Mike (Doctor) "This is a little bit unusual, as we usually focus on the clinical side of things, but the case this time is actually us."

Bystanders

It is important to be aware that bystanders (for example members of the public) are at risk of being negatively impacted by resuscitation exposure. Bystanders often do not share the same clinical understanding or access to follow-up and organisational support as responders. Where possible and where it is appropriate to do so, offer support as described in the post-resuscitation procedure to bystanders.

Post-mortem data

Some responders may have privileged access to post-mortem information that may be used as part of an OD (to improve team performance). Additionally, some responders may request post-mortem information to help provide some 'closure'. Where permissions allow, it would be reasonable to share this information with the responder if requested, but it is not recommended to do this routinely for all responders as a wellbeing intervention.

[34] **Schwartz Rounds (General Medical Council, 2019)**
https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/reflective-practice/schwartz-rounds

Influence of the organisation on responder wellbeing

It is important to contextualise the post-resuscitation procedure in the wider range of organisation, leadership, team and individual factors that influence responder wellbeing.

Research shows that organisational factors have a significant impact on responder wellbeing, far more so than previously understood.[35, 36] They can potentially be more impactful than the exposure to the human suffering and distress associated with resuscitation events. The focus for responder wellbeing has shifted recently from the individual to the organisation.[37]

There are many organisational factors that impact responder wellbeing, including:

- workload
- working hours
- staffing levels
- exposure to resuscitation
- emotional demands of the job
- rest periods
- shift working and sleep deprivation
- overstaying shift ends
- missing breaks
- perceived or actual bullying and harassment
- autonomy
- professional values
- support and supervision
- resources
- flexibility of work arrangements and rotas
- rotas allowing teams to stick together and bond over time
- role ambiguity
- recognition and feedback
- food, drink and rest facilities
- transport after hours
- protection from infection
- verbal and physical abuse.

There are also important non-work stressors such as relationship problems, illness within the family, caring responsibilities and financial difficulties that affect wellbeing at work as well.

Matt (Student) "There are so many factors affecting responder wellbeing in addition to resuscitation exposure. These all need to be addressed to improve responder wellbeing".

[35] **What could make a difference to the mental health of UK doctors? A review of the research evidence (Journal of Occupational Medicine, 2018)** https://www.som.org.uk/sites/som.org.uk/files/What_could_make_a_difference_to_the_mental_health_of_UK_doctors_LTF_SOM.pdf

[36] **The Mental Health and Wellbeing of Nurses and Midwives in the United Kingdom (Journal of Occupational Medicine, 2020)** https://www.som.org.uk/sites/som.org.uk/files/The_Mental_Health_and_Wellbeing_of_Nurses_and_Midwives_in_the_United_Kingdom.pdf

[37] **Mental health care for medical staff and affiliated healthcare workers during the COVID-19 pandemic (European Heart Journal. Acute Cardiovascular Care, 2020)** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7189614/

Primary intervention

Primary intervention aims to address the stressors at the source, as prevention is better than cure. Successful organisations do what they can to reduce exposure to stressors and proactively offer support. Simply put, successful organisations do all they can to protect their most valuable resource; their staff.

Examples of preventative organisational measures include:

- reducing working hours
- genuine protection of breaks, shift ends and leave
- extended recovery periods for night shift work
- providing food, drink and rest facilities
- Schwartz rounds[38]
- crafting rotas to fit lifestyles
- employing more staff and 'overstaffing' at baseline
- zero tolerance policies on bullying, harassment, verbal and physical abuse
- ensuring effective PPE
- praise and rewards for responders.

Note that physician-organisation collaboration[39] to effect these changes is preferable if possible.

Secondary intervention

This type of organisational intervention aims to help individual staff members to change their perception or ability to cope with existing stress. It mitigates the effects of existing stressors. This is not a substitute for primary prevention, but it is important to provide.

Examples of a secondary intervention are:

- TRiM peer support training[30, 47]
- active monitoring and regular check-ins by supervisors
- offering active coping skills training
- stress and time management training.

Operational Debriefing falls into this category.

Tertiary intervention

Tertiary intervention describes targeted support, usually once individuals have developed (or require assessment for) a mental health condition.

Of course, some responders do develop mental health conditions despite the best preventative and early intervention approaches, and intervention is required to help them to recover. It is important that the organisation has a contingency to provide professional psychological assessment and management, as well as occupational health services, for responders who become mentally unwell.

[30] **The Mental Health and Wellbeing of Nurses and Midwives in the United Kingdom (Journal of Occupational Medicine, 2020)** https://www.som.org.uk/sites/som.org.uk/files/The_Mental_Health_and_Wellbeing_of_Nurses_and_Midwives_in_the_United_Kingdom.pdf

[38] **Schwartz Rounds (General Medical Council, 2019)** https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/reflective-practice/schwartz-rounds

[39] **Physician-Organization Collaboration Reduces Physician Burnout and Promotes Engagement: The Mayo Clinic Experience (British Journal of Healthcare Management, 2016)** https://pubmed.ncbi.nlm.nih.gov/27111930/

[47] **Psychological peer support for staff: implementing the Trauma Risk Management model in a hospital setting (Nursing Management, 2021)** https://journals.rcni.com/nursing-management/evidence-and-practice/psychological-peer-support-for-staff-implementing-the-trauma-risk-management-model-in-a-hospital-setting-nm.2021.e1977/abs

Often responders experience stigma and decide not to declare their illness due to fear of being perceived as 'not coping' and possible restrictions on work and job loss. Discreet and confidential services that allow the responder the most autonomy over their work is preferable.

An example of tertiary intervention is:

- self-referral to occupational mental health services, for example, NHS Wellbeing Hubs or Employee Assistance Programs
- occupational health assessment support with work adjustments
- availability of timely, professional, evidence-based mental health treatments.

Influence of leaders on responder wellbeing

Leaders, at all levels from the most junior supervisor upwards, can act to influence the wellbeing of their teams in several ways:[40]

- **Be a good leader** – this sounds trite, but doing a good job in the role with which you are tasked is the priority. Be confident in your ability.
- **Communication** – this must go both ways; make sure to listen to your team and allow team members to share their feelings and concerns.
- **Kindness and compassion** – leaders (supervisors) need to be approachable and feel confident to have psychologically savvy conversations with team members.
- **Humility and humanity** – acknowledge and validate stigmatised feelings, and don't be afraid to share your own vulnerabilities.

This provides psychological safety for your team members to disclose theirs when it counts.

- **Model** – good self-care and help-seeking behaviour.
- **Champion** - best practice of post-resuscitation procedure (OD, active monitoring, reflective practice) for your teams and empower others to lead this.
- **Know** - what to do if any members of your team are struggling. Be familiar with what is common, what is concerning and how to signpost them to resources.

Studies in soldiers show us that good team leadership, morale and cohesion may reduce the development of trauma-related mental health pathology.[41, 42]

Matt (Student) "When the senior doctor role modelled being open about their vulnerability, I felt like I too could be open about anything I was struggling with and not be afraid to ask for support if I needed it"

[40] **Mental health care for medical staff and affiliated healthcare workers during the COVID-19 pandemic (European Heart Journal. Acute Cardiovascular Care, 2020)** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7189614/

[41] **Cohesion, leadership, mental health stigmatisation and perceived barriers to care in UK military personnel (Journal of Mental Health, 2018)** https://www.tandfonline.com/doi/abs/10.3109/09638237.2016.1139063?journalCode=ijmh20

[42] **Leadership, cohesion, morale, and the mental health of UK Armed Forces in Afghanistan (Psychiatry, 2012)** https://pubmed.ncbi.nlm.nih.gov/22397541/

Influence of colleagues on responder wellbeing

Peer support is the cornerstone of responder wellbeing. Often, we feel it the most when we find ourselves without it, working with a new and unfamiliar team or isolated across shift patterns or physical distance from those we know well. This is because truly knowing each other, 'on and off the pitch', so to speak, and developing trust, has an immeasurable effect on our wellbeing. You might be the only person in your workplace who can really recognise if your colleague is struggling, despite appearing fine (or even 'just a bit grumpy') to everyone else.

Having said this, it is definitely possible to extend support to colleagues you have just met. Talking openly and non-judgementally about the psychological difficulties of the job and wellbeing strategies is a way to discover common ground and forge new bonds. Because of their shared experiences at work, peers have the ability to communicate with each other, in a sort of shorthand,[43] in a way that they may not feel able to share with friends and family who are not familiar with their work environment.

Often, we find that we can speak more freely to our peers than we can to any other people about how we are feeling at work. This alone, makes your role as a colleague potentially lifesaving.

If in doubt, ask twice:

"Are you OK?"

"Yeah not too bad, thanks"

"Are you *really* OK?"

"Is there anything else going on?"

"Is there something on your mind?"

"No pressure to talk about it to me if you don't want to, but I just thought I'd check in and ask how you're doing?"

[43] **Mental health care for medical staff and affiliated healthcare workers during the COVID-19 pandemic (European Heart Journal. Acute Cardiovascular Care, 2020)** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7189614/

Here are a few practical tips for what you can do to support your colleagues

As a colleague you can support your co-workers by:

- spotting signs of concern in them (nightmares, difficulty sleeping, unable to stop worrying, jumpy, easily irritable, medically unexplained symptoms appearing, flashbacks of stressful events)
- offering them the opportunity to talk (do not force them to do so, but be available to listen, laugh or cry with them)
- signposting them to supportive resources
- being kind, consistent and reassuring
- encouraging them to maintain good self-care
- helping them explore the cause of their distress, and if you can help them address it, or if you need to escalate concerns.

TABLE 2: Ways colleagues can support each other (adapted from Walton, Murray & Christian 2020).

There are also courses on psychological/stress first aid that you can take to learn more about supporting your colleagues (you can find more examples in our Resources section). Here is a video showing a pre-hospital team supporting each other following a traumatic case.[44]

Matt (Student) "Once we talked to each other, we realised we'd both had similar experiences. It was a light-bulb moment. It made me realise how common these feelings are."

[44] **Resilience - One Team's Trauma (Matthew Walton Medical, 2017)** https://youtu.be/DY60ZOWBvDc

Individual wellbeing

Now, you.

How do you look after yourself? What habits have you developed?

What works for you and what doesn't?

There are some little things we can all do in our day-to-day lives to ensure we maintain our wellbeing, which includes:

- keeping in touch with family and friends
- doing things you enjoy
- ensuring adequate sleep, hydration, nutrition and exercise
- noticing what is in your control and what is not
- being grateful and focusing on the positives
- taking your breaks and leaving on time
- taking time to recognise the impact of your work.

Importantly, recognise in yourself when you are nearing your limit. At times in our lives, we are all likely to experience this and require help. There is no shame in feeling overwhelmed or not coping. You may have spent too long being strong, and it is time to focus on yourself instead of others for a while until you start feeling more like yourself again.

Seeking professional advice early on may well mean that the interventions needed to recover are less complex.

We all have coping styles and strategies, whether we are aware of them or not, to help us get through tough times.[45, 46]

Some (adaptive) coping strategies we should nurture, include:

- accepting the situation
- talking to trusted people about our problems
- asking for help
- using humour when and where appropriate
- practicing religion for those who are religious
- positive reframing
- practicing self-compassion.

[45] **Good Cope, Bad Cope: Adaptive and Maladaptive Coping Strategies Following a Critical Negative Work Event (Applied Psychology, 2005)** https://psycnet.apa.org/doiLanding?doi=10.1037%2F0021-9010.90.4.792

[46] **Coping With Staff Burnout and Work-Related Posttraumatic Stress in Intensive Care (Pediatric Critical Care Medicine, 2017)** https://pubmed.ncbi.nlm.nih.gov/28459762/

Some (maladaptive) coping strategies we should try to avoid:

- denial of the situation
- avoidance or repression
- substance abuse and self-harm
- rumination
- self-blame
- negative self-talk
- venting
- withdrawal or disengagement
- resignation (giving up).

If there is one message to take away, it is this:
If you are struggling, tell somebody you trust and who might be able to help you.

Tony "If you're struggling, if you're finding things difficult, talk to someone you trust. They will listen and they will help you"

Conclusion

Having taken the initiative to read this resource, you have already demonstrated that you have taken an important step towards caring for yourself and people around you.

You now have the knowledge about how you may feel after a resuscitation event and the possible ways in which you might be impacted by prolonged exposure.

You know that as well as positive reactions, there are neutral and negative reactions.

You know that these are common, and you know how to recognise when more support is required and where it can be found.

You know about helpful post-resuscitation procedures and how to support your colleagues.

You know about the influence of the organisation and leadership on your wellbeing and that there are opportunities to help at every level.

Most importantly, you know how to look after yourself.

Mike (Doctor), Matt (Student, now a qualified Doctor) and **Tony (Paramedic)** continue to provide life support to patients in need.

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Tables

TABLE 1: Acute stress reactions (adapted from Walton, Murray & Christian 2020)

Indicators of acute stress reactions			
Physical	**Behavioural**	**Emotional**	**Cognitive**
Palpitations	Avoidance	Numbness	Poor concentration
Nausea, low appetite	Recklessness	Anxiety	Intrusive thoughts
Chest pain	Detachment	Low mood	Flashbacks
Headaches	Withdrawal	Anger, fear	Poor memory
Abdominal pains	Irritability	Mood swings	Confusion
Insomnia	Drug or alcohol use	Loss of pleasure	Hyper vigilance
Hyperarousal	Conflicts with others	Low confidence	Rumination

TABLE 2

Ways colleagues can support each other (adapted from Walton, Murray & Christian 2020)

As a colleague you can support your co-workers by:

- spotting signs of concern in them (nightmares, difficulty sleeping, unable to stop worrying, jumpy, easily irritable, medically unexplained symptoms appearing, flashbacks of stressful events)
- offering them the opportunity to talk (do not force them to do so, but be available to listen, laugh or cry with them)
- signposting them to supportive resources
- being kind, consistent and reassuring
- encouraging them to maintain good self-care
- helping them explore the cause of their distress, and if you can help them address it, or if you need to escalate concerns.

Figures

FIGURE 1 - Post-resuscitation procedure

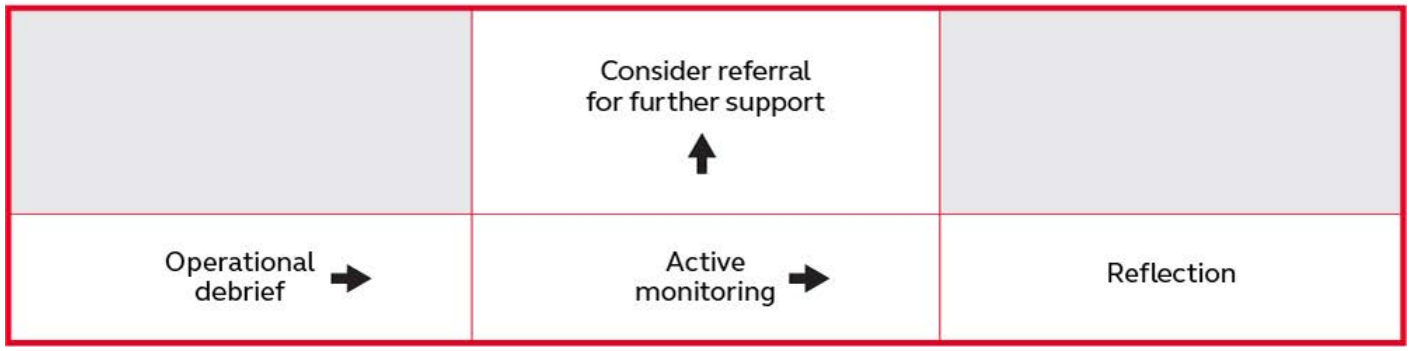

FIGURE 2

STOP5 DEBRIEF PROFORMA (Overleaf)

Permission has been granted kindly by Craig Walker to use and adapt 'STOP5 Hot Debrief Model' created by Edinburgh EM and the Scottish Centre for Simulation and Clinical Human Factors

- This figure is a form that can be printed / contains the information required to conduct a STOP5 OD.

FIGURE 2: STOP5 OD proforma

Finally, consider opportunistic psychological support for team members.

STOP for 5 minutes

Thank the full team and ask **"Is everyone ok?"**

If **YES** then continue as below and **STATE FIRST:**

- ✓ We are going to have a five minute team debrief
- ✓ Purpose is to improve quality of patient care, it is not a blaming session
- ✓ Your participation is welcomed but not compulsory
- ✓ All information discussed during this debrief is confidential

HOT DEBRIEF	Type of Case (tick)	Please list all staff members present
Date:	☐ Cardiac Arrest	
Time:	☐ Other	
Location:	☐ Staff Triggered	**This form completed by:** _____

Summarise the case

Things that went well

E.g.: Preparation

- ✓ Equipment
- ✓ Roles
- ✓ Communication
- ✓ Protocol Adherence
- ✓ Timing

Opportunities to improve

As above

Points to action and responsibilities

A staff member shoud be assigned to follow up on any issues identified e.g., restocking equipment, sharing learning

Please note this form does not replace usual error reporting (e.g.) DATIX - if required you must do one

Edinburgh Emergency Medicine

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☐ **HOT DEBRIEF not completed**

Reason: _____

Is a COLD DEBRIEF required?

YES ☐ **NO** ☐

Adapted from the STOPS Hot Debrief Model created by Edinburgh EM and the Scottish Centre of Simulation and Clinical Human Factors: bit.ly/STOP5ceem

Resources

List of resources for healthcare worker help-seeking

- England only - NHS England staff wellbeing Hubs (Email self-referral) https://www.england.nhs.uk/supporting-our-nhs-people/support-now/staff-mental-health-and-wellbeing-hubs/
- England & Scotland - Practitioner Health (Self-referral) https://www.practitionerhealth.nhs.uk/about-practitioner-health
- Scotland - NHS Wellbeing Resources (Resources). https://sway.office.com/p3QWjY4altHviB6o?ref=email
- Scotland - National Wellbeing Hub for Healthcare Workers (Resources) https://wellbeinghub.scot
- Scotland - "NHS 24" Wellbeing Resources (App, phone) & Charities (phone) https://www.nhs24.scot/staff-information/staff-wellbeing/
- Wales & England - Health & Care professions Council Resource list (Phone) & Charities (phone) https://www.hcpc-uk.org/covid-19/your-health-and-wellbeing/wellbeing-resources/
- Northern Ireland - Health and social Care Public Health Agency (phone) https://www.publichealth.hscni.net/covid-19-coronavirus/guidance-hsc-staff-healthcare-workers-and-care-providers/staff-health-and

Self-assessment

- Mental Health self-assessment tool (Anxiety, Depression, PTSD, Alcohol & Substance, Work Adjustment) https://checkwellbeing.leadershipacademy.nhs.uk/check-my-wellbeing/psychological-wellbeing-checker/
- Burnout simple self-test that can be useful to monitor your risk of burnout and direct you to some steps to reduce your feelings of burnout. https://www.mindtools.com/pages/article/newTCS_08.htm

Video resource

- 'One team's trauma' – debriefing, de-stigmatisation & peer support. https://youtu.be/DY60ZOWBvDc **Resource NB is source for the photo case study used throughout the document.*

Other

- Debriefing reading link https://litfl.com/clinical-debriefing/

Resuscitation Council UK

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resus.org.uk

enquiries@resus.org.uk

020 7388 4678

Resuscitation Council UK

First Floor

60-62 Margaret Street

London

W1W 8TF