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Addressing Emergency Department Nurses' Experiences of Workplace Violence through the Development of a Peer-based, Post Code Gray Support Tool

By

LAURA ADRIANA JUAREZ
THESIS

Submitted in partial satisfaction of the requirements for the degree of

MASTER OF SCIENCE

in

Nursing Science and Health Care Leadership

in the

OFFICE OF GRADUATE STUDIES

of the

UNIVERSITY OF CALIFORNIA

DAVIS

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2021

## Acknowledgements

As I reflect on this journey, it is hard to find the right words to describe the amount of gratitude I feel. There have been many people who have uplifted me and helped me throughout this program that I would like to acknowledge.

To the Gordon and Betty Irene Moore Foundation, thank you for your generosity and commitment to improving healthcare. It has been an honor to be a student at the Betty Irene Moore School of Nursing.

To Dr. Draughon Moret, thank you for your guidance, time, honesty, and kindness throughout this entire thesis process.

To Dr. Ackerman-Barger, Dr. Apesoa-Varano, Dr. Fedyk, and Faculty, your support is appreciated, and I am grateful to have had the opportunity to learn from you all.

To my family and friends, I love you. Thank you for your love, patience, and understanding throughout the time I spent in school and at work.

To my coworkers who accommodated my school schedule and told me I could do it. I appreciate you and all that we endure together day in and day out.

To my classmates who became my family. You have been nothing short of amazing. You have all made this experience unforgettable.

## Abstract

Verbal threats and physical assault while caring for patients has become a global problem in the healthcare industry. Nurses make up a large percent of healthcare employees and often spend the most face time interacting with patients, increasing their risks of experiencing violence. Nurses are affected by violence in ways that impact their well-being on both a personal and professional level. A lack of support to assist nurses in coping with these frequent occurrences of violence was identified. This project aimed to formulate a tool that combined debriefing and psychological first aid methods to be utilized by emergency department nurses and staff for post-code gray incidents. The tool was designed to be a brief, immediate, and informal response intervention that would meet the fast work pace of the emergency department to establish a caring dialogue between people, elevate a culture that does not accept violence as "part of the job," and promote organizational support for nurses.



*Keywords: workplace violence, emergency department, nurses, critical incident stress debriefing, psychological first aid, code gray, badge buddy*

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# Introduction

## Workplace Violence in Healthcare: A Growing Concern

As defined by the Occupational and Safety Health Administration (OSHA, n.d.), workplace violence is any physical or verbal violent action or threat of violence that occurs while a person is at work. In healthcare, workplace violence is a problem that affects workers on a global scale (World Health Organization [WHO], n.d.). Workplace violence among healthcare workers was estimated to be much higher than is actually reported (The Joint Commission, 2018). The OSHA found that out of 25,000 yearly reported workplace violence events, 75% of them took place in healthcare and social service environments, making employees of healthcare four times more likely to experience workplace violence than in other industries (The Joint Commission, 2018).

In 2019, there were over three million registered nurses (RN) in the United States (U.S. Bureau of Labor Statistics, n.d.). As the leading number of employees in healthcare and the primary providers of direct patient care (American Association of Colleges of Nursing [AACN], n.d.), nurses have been named as one of the highest at-risk groups of healthcare workers that experience workplace violence with patients being among the top perpetrators (WHO, n.d.). Violence committed against nurses can take different forms, such as physical and verbal violence. In a qualitative interview study by Stevenson et al. (2015), descriptions of nurses' experiences of violence from patients were explored. The interviews revealed that nurses' experiences of physical violence included patient possession of a weapon and acts such as being spit at, followed, trapped, grabbed, kicked, punched, and choked (Stevenson et al., 2015). Interviews also addressed verbal abuse, including being cursed at, threatened, belittled, and sexually harassed (Stevenson et al., 2015). While it was acknowledged that violence also occurs

in inpatient hospital units, the emergency department (ED) is one of the most highly reported settings of workplace violence (Perkins et al., 2020). Despite workplace violence advocacy and prevention efforts, nurses still experience a daily climate of violence that has the power to affect them and the care they provide.

## Applied Project

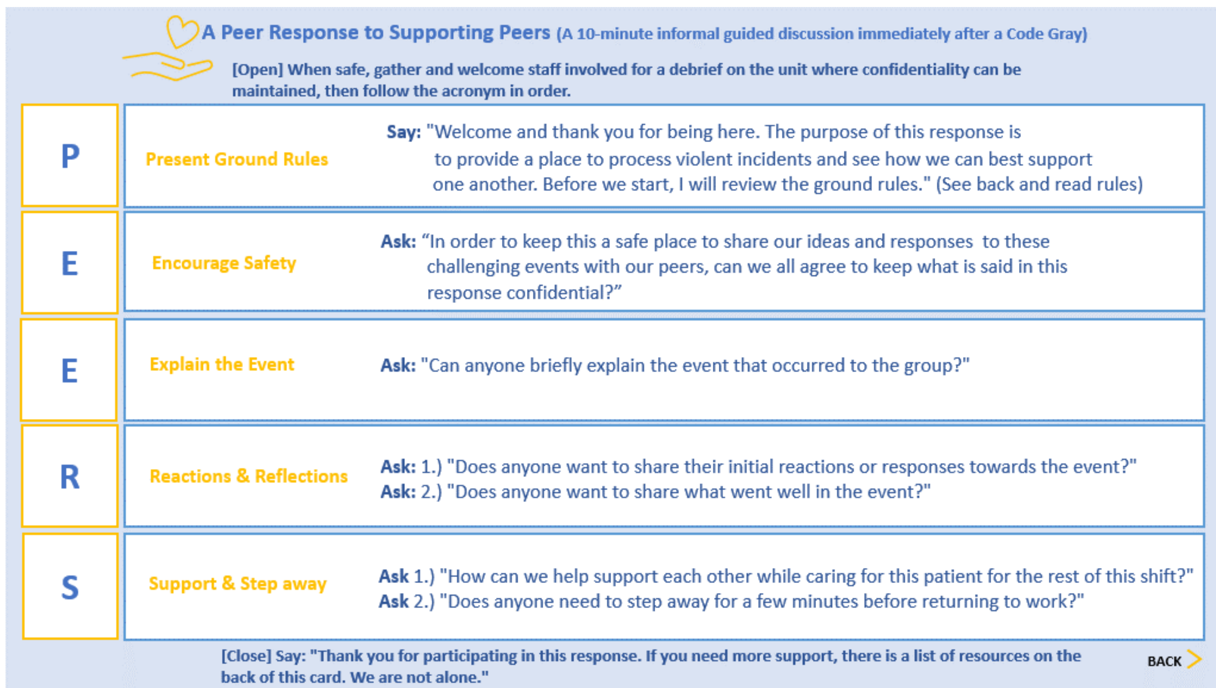
The thesis details the creation of the P.E.E.R.S. badge buddy tool (see Figure 1) that will serve as a supportive, immediate response intervention and guide for directing informal conversation among ED nurses and staff in the aftermath of a code gray event in a pilot project. A badge buddy is a card that is attached to the loop of a healthcare professional's identification (ID) badge reel. There can be multiple badge buddies on one loop. They are typically placed behind the ID badge and hang like a set of keys. A badge buddy is usually the size of a credit card or larger and is meant to be visually simple.

Badge buddies are used for several purposes. They often serve as easily accessible and quick resources for frequently used or important staff or clinical information. Examples of content that badge buddies may include are telephone numbers for different departments or other clinical areas that may be used daily, protocols for clinical management of a patient during a low blood sugar level event, emergency code names for overhead pages in the hospital (i.e., "code red," which alerts others of a fire in the hospital), and steps on how to navigate what to do and who to call if a workplace injury has occurred. Badge buddies are beneficial because of how accessible they are to healthcare providers in the moment that they need specific information from anywhere in the hospital. In a fast-paced environment, such as the ED, quick access to information can be of value as time is often difficult to spare.

The P.E.E.R.S. badge buddy tool was designed to serve as an abbreviated step-by-step critical incident stress debrief (CISD) with influences from psychological first aid practices (PFA) to fit the fast-paced workflow of nurses in the ED. Through debriefing and PFA, this tool was meant to allow nurses and staff to hold a space to acknowledge and reflect briefly on a violent event, give them the opportunity to share empathy, check on one another for immediate needs, and strengthen cohesion within the team after code gray events. This tool was created to influence a shift in the culture around workplace violence in the ED that may reduce the normalization of violence, foster the initiation of early coping, and promote support from organizations and peers.

**Figure 1**

*P.E.E.R.S. Badge Buddy Tool*



**A Peer Response to Supporting Peers** (A 10-minute informal guided discussion immediately after a Code Gray)

**Debriefing ground rules: Think before you speak**

- Debriefing is voluntary, not mandatory, you can join when able to and leave when needed
- We are here to listen to one another; not blame
- This is a safe place and what is said will not be held against us
- All feelings and ideas are welcome and valid
- Respect one another

***Additional Support Resources:**

- **Academic and Staff Assistance Program (ASAP):**
  https://hr.ucdavis.edu/departments/asap
- **Support U Peer Responder Program:**
  https://health.ucdavis.edu/clinician-health-and-well-being/Program/Support-U-Peer-Responder-Program.html
- **ED debriefing champion:**
  Vocera "Debrief champ"

***"We deceive ourselves when we fancy that only weakness needs support. Strength needs it far more." - Sophie Swetchine***

*Figure 1. The front and back of the P.E.E.R.S. badge buddy tool. The tool is a response intervention based on a guided discussion amongst the healthcare team after a code gray event. P.E.E.R.S. provides step-by- step guidance on how to facilitate the response with peers.*

## Background

### Workplace Violence in the Emergency Room

According to the National Hospital Ambulatory Medical Care Survey that took place between 2016 and 2017, there were 139 million ED visits in the United States (National Center for Health Statistics, 2017). The ED is unique in that it often hosts the first interactions that take place between healthcare workers and patients (ALBashtawy et al., 2015). These initial encounters between staff and patients make the ED a highly susceptible area in which violence can occur (ALBashtawy et al., 2015). In 2011, the Emergency Nurses Association (ENA) published an ED surveillance study that sought to shed light on the magnitude of the prevalence of violence in the ED. The study findings revealed that over the course of seven days, in which participating nurses worked approximately a total of 37 hours, 54.5% of the 7,169 participating emergency nurses experienced physical or verbal violence or both (ENA, 2011).

Factors making the ED a hotspot for violence can often be attributed to patient-related elements and the nature of the environment. Tadros and Kiefer (2017) shared that some patient-related reasons for increased violence in the ED can be due to the presence of patients who are acutely under the influence of drugs and alcohol or have psychiatric illness, many of whom may have been taken to the ED involuntarily. Environmental elements mentioned were aggravating waits in cramped, loud spaces and gang violence or domestic quarrels that often spill from their starting points into the ED setting (Tadros & Kiefer, 2017). Understanding the effect of violence on healthcare's largest workforce is vital to the future of nursing.

**Problem and Significance in Healthcare**

In the study by Greenslade et al. (2020), workplace violence was identified as one of the top stressors among ED staff, along with child death or trauma, inability to give quality care, and overwhelming work demands. Exposure to workplace violence has adverse consequences. Psychological effects can include experiencing components of post-traumatic stress disorder symptoms (Fujimoto et al., 2017; Gillespie et al., 2013; Stevenson et al., 2015) as well as anxiety and depression (Cannavo et al., 2019). Occupational-related burnout was another reported effect of violence that may result in loss of pleasure in the job, social isolation, depersonalizing patients, and avoidance of patients with abusive behaviors (Gates et al., 2006). Of note, emotional well-being can also be affected and result in feelings of anger or fear after a violent event occurs (Kitaneh & Hamdan, 2012). Maladaptive health behaviors, such as increased tobacco and alcohol use, food intake, and sleep disturbances, have also been documented in nurses exposed to workplace violence (Cannavo et al., 2019; Stevenson et al., 2015). The high prevalence of violence in healthcare and the impact it can have on nurses is a dual force that raises questions and concerns about how nurses are being supported.

Unfortunately, the regularity of verbal and physical violence has created a culture in which the experience of violence is a normalized and accepted occupational risk (Al-Qadi, 2020). Gillespie et al. (2013) discussed how this workplace culture can affect coping and retention. They explained that nurses who were unable to adapt to the regularity of violence in their environments or cope with the event afterward were labeled as frail and unfit for the job by colleagues and leadership and usually left the department (Gillespie et al., 2013). They also stated that nurses themselves may become unsure of their own confidence and abilities to continue providing care to patients which also may influence them to leave their jobs (Gillespie et al., 2013). Unhealthy expectations of how nurses should deal with violence can create problems for health systems and the profession's future.

The 2020 NSI National Healthcare Retention and RN Staffing Report by NSI Nursing Solutions, Inc. reported that EDs commonly lose whole RN staff every five years (NSI Nursing Solutions, Inc., 2020). In one study, Jeong and Kim (2018) found that more than half of the participating ED nurses who had experienced violence while at work considered resigning from their workplace. When examining how coping styles played a role in nurses' intentions to resign from their work, Jeong and Kim (2018) found that decreased job satisfaction and coping methods that were driven by emotions, such as blaming themselves, acting unfazed by a situation, or just "dealing with it" after violent incidents, were strongly related to decisions to leave the workplace. Additionally, emotion-based coping styles among nurses seemed to be more influential in the decision to potentially leave than actual job satisfaction (Jeong & Kim, 2018). Violent workplace events coupled with ineffective methods of coping in the aftermath can be detrimental to the mental health outcomes of nurses, patient care, expenses involved in job turnover, and overall work environment. Therefore, building a resilient nursing workforce

equipped with the tools they need for support is vital to ED nurse well-being, the quality of patient care, and retention.

### Debriefing after Trauma

As defined by Hanna and Romana (2007), debriefing is a technique that is commonly used following critical events in which dialogue among peers occurs in order to foster the processing of incidents and sharing of information. They stated that debriefing initiated by leadership in workplaces could be a valuable intervention after exposure to a traumatic event because it acknowledges a person or group's suffering, their responses to that suffering, and encourages coping (Hanna & Romana, 2007). Further, Maloney (2012) stated that the impact of stress provoked by acute and repeated exposure to critical incidents can be harmful to healthcare professionals. Using debriefing as one of many strategies, Maloney (2012) discussed the need to promote a climate that embodies a caring culture for nurses that contributes to alleviating the burden of stress related to critical incidents at work. An organization's response and actions following a critical incident can be critical to an employee's recovery (Paterson et al., 1999). When organizations overlook concerns for employees, it can be a contributing source of further injury (Paterson et al., 1999).

## Literature Review

Violence in the workplace can impact the care nurses provide, the longevity of their career, their mental and physical health, and quality of life. Protecting the nursing workforce by changing the nursing culture around violence and providing a supportive environment for coping is especially important. Post-event debriefing can offer relief to the stressors nurses face due to violence and can provide a means of supporting their coping process. The purpose of this literature review is to discuss themes related to post-incident debriefing in the ED.

## Search Strategy

A search of the Scopus and PubMed databases was conducted. Keywords used in the search included, nurs*, workplace AND violence, psychological debrief*, post-event, post*, critical AND incident AND stress AND debriefing AND emergency AND room OR emergency AND department OR ER OR ED. Articles were included if they focused on patients as the perpetrators of violence in the ED, nurses and other ED staff, and the psychological aspects of debriefing. Exclusion criteria included studies exclusive to nursing students, violence prevention or training, horizontal or lateral violence, professions not in healthcare, not written in English, not a primary study, and debriefs highly focused on clinical or educational performance. Additional articles were hand searched using "similar articles" or "related articles" functions in the respective databases. Fifteen articles met inclusion criteria for review.

## Study Demographics

The reviewed studies included populations made up of mostly nurses as well as physicians, fellows, physician assistants (PA), techs, certified nursing assistants (CNA), and ancillary and administrative staff in the ED setting. A variety of geographical areas studied were represented. The studies were conducted in Australia (n = 4), United States (n = 4), United Kingdom (n = 3), Canada (n = 2), Ireland (n = 1), New Zealand (n = 1), and Scotland (n = 1). Sample sizes ranged from six (Pich et al., 2011) to 461 (Azizoddin et al., 2020). Eight studies were conducted at a single hospital site (Laposa et al., 2003; Pallas, 2020; Spencer et al., 2019; Pich et al., 2011; Cantu & Thomas, 2020; Ugwu et al., 2020; Cudmore, 1996; Clark et al., 2019), and seven were conducted at more than one site (Theophilos et al., 2009; Ireland et al., 2008; Morrison & Joy, 2016; Ross-Adjie et al., 2007; Healy & Tyrrell, 2013; Azizoddin et al., 2020; Sandhu, et al., 2014). Two studies were qualitative (Pich et al., 2011; Clark et al., 2019), eight

were quantitative (Laposa et al., 2003; Spencer et al., 2019; Cantu & Thomas, 2020; Ugwu et al., 2020; Cudmore, 1996; Theophilos et al., 2009; Healy & Tyrrell, 2013; Sandhu et al., 2014), three were mixed methods (Ireland et al., 2008; Morrison & Joy, 2016; Ross-Adjie et al., 2007), and two were implementation projects (Pallas, 2020; Azizoddin et al., 2020).

## Literature Synthesis

### *Workplace Culture and Coping with a Critical Incident*

Given the spontaneous, and opportunistic nature of the ED, nurses may experience one or more critical incidents while navigating through a single shift. How nurses cope with the stress caused by critical incidents appears to be influenced by their workplace culture. From an organizational standpoint, there seem to be feelings of a perceived lack of support from hospital administration in the post-incident phase (Laposa et al., 2003; Ross-Adjie et al., 2007). In Ross-Adjie et al.'s (2007) mixed methods study, they researched multiple Australian ED's from different geographical areas with a sample size of 156 ED nurses to find out how nurses ranked stressful events in the ED and their debriefing practices after these events. Nurses expressed feeling that management did not readily reach out to staff after a critical incident and that there was a need for management to demonstrate more of an active interest in the daily stress that staff endured (Ross-Adjie et al., 2007).

In addition to feeling inadequately supported by management, there appeared to be an existing culture illustrated in the ED that may be impacting how nurses cope with critical incidents. Pich et al. (2011) conducted a qualitative study at a single site in Australia with a sample size of six ED RNs to examine nurses' experiences of violence from patients. All participants from this study reported that violence was "inevitable," with some stating that it was such a regular occurrence that it is, "just part of the job" (Pich et al., 2011). Three studies

reported an expectation of ED nurses to be able to cope with critical incidents as the occurrence of critical incidents are accepted and viewed as a nursing norm (Pich et al., 2011; Morrison & Joy, 2016; Ireland et al., 2008). The source of where this coping culture may root differed among studies and included a lack of resources forcing nurses to take matters into their own hands (Pich et al., 2011), fear of being viewed as inadequate or having poor coping mechanisms by leadership (Morrison & Joy 2016; Ross-Adjie et al., 2007; Healy & Tyrrell, 2013), the assumption of management that everyone is doing fine (Ross-Adjie et al., 2007), fearing that perceived coping skills might affect future job advancement (Ross-Adjie et al., 2007), or that a display of anguish may cause nurses to be moved to an alternative department (Healy & Tyrrell, 2013).

Also contributing to the workplace culture of how nurses cope with critical incidents in the ED is the pressure that is placed on nurses by nurses to fulfill their duties to patients while meeting the demands of their quickly moving workflows. Clark et al.'s (2019) qualitative study took place in the United States at a single hospital site with a sample size of 18 participants, including 17 pediatric ED nurses and one ED CNA. Clark and colleagues (2019) explored participants' outlook and preferences on the CISD process. When discussing emotional aspects of the CISD process, some nurses identified the compartmentalization of emotions in the aftermath of emotionally charged critical incidents as an essential part of remaining professional, functional, and focused for the rest of the shift (Clark et al., 2019). The participants described this action of stowing their feelings away as a protective measure against potentially incapacitating and overwhelming feelings (Clark et al., 2019). Despite being identified as an ED workplace stressor (Ross-Adjie et al., 2007), two studies revealed that nurses often hide behind their workloads in the ED as a means of coping with their emotions (Morrison & Joy, 2016;

Clark et al., 2019). Therefore, it appeared as though nurses may be using one stressor to cope with another stressor. Workplace culture in the ED and the reasons why the culture may exist were concerning in that it may reflect nurse hesitancy to participate in debriefings. In Cantu's and Thomas' (2020) quantitative study in the United States at a single site consisting of a sample of 39 ED nurses, PAs, physicians, fellows, and techs, staff's perspectives of critical incidents, willingness to debrief, and level of well-being right before the start of the Coronavirus pandemic (COVID-19) in that area were assessed. Their findings highlighted the need to strengthen institutional investment in the well-being of providers through interventions such as debriefings and peer support (Cantu & Thomas, 2020).

***Perceived Effectiveness of Debriefing and Identified Differences Among Staff***

The perceived effectiveness of debriefing is an important concept to explore as it may affect buy-in from stakeholders. With competing priorities and time constraints in the ED, nurses' willingness or ability to participate in a debrief can be affected. Regardless of participation, nurses stated a desire to have the option to debrief after a critical incident (Pich et al. 2011; Ross-Adjie et al., 2007; Theophilos et al., 2009; Ireland et al., 2008; Cantu & Thomas, 2020; Cudmore, 1996). Despite the workplace culture around coping with critical incidents in the ED, when debriefing does occur, all 15 articles reviewed supported that it was perceived to be important and beneficial (Laposa et al., 2003; Theophilos et al., 2009; Ireland et al., 2008; Pallas, 2020; Spencer et al., 2019; Pich et al., 2011; Morrison & Joy, 2016; Cantu & Thomas, 2020; Ross-Adjie et al., 2007; Healy & Tyrrell, 2013; Ugwu et al., 2020; Azizoddin et al., 2020; Cudmore, 1996; Sandhu et al., 2014; Clark et al., 2019). Nurses reported that participation in debriefings benefited them by increasing how supported they felt in the aftermath of a critical incident (Laposa et al., 2003; Spencer et al.,2019; Sandhu et al., 2014). Discussing critical

incidents in a group setting allowed nurses to find connections and discover shared feelings with others surrounding clinical events that seemed to bring a sense of relatability and relief from emotional isolation (Pallas, 2020; Spencer et al., 2019; Ross-Adjie et al., 2007; Azizoddin et al., 2020; Cudmore, 1996). In an implementation project at a single site in Australia, Pallas (2020) developed and initiated a response program driven by peers with the goal to provide immediate interventions after stressful incidents in the ED. In the third step of Pallas' (2020) debriefing model, "Ask if anyone wants to share their feelings about the event," he explained that providing people with an opportunity to share their emotions and responses to a critical incident can help those affected realize that their joint reactions to these distressing events are normal. Debriefing was said to make initiating dialogue about well-being among colleagues less difficult after a critical incident and was even reported to contribute to weakening the workplace culture of accepting violence as "part of the job" and using workloads to cope as previously mentioned (Pallas, 2020). Aside from enhancing solidarity through interpersonal relationships, debriefing may also improve understanding between nurses and leadership, thus increasing the perceived benefits of debriefing after critical incidents (Laposa et al., 2003; Azizoddin et al., 2020).

Though acknowledged that critical incident experiences may be processed and managed differently by everyone, debriefing as a supportive strategy after critical incidents may have an impact on nurses' well-being (Morrison & Joy, 2016). Five studies found that nurses believed that one of the objectives of debriefing is to provide emotional or psychological support (Healy & Tyrrell, 2013; Ugwu et al., 2020; Cudmore, 1996; Sandhu et al., 2014; Ireland et al., 2008). In the study by Cantu and Thomas (2020), when reporting their experiences with debriefing, 100% of the nurses who had participated in a debrief about a critical incident in the past year stated that it contributed positively to their well-being. In addition to perceived individual benefits,

debriefing also affected perceived group well-being. Six studies stated that team objectives of debriefing were believed to promote unity and lift morale (Sandhu et al., 2014; Pallas, 2020; Healy & Tyrell, 2013; Azizoddin et al., 2020; Ugwu et al., 2020; Cudmore, 1996). Furthermore, Cantu and Thomas (2020) found that debriefing may create opportunities for new or unfamiliar team members to form a supportive network among their other colleagues.

Interestingly, there were notable differences in how debriefing was perceived across provider disciplines as well as experience of providers. In the quantitative study, Theophilos et al. (2009) recruited a sample of 26 total nurses and physicians in Australia and New Zealand at multiple pediatric ED sites to investigate current debriefing practices and staff needs. There was an overall consensus that debriefing was important; however, it was rated as more important to nurses than doctors (Theophilos et al., 2009). Although, when looking at willingness to debrief, Cantu and Thomas (2020) found no differences among interdisciplinary roles. This combination of importance and willingness to debrief across various clinical roles may indicate high acceptance of debriefing practice in the ED (Cantu & Thomas, 2020). Moreover, the percentage of those willing to debrief was higher among those with the least and most years of clinical experience, while those in the mid-level years were less willing to debrief (Cantu & Thomas, 2020).

Healy and Tyrell (2013) did a quantitative study among 103 nurses and physicians across three EDs in Ireland to determine how important they believed the need for debriefing was after critical events. There was a relationship found that indicated that the more critical incidents a person experienced, the more significant debriefing was believed to be (Healy & Tyrrell, 2013). Perhaps this relationship between experience and debriefing importance existed because providers with less experience have encountered less critical incidents, while their colleagues

with more experience have encountered more critical incidents (Healy & Tyrrell, 2013). Despite reports of a desire to debrief among novice providers (Cantu & Thomas, 2020), Healy and Tyrell (2013) stated that they may have lower reports of perceived debriefing importance because of the possible belief that debriefing is linked to difficulty in coping.

Spencer et al. (2019) performed a single site, quantitative study in the United Kingdom with a sample size of 414 participants that included nurses, physicians, fellows, and CNAs from the ED, acute medical, and intensive care units (ICU). The study focused on the psychological effects and debriefing practices surrounding in hospital cardiac arrests (IHCAs). The authors revealed that providers with more experience were also shown to have a higher probability of being a participant or a leader in a debrief (Spencer et al., 2019). Given the acceptance rate of debriefing by providers with more years of practice, they may have an opportunity to influence acceptability for those with less years (Cantu & Thomas, 2020). Senior influence on those with less experience may be important as two studies showed that experience seemed to be correlated with a larger effect of stress perceived from a critical incident, with less experienced staff being more affected (Spencer et al., 2019; Morrison & Joy, 2016). Spencer et al. (2019) concluded that less experienced staff may be at higher risk of suffering the psychological consequences of critical incidents and therefore, may require extra support. In Cudmore's (1996) quantitative study conducted in the United Kingdom at a single site with 34 participants made up of experienced nurses, CNAs, and student nurses, she examined whether post-resuscitation, discussion-based interventions, such as debriefing and defusing were occurring, and if so, what were nurses' perceptions of these interventions. She found that no correlations between staff ranks and perceived need for debriefing were identified (Cudmore, 1996).

Lastly, although mostly positive perceptions of debriefing were found in the studies, there were some reports of negative feelings towards debriefing. Reasons nurses thought debriefing to be unhelpful involved structural issues such as lack of trained facilitators (Ross-Adjie et al.,2007) and organization (Spencer et al., 2019).

***Lack of Debriefing in the ED and Existing Barriers***

Though debriefing appears to be perceived as useful and received well by nurses and teams of healthcare providers, 11 of the reviewed studies reported that debriefing was underutilized in the ED as a regular practice (Laposa et al., 2003; Theophilos et al., 2009; Spencer et al., 2019; Pich et al., 2011; Morrison & Joy, 2016; Cantu &Thomas, 2020; Ross-Adjie et al., 2007; Healy & Tyrrell, 2013; Ugwu et al, 2020; Cudmore, 1996; Sandhu et al., 2014). Nine of the reviewed studies reported various barriers that may limit the practice of debriefing in the ED. Some of the most notable barriers of debriefing in the ED were lack of time (Spencer et al., 2019; Morrison & Joy, 2016; Sandhu et al., 2014), lack of debriefing policy or guidance (Theophilos et al., 2009; Ireland et al., 2008; Healy & Tyrrell, 2013, Ross-Adjie et al., 2007; Ugwu et al., 2020; Cudmore, 1996; Sandhu et al., 2014 ), and lack of debriefing training (Ireland et al., 2008; Spencer et al., 2019; Morrison & Joy 2016; Ross-Adjie et al., 2007; Ugwu et al., 2020; Sandhu et al., 2014). The importance of policy, guidance, and training was emphasized to keep debriefing uniform and unvarying (Cudmore, 1996). Training was found in some studies to play a vital role in the effectiveness and practice of debriefing in hospitals (Spencer et al., 2019; Ross-Adjie et al., 2007; Sandhu et al., 2014; Ugwu et al., 2020). Whether or not training was received was shown to have an influence on a facilitator's confidence to initiate and lead a debrief as well as the frequency in which a facilitator would initiate a debriefing in the ED (Spencer et al., 2019). The absence of training was associated with

uneasiness in responding to others' reactions to events and a lack of knowledge in performing a debrief (Spencer et al., 2019). The quality of debriefing was also stated to be decreased when the facilitator was not previously trained (Ross-Adjie et al., 2007; Sandhu et al., 2014). Ugwu et al. (2020) conducted a single site study in the United States comprised of a mixed sample of 130 physicians, fellows, PAs, and nurses. Their goal was to examine current debriefing practices and barriers to debriefing after critical incidents. They found that training was also reported to be useful during debriefing to guide facilitators on important points to cover (Ugwu et al., 2020). Regarding the lack of guidance, Ugwu et al. (2020) stated that having a structured debriefing guide is significant to debriefing as it may assist with debrief flow, keeping conversations organized, remaining focused on key points and objectives, and being timely.

The barriers of time and structure were noted to challenge the feasibility of debriefing in the ED. Staff ability to participate in a debriefing after critical incidents was often affected by being unable to find coverage while they stepped away (Pallas, 2020; Ross-Adjie et al., 2007). Additionally, Ugwu et al. (2020), Healy and Tyrrell (2013), and Sandhu et al. (2014) found that ED workload was one of the leading barriers to debriefing. The high number of patients to see and overall busy nature of the ED were mentioned as part of this workload (Sandhu et al., 2014; Morrison & Joy, 2016). Shift patterns in the ED were also pointed out to be a challenging structural issue to initiate a debrief as many people do not begin and end shifts at the same time. This creates complications as organizing an ideal time that suits all affected staff can become difficult (Ireland et al., 2008; Ross-Adjie et al., 2007; Sandhu et al., 2014). If a debrief did not occur on the same shift after a critical incident, there was disapproval expressed by staff about having to come in on a day off or having to recall the event days later (Clark et al., 2019).

Of note, all of the studies in this literature review involved group debriefing. Though not perceived as the top barrier for staff, in the study by Ugwu et al. (2020) feeling disapproval or judgement from others may inhibit the supportive objective of a debrief. Furthermore, interpersonal interactions can impair a debriefing intervention when there is discord between staff (Healy & Tyrrell, 2013). Additionally, the reflective nature of debriefing may bring light to staff behavior and the way actions were conducted during a critical incident, which may not always be positive (Pallas, 2020). Due to this, Pallas (2020) stated that providing a safe space to have a discussion without the fear of there being a potential for legal issues is important in retaining confidentiality and trust. Not feeling safe to share in a group because of existing interpersonal conflicts, fear of negative outside opinions, or penalization may negatively affect the supportive environment needed for a debrief by decreasing overall participation and willingness to disclose honest responses.

***ED Unit-Specific Debriefing Tool Developments***

Two articles in this literature review introduced tools that addressed some of the barriers of debriefing in the ED. Pallas (2020) created a support process named, “Hot Acute Incident Response (Hot AIR).” Acknowledging time constraints in the ED, this model would take ten minutes and would usually take place anywhere from immediately to hours after a critical incident (Pallas, 2020). If coordination of a Hot AIR intervention was complicated by lack of time, they were scheduled at the completion of the shift on a voluntary basis (Pallas, 2020). To better support the turnout of a Hot AIR intervention, nursing leadership was usually called upon to help find ways to relieve affected staff so that they could attend (Pallas, 2020). This not only increased staff ability to attend but also emphasized hospital support for staff participation in this intervention. To counter lack of guidance, the Hot AIR model was a predeveloped, scripted,

seven-step process that was given to trained staff on a small card that they could wear on their badges (Pallas, 2020). They felt that these small cards not only created a uniformed response to critical incidents but also believed that the use of this card improved facilitators' ability to stick closely to the response protocol (Pallas, 2020). Training on the Hot AIR intervention was provided to many staff members from multiple disciplines in a short in-service on the unit where trained participants would then receive a champion sticker which would allow others to easily identify them as a trained leader (Pallas, 2020). Pallas (2020) stated that expanding training to include staff and not just leadership allowed for an abundance of trained staff to be available on every shift.

Similarly, Clark et al. (2019) designed a unique debriefing tool for pediatric ED staff in which they also addressed some of the aforementioned barriers. Authors of this study referred to the process of their model as a "microdebriefing" (Clark et al., 2019, p. 408). Like Pallas' (2020) model, this too had a time expectancy of approximately ten minutes. Facilitators for this model were trained in a class in which they received a continuing education unit (Clark et al., 2019). Additionally, like Pallas (2020), Clark et al.'s (2019) model included a card which they called "Ala Carte Debriefing Template," that could be displayed on staff badges. Though this was not a scripted debrief, the card served more as a topic and discussion guide for the debrief. Lastly, Pallas' (2020) model addressed potential fears about confidentiality and legal issues associated with debriefing by making the choice to not include documentation of the debriefings.

In the quantitative study, Sandhu et al. (2014) surveyed 183 combined physicians, nurses, nurse educators, and fellows across ten pediatric EDs in Canada to explore current post-resuscitation debriefing practices and challenges to debriefing after such events. While recognizing the valuable worth of debriefing for hospital staff, Sandhu et al. (2014) pointed out

that debriefing remained underutilized, underdeveloped, and inadequately supported. Perhaps using unit-specific debriefing models, such as the ones described by Pallas (2020) and Clark et al. (2019) which promoted timely discussion, trained facilitators, guided or scripted debriefs, and the support of leadership, would lead to debriefing being more successfully practiced in the ED.

***Exploring Logistics of Debriefing and Staff Preferences in the ED***

Exploration of current debriefing practices, as well as the preferences of staff regarding length of session, when and where it should take place, who should facilitate it, which situations require a debriefing, and what a debriefing should consist of, may be important in informing debriefing tool development. Existing practices and preferences may assist in creating a debriefing tool which addresses current barriers and incorporates favorable preferences that may increase its usage and enthusiasm amongst staff in the ED. When addressing the question of what to debrief, violence was mentioned in four studies as a critical incident that may call for a debriefing (Laposa et al., 2003; Theophilos et al., 2009; Pich et al., 2011; Ross-Adjie et al., 2007). In studies by Pich et al. (2011), Ross-Adjie et al. (2007), Healy and Tyrell (2013), debriefing sessions were said to usually follow “major” events. For events not considered, “major,” staff expressed feeling that there was an expectation for them to cope with the events on their own or accept them (Pich et al., 2011; Ross-Adjie et al., 2007). Perceptions that debriefing is for major events may create gaps in addressing the stress from events in which the outcome is not perceived as “major” but can still impact nurses emotionally or psychologically. Debriefing sessions were reported or perceived by staff to be geared most towards clinical and emotional aspects of a critical incident (Theophilos et al., 2009; Ireland et al., 2008; Healy & Tyrell, 2013; Ugwu et al., 2020; Azizoddin et al., 2020; Cudmore, 1996; Sandhu et al., 2014). When examining what staff preferences were to help decrease stress after a critical incident and what

they would like to see included in a debriefing, Clark et al. (2019) revealed that staff felt there was not enough positive reinforcement following critical incidents, but that it was desired. Staff also spoke about the high-level of knowledge and performance used in the setting of a critical incident and how important it was to them to have these aspects of their work recognized (Clark et al., 2019). Positive reinforcement directed toward specific people and responses were also noted to be a helpful way for staff to gain positive insights from a stressful event (Clark et al., 2019).

As a recognized barrier to debriefing in the ED, Pallas (2020) and Clark et al. (2019) both gave a nod to the limited amount of time and ongoing clinical staff responsibilities. As a result, they created simplified debriefing tools that were intended to last around ten minutes in length (Pallas, 2020; Clark et al., 2019). One other study reported that their debriefing sessions lasted 25 to 30 minutes; however, they were conducted electronically at set times of the evening when staff were off shift during the start of the COVID-19 pandemic (Azizoddin et al., 2020).

Timing from the end of a critical incident to the debriefing seemed to differ among the studies reviewed. Multiple studies explored debriefing trends and found that debriefing following a critical incident was most commonly initiated immediately (Pallas, 2020; Ross-Adjie et al., 2007; Ugwu et al., 2020), within 24 hours (Theophilos et al., 2009; Healy & Tyrrell, 2013) or within seven days (Ireland et al., 2008). Despite the range of timing reported in current practices, staff preferences represented in three studies seemed to favor debriefing immediately after a critical incident (Sandhu et al., 2014; Ross-Adjie et al., 2007), prior to completion of the shift (Ross-Adjie et al., 2007; Clark et al., 2019; Sandhu et al., 2014), or within 24 hours (Clark et al., 2019). While finding the most practical and feasible time to debrief may be difficult to pinpoint,

some articles brought light to the impacts of taking a break after a critical incident, possibly making immediate debriefing an ideal option when responding to occurrences in the ED.

Reserving time to take a break in the ED may seem difficult to achieve for staff. According to their results, Spencer et al. (2019) shared that more than half of the participating staff reported that they never took a break after IHCAs. During their study, Spencer et al. (2019) looked at the effects of taking a break on staff after IHCAs. Their results revealed that those staff members who took a break after IHCAs were 2.4 times less likely to develop PTSD than those who did not (Spencer et al., 2019). In relation, staff's trauma-screening questionnaire (TSQ) scores, which served as a predictor for PTSD, were higher among those who did not take a break (Spencer et al., 2019). Spencer et al. (2019) attributed this finding to the possibility that utilizing the chaotic workflow of the ED after a critical incident as a coping mechanism to an event may increase one's susceptibility to PTSD. In a mixed methods study, Morrison and Joy (2016) investigated the severity of symptoms, experiences, and methods of coping with secondary traumatic stress amongst 80 nurses across four EDs in Scotland. Similar to Spencer et al.'s (2019) study, having no break in between a critical incident and returning to work was also noted in Morrison and Joy's (2016) study as one participant described the coming and passing of a critical incident followed by an enormity of continuously rolling tasks and priorities, not realizing the impacts of the critical incident until a later time.

In the "microdebriefing" guide created by Clark et al. (2019), one of the options they created for debriefing based on staff preferences for destressing after critical events supported "off unit time" promoting non-clinical activities that emphasized self-care. Cudmore (1996) also supported transition time between returning to work and critical incidents, recommending that this time could be used to evaluate whether a formal debriefing should be held, offer positive

recognition to staff, and give staff the opportunity to informally speak about the situation which may be beneficial to their coping in the immediate stages. The significance of taking a break after a critical incident occurs may serve as a protective factor against the development of mental health issues, discourage practicing potentially unhealthy coping skills, and allow for decompression and ventilation which may benefit nurses as they continue taking care of patients and themselves throughout the rest of their shift.

The location where a debriefing takes place may be a crucial factor in attendance. Both Ireland et al. (2008) and Pallas (2020) stated that debriefs in the ED were typically employed in the same department where the event occurred. Pallas (2020) continued to say that they made an effort to stay close to the care areas in order to promote good staff turnout by minimizing the need to fully disengage from the department.

When examining who made up the attendees in a debriefing, seven studies mentioned that clinical teams were the majority (Theophilos et al., 2009; Ireland et al., 2008; Spencer et al., 2019; Cantu & Thomas, 2020; Ugwu et al., 2020; Azizoddin et al., 2020; Pallas, 2020). Staff preferences seemed to favor the belief that all people involved in the critical incident should be included in the debriefing (Cudmore, 1996; Clark et al., 2019). Despite current practice and reported preferences, Theophilos et al. (2009) and Ireland et al. (2008) found that specific members of the clinical team seemed to dominate attendance, while other staff had less involvement. Additionally, Spencer et al. (2019) reported that more experienced clinicians were more likely to attend debriefings. Uniquely, Clark et al. (2019) highlighted the inclusion of more than just those providing clinical care during a critical incident. They went on to explain that participants of their study expressed that regardless of discipline, all staff who encountered any phase of a critical incident, including ancillary staff such as housekeepers and administrative

staff, should be included in debriefings (Clark et al., 2019). They added that anyone involved could be affected by a critical incident, whether they played a part in the direct clinical aspect or not (Clark et al., 2019).

The question about who should facilitate a debriefing was also examined. Most commonly, facilitators of debriefings were noted to be physicians or nurses (Theophilos et al., 2009; Ireland et al., 2008; Pallas, 2020; Spencer et al., 2019; Ross-Adjie et al., 2007; Ugwu et al., 2020; Azizoddin et al., 2020; Sandhu et al., 2014). Although found in fewer studies, other roles such as social workers (Pallas, 2020; Ugwu et al., 2020) and psychologists (Theophilos et al., 2009; Azizoddin et al., 2020) were also noted to facilitate debriefings. Staff preferences on who should facilitate a debriefing included either an attending physician or a charge nurse (Cudmore, 1996; Sandhu et al., 2014; Clark et al., 2019). In surveys about current debriefings, participants had mixed responses stating that the majority of debriefings were led by someone not involved in the critical incident (Theophilos et al., 2009) or by someone who was involved in the critical incident (Ireland et al., 2008). Similarly, the responses about whether the facilitator leading the debrief should or should not be a person involved in the critical incident varied. Ireland et al. (2008) reported that debriefs were commonly led by people who were involved in the critical incident, while others reported the belief that the facilitator does not have to be involved in the critical incident to facilitate a debriefing (Sandhu et al., 2014). Participants in Ross-Adjie et al.'s (2007) study expressed that someone who did not work in the ED was preferred in order to preserve confidentiality. Despite this variability, Clark et al. (2019) mentioned that ED nurses felt that another nursing peer, someone who they felt they could relate closely to and vice versa, made debriefing optimal.

### ***The Importance of Informal Support and Peers***

The natural gravitation to peers after a critical incident seemed to be a commonly occurring staff behavior which highlighted influences of the supporting role that peers play in the aftermath of an event. Cudmore (1996) mentioned informal defusing, explaining it as a spontaneous conversation among peers directly after an event about the event. The opportunity for these informal conversations were said to arise usually as staff cleaned up, refilled supplies, or during breaks (Cudmore, 1996). Talking and reflecting with peers on a regular basis was acknowledged as a highly practiced norm without the realization that they were actually managing stress (Morrison & Joy 2016). Informal conversations among peers in the ED were reported to happen more frequently than formal ones, such as debriefing (Spencer et al., 2019; Pich et al., 2011; Morrison & Joy, 2016; Cudmore, 1996; Laposa et al., 2003). These conversations were often looked to as a valuable method of coping with the stress of a critical incident (Pich et al., 2011; Morrison & Joy 2016; Cudmore, 1996; Ross-Adjie et al., 2007; Sandhu et al., 2014; Clark et al., 2019) and were said to serve as a perceived benefit to making improvements and lifting team spirit (Cudmore, 1996). Laposa et al.'s (2003) study at a single site in Canada with sample size of 51 nurses, physicians, unit secretaries, techs, and cleaning services personnel examined responses to questionnaires about PTSD severity, stressful events at work, and management of this stress. Of significance, fostering positive social relationships in the ED were highlighted as a suggested protective factor against PTSD symptoms (Laposa et al., 2003). Good relationships between staff may increase the likelihood of them participating in defusing with one another which can be beneficial to their well-being (Laposa et al., 2003). Most participants in Thomas and Cantu's (2020) study revealed that they wanted and were willing to have post-incident, peer-based conversations about critical incidents with one another. The

intuitive, informal peer-to-peer interactions occurring after critical incidents shines light on the important resource that peers may play in dealing with critical incidents.

Peers in particular were found to be significant outlets for decreasing stress and processing emotions related to critical incidents (Clark et al., 2019). ED staff spoke about owing the same care to coworkers as they did patients when something traumatic happens and how much the support of peers can affect how work stress is managed (Morrison & Joy, 2016). Social support from work peers was said to be more favorable and effective than other sources of support, such as family and friends, because fellow staff had a shared understanding of the event and felt they could relate more closely to one another's emotions (Clark et al., 2014).

Concerns regarding burdening others with event details and adherence to patient privacy also made work peers a more desirable option as the inability to fully talk about an event with others could disrupt stress reduction efforts (Clark et al., 2014). While the complexity of the ED offers a variety of challenges for debriefing, Pallas (2020) and Cantu and Thomas (2020) emphasized the practicality of using peers as responders in the immediate phase of a critical incident. Peers were explained to be an accessible, low-resource support for post-incidents in which staff from different disciplines could participate, interact, and strengthen interdisciplinary cohesion (Pallas, 2020; Cantu & Thomas, 2020). While support from peers and debriefing interventions seem to be beneficial in the ED after critical incidents, they may not always be an effective stand-alone intervention for those experiencing trauma in the workplace as further support may be needed (Pallas, 2020).

### ***Resources Beyond Debriefing***

Organizational options for further support extending beyond debriefing were either offered or suggested in six studies (Ireland et al., 2008; Pallas, 2020; Ross-Adjie et al., 2007;

Cudmore, 1996; Clark et al., 2014; Azizoddin et al., 2020). Whether further support is needed outside the capacity of a debrief (Clark et al., 2014), the literature showed opportunities to debrief was initially missed or declined (Cudmore, 1996; Ross-Adjie et al., 2007) or staff preferred a one-to-one debriefing environment over a group setting (Ross-Adjie et al., 2007). Therefore, knowledge about options for accessible, no cost, confidential support services provided by the organization is essential (Ross-Adjie et al., 2007). In Ireland et al.'s (2008) mixed methods, multiple site study staged in the United Kingdom, they surveyed 180 nurses and physicians regarding existing debriefing practices after unsuccessful resuscitation of pediatric patients. They reported that debriefing should serve as a gateway to organizational support services should staff need them (Ireland et al., 2008). Not having the proper follow-up support can potentially put pressure on staff to provide support for which they are not trained to do (Ross-Adjie et al., 2007). Knowing that peers may be followed-up with after traumatic events was reported to alleviate any expectations of staff to support peers beyond the boundaries of comfort (Pallas, 2020).

### *Debriefing Best Practices*

**Ground Rules.** Since the nature of a debriefing may include sharing emotions or reflecting on an emotionally charged event, the establishment of ground rules may be significant in setting the tone for a safe and low-pressured space in which people feel comfortable participating. Firstly, voluntary, unforced participation was the most mentioned ground rule in the studies reviewed (Ireland et al., 2008; Pallas, 2020; Ross-Adjie et al., 2007; Azizoddin et al., 2020; Cudmore 1996; Clark et al., 2014). In addition, an environment free of judgment and blame was reported to be valued by staff (Ireland et al., 2008). An environment that did not enforce this rule may turn debriefing into a time of criticism and complaining, which staff

reported may counteract the purpose of the intervention causing increased stress and angst (Ross-Adjie et al., 2007).

Maintaining confidentiality was another ground rule which highlighted the importance of protecting participants in debriefing (Pallas, 2020; Azizoddin et al., 2020). In discussing confidentiality in the context of debriefing, Pallas (2020) reported that he chose to not document interactions between staff in order to preserve the privacy of others and safeguard the information being shared. In another study, Azizoddin et al. (2020) implemented an online debriefing program at two sites in the United States in which 81 people total attended over six weeks to promote resilience and make quality improvements during COVID-19. Contrary to Pallas (2020), Azizoddin et al. (2020) did provide a summarized document of the debriefing session contents; however, confidentiality was maintained as all responses were labeled anonymous and used for the purposes of communicating group concerns with leadership, making suggestions for the future, stating requests, and improving processes. Setting up ground rules such as making debriefing optional for staff, enforcing a blame and judgement free zone, and maintaining confidentiality, may be important in staying true to the intentions of a debriefing and how well people receive it.

**Recommendations for Debriefing Practice in the ER.** While it is generally believed that ED staff frequently encounter critical incidents in their working environment, there remains a lack of designed approaches and responses for guiding immediate and follow-up support for staff (Pallas, 2020). The ED is a fast-moving, unforeseeable environment which may benefit from a structured debriefing model that is tailored to fit these conditions in a timely fashion with minimal interruptions to workflow (Ugwu et al., 2020). Although traditional models of debriefing, such as CISD, do exist, incorporating them into the ED can be difficult due to the

busy, time-sensitive nature of the work (Clark et al., 2014). Learning the obstacles that are unique to a unit and finding ways to meet them through the development of a debriefing, such as "microdebriefings," may give staff the opportunity to build resilience against ongoing critical incidents and improve the quality and safety of care when time does not allow for a formal debrief (Clark et al., 2014).

Acknowledging the challenges of the ED may be important when making recommendations about debriefing as recommendations from the literature seemed to stem from barriers regarding time, training, and guidance. Creating a protocol that allows staff to step away from their work in order to participate in a debrief was suggested as a way to support staff debriefing time (Morrison & Joy 2016; Ross-Adjie et al., 2007; Cudmore, 1996). Also, providing training to those who would employ a debriefing (Ross-Adjie et al., 2009; Ugwu et al., 2020; Spencer et al., 2019; Cudmore, 1996; Sandhu et al., 2014) and establishing guidelines for debriefing were recommended (Healy & Tyrell, 2013; Spencer et al., 2019). To aid with both of these recommendations, the development of a debriefing tool or guide for facilitators was suggested as a way to potentially increase the quality and use of debriefing in the ED (Sandhu et al., 2014; Ugwu et al., 2020). The inclusion of debriefing as part of the educational training for staff and students of healthcare professions was urged (Ugwu et al., 2020; Spencer et al., 2019). Additionally, it was suggested that responses to critical events include a combination of informal defusing and formal debriefing methods as this could be a viable, realistic option specific to the ED (Sandhu et al., 2014). Lastly, while debriefing may be perceived as beneficial and important to staff in the ED, there remains a call for further research regarding effectiveness and best method options in the diverse setting of the ED (Laposa et al., 2003; Ireland et al., 2008; Spencer

et al., 2019; Pallas, 2020; Cantu & Thomas, 2020; Ugwu et al., 2020; Cudmore, 1996; Sandhu et al., 2014; Clark et al., 2014).

**Limitations of the Literature**

The studies in this literature review did have several limitations. One of the most notable limitations was the retrospective nature of most of the studies, which may have led to recall bias. Another limitation was the fact that self-report was a main point of data collection. Both potential biases left room for the possibility of suppression, enhancement, or fabrication of information when reporting about experiences. In hindsight, researchers could have also obtained data from sources, such as unit debriefing forms and incident reports, in order to include more objective information regarding critical incidents and post-incident debriefs. Furthermore, the collection of studies in this review were mostly based off convenience samples in which responses were voluntary. Therefore, nonresponse bias was a factor in the literature. Those who participated in the studies may have valued and supported post-incident debriefing more than those who did not wish to participate, which may have led to a misrepresentation of the population. Also, due to the sensitive nature of critical incidents, participants may have skipped questions that they did not feel comfortable answering, which may have skewed results.

Moreover, the results of these studies were difficult to generalize for several reasons. Many studies were conducted at a single site and had samples that were primarily comprised of females and experienced clinicians. The inclusion of a more diverse sample may bring to light information about the differences between sexes and experience levels and how they cope with and receive support after critical incidents. Geographical considerations were also a barrier to making generalizations (i.e., rural vs. metropolitan). The differences in ED specialties, such as adult versus pediatric care, workflow, existing support, and work culture, and the mix of

healthcare workers in the ED, make the inferences about whole units or the nursing profession difficult. Finally, out of the 15 studies, only one specifically addressed workplace violence and post-incident debriefing (Pich et al., 2011).

## Summary

The literature reviewed suggested that while debriefing is perceived to be valuable to staff and their well-being after critical incidents, there are various barriers that make it challenging to practice in the ED. This literature review conveyed the importance of peers as a source of support and relatability after critical events and recommended a mixture of informal and formal debriefing techniques. The combination of findings from the literature advocated for a post-incident debriefing tool that was guided, resource efficient, peer-driven, and timely to realistically meet the needs of staff in the bustling ED environment.

# Approach

This section outlines the methods of this applied project including the approach to developing the badge buddy description (see Appendix B) and badge buddy itself (see Figure 1) as well as the means for receiving feedback on the tool from an expert review panel (see Appendix C).

## Project Description and Goals

The applied project was the formulation of a badge buddy tool called P.E.E.R.S. that could be used to guide the facilitation of an informal discussion response after a code gray (see Figure 1). It incorporated support from peers among ED nurses. The tool was designed to be used in the immediate post-incident phase of a violent interaction between a nurse and patient that results in a code gray. The goal behind formulating this tool was to (a) create a space for nurses to process and express their feelings toward violent events in a manner that fit their

workflow and allow them to transition between the actual event and returning to their duties; (b) allow nurses to build a therapeutic environment that does not support the current culture of violence in the workplace; and (c) potentially mitigate the negative consequences of violence on nurses. The tool was targeted for nurses in the ED setting of a large academic medical center in California but could include other members of the healthcare team in the response. While this tool was crafted, it was not implemented as part of the thesis process. See Appendix D for an example of how this tool might be used in practice.

**Developing Foundation from Current Practice**

Two existing employee support resources were identified at the targeted medical center. Meetings were set up to discuss the programs and this project in further detail. The first discussion took place with the director of the academic and staff assistance program (program A). As a result of this meeting, a discussion with the peer support program (program B) coordinator was recommended. After reflecting on the conversations from the meetings, a comparison of the two programs was made. Program A consisted of a formal debriefing program for employees that was carried out by a clinical psychologist and follows the CISD model which typically lasted between one to three hours. The timing of the debrief was scheduled depending on best availability of staff and was performed individually or in a group. Program B differed in that it was an informal, one-on-one response using trained peer responders, including peers from the same unit. The initial interaction happened immediately after a critical incident and was based off the PFA framework. Program B could serve as a bridge for participants until they got to program A, assuring that at no time a person was without support. Neither program was intended to be for diagnostic purposes, nor were they a replacement for professional psychological services, and participation was always voluntary. As a result of both meetings, the

decision to combine components from both the CISD model and PFA framework for the badge buddy tool was made.

The third meeting came about after speaking with the Clinical Nurse Leader in the ED who recommended presenting the preliminary idea of this project to the ED Safety Committee. An email was sent to the ED Safety Committee Chair during summer 2020 and an invitation was setup with a 15-minute timeslot for presentation to measure interest and generate thoughts regarding this unit-specific acute response to code grays. Feedback from members acknowledged the lack of space after violent incidents and returning to work, and they stated that going to the next task was what they felt was expected of them and necessary to their workflow. They expressed interest in an intervention that fit the workflow, promoted togetherness, and supported them through the rest of their shift. As a result of this meeting, the chair of this committee then recommended attending the ED debriefing champion class.

After reaching out to the chair of the ED Debriefing Champion class via email, the class was attended summer 2020 to gain further insight on current debriefing practices particularly in the ED apart from programs A and B. Class facilitators shed light on their recently developed informal, scripted “Mini Debriefing (15 minutes or less),” that addressed both the clinical facts of a critical incident as well as the psychological and emotional matters of the lived experience of the people involved. The class attended was the fifth class taught, signifying the novel nature of this type of debriefing at this institution. They also stated that the ED was embracing a movement toward peer support. This style of debriefing was recently established after a unit survey was completed regarding debriefing where surveyors had the opportunity to learn about staff feelings regarding support on the unit, barriers to debriefing support, and situations in which staff would want to debrief.

During this class, training on how to run through a short debrief was simulated. As an example, one of the simulations included watching a video about a real experience in which a young man was pulled from the water of a crowded beach while on vacation, unresponsive, requiring cardiopulmonary resuscitation (CPR), with his distraught friend by his side. After each of the different video scenarios, each person followed the scripted debriefing tool provided that was used by this ED to facilitate being a participant in the debriefing process as well as leading the debriefing process. This was helpful in seeing how following a debrief with specific guidelines and ground rules could make leading the debrief easier for all participants.

All three support programs explored at the targeted medical center demonstrated institutional support for staff in the aftermath of a critical incident. These programs were interconnected to one another, which allowed staff to receive a streamline of support from the incident to the intervention and promote knowledge around support options available to them that best suit their needs or style of coping.

**Influences from the Literature**

Components of this tool revolving around time and training were influenced by barriers discovered in the literature. With the ED moving at a fast pace, time was an important factor to consider when building the badge buddy. Even after violent events, the unforgiving, fast-paced nature of the ED with its many competing priorities can leave little time for debriefing (Spencer et al., 2019; Morrison & Joy, 2016; Sandhu et al., 2014). Therefore, to make the response intervention more feasible for nurses, the decision to make the tool fit a ten-minute timeframe was made. Another identified barrier in the literature was a lack of trained facilitators (Spencer et al., 2019; Ross-Adjie et al., 2007; Sandhu et al., 2014; Ugwu et al., 2020), policy, and guidance (Theophilos et al., 2009; Ireland et al., 2008; Healy & Tyrrell, 2013, Ross-Adjie et al., 2007;

Ugwu et al., 2020; Cudmore, 1996; Sandhu et al., 2014). This tool was built to be simple so that anyone who wanted to lead a response intervention at any given time, whether it was done by themselves, between two coworkers, or among the involved group, would be able to do so by following the information on the badge buddy (see Figure 1). By creating a simple tool, the possibility of training everyone to use was higher. Saturating the department with trained staff, rather than designating only certain staff could assure that trained staff would be available on each shift (Pallas, 2020). Having a scripted response intervention was considered to guide the facilitator and keep each response intervention standard (Pallas, 2020). Placing the script on a badge buddy made it mobile and readily available.

The location of the P.E.E.R.S. response intervention was chosen to be somewhere near or on the unit (Ireland et al., 2008; Pallas 2020) as this may have increased the likelihood of attendance (Pallas, 2020). The decision to implement the P.E.E.R.S. response intervention in the immediate phase of a code gray was made in order to provide space between the event and returning to work duties as this was supported by several studies (Spencer et al., 2020; Clark et al., 2019; Cudmore, 1996) and was noted to be a potential protector from the negative impacts of an event (Spencer et al., 2020; Clark et al., 2019; Cudmore 1996). The inclusion of all involved staff in the P.E.E.R.S. response intervention was important as clinicians are not the only staff affected by the events that occur in the ED (Clark et al., 2019). The peer-driven aspect of this project was influenced by the natural (Cudmore, 1996; Morrison & Joy, 2016) and frequent (Spencer et al., 2019; Pich et al., 2011; Morrison & Joy, 2016; Cudmore, 1996; Laposa et al., 2003) reliance on peers for support through informal discussion known as defusing which studies mentioned as beneficial for staff coping (Pich et al., 2011; Morrison & Joy 2016; Cudmore, 1996; Ross-Adjie et al., 2007; Sandhu et al., 2014; Clark et al., 2019), well-being (Laposa et al.,

2003), and team morale (Cudmore, 1996). The P.E.E.R.S. response intervention demonstrated on the badge buddy was meant to be an informal, structured discussion about an event. Ground rules were included in the badge buddy to setup boundaries for staff and emphasize voluntary participation (Ireland et al., 2008; Pallas, 2020; Ross-Adjie et al., 2007; Azizoddin et al., 2020; Cudmore 1996; Clark et al., 2014), maintain confidentiality (Pallas, 2020; Azizoddin et al., 2020), and promote a healthy blame-free, non-judgmental discussion (Ireland et al., 2008) (see Figure 1).

Additionally, the literature revealed that most violence experienced by nurses is verbal and occurs very frequently (Pich et al., 2011). As a result of this knowledge, in order to avoid overuse of the tool which may dull the significance of the P.E.E.R.S. response intervention and the impact on staff, code grays were chosen as the target reason for activating the response intervention because they often involve some form of physical violence, verbal violence, or both towards staff (Knott, J. C., Bennett, D., Rawet, J., & Taylor, D. M.,2005). While physical violence can often result in visible injury, the injuries of verbal violence can be less obvious. Code grays present the opportunity to capture and address the potential negative impacts of both physical and verbal violence on a nurse.

**Content**

The graphic design of the badge buddy was intended to be visually simple and user-friendly. The badge buddy overall included how to open the response intervention, ground rules for the discussion, a sequential five-step process represented by the acronym P.E.E.R.S, a closing statement, and additional institutional and unit support resources (see Figure 1). The acronym P.E.E.R.S. was chosen as a word that represented the peer-driven nature of the tool and to make

it easy to recall. The acronym served as a scripted guide for facilitators to follow in order to lead the team in discussion and direct dialogue.

The “P” stands for “Present Ground Rules,” and includes an opening statement for the participating staff and reviews the ground rules of the response intervention. The “E” stands for “Encourage Safety,” and declares a safe place of sharing and maintaining confidentiality of the discussion that takes place. Opening the discussion with these two components was important for setting the tone of the response and setting up boundaries for all involved. The second “E” stands for “Explain the Event,” and asks participants to briefly explain the event under discussion. This was included to briefly provide an overview of the situation that the discussion revolved around. The “R” stands for “Reactions and Reflections,” and invites participants to share their reactions and what went well. These were added to the tool to create a sense of shared support, community, and relatability among participants. The “S” stands for “Support and Step Away,” and asks participants how they can support one another for the remainder of the shift, or if anyone needs to step away from the unit before continuing to work. This was added to promote a culture of caring for self and others during violent incidents. Alternate resources were offered by the institution and were included in the tool to increase awareness of other options for support and to combat the stigma of needing assistance to cope as a sign of weakness.

While the P.E.E.R.S. tool was created to trigger an optional and informal debriefing after a code gray, the hospital protocols after incidents of workplace violence will still be upheld. One way that the P.E.E.R.S. tool could mesh with existing protocols is during the support and step away feature of the tool. This could be used as a time to fill out required documents, such as an incident report (IR) about the event, if the participants chose to use their “step away” time for this. Making the tool an optional response instead of an official protocol was decided because the

priority objective of the tool was to initiate a supportive workplace culture through conversation among peers surrounding an event without the pressure of it being required or documented. Though the expectation was that the tool would serve to support staff, potential misuses of the tool could arise if participants are not following the ground rules.

**Process of Evaluation**

A panel of five experts reviewed and evaluated the preliminary P.E.E.R.S. badge buddy response tool and feedback was returned. The expert panel included stakeholders from the targeted medical center, such as the Director of the Academic and Staff Assistance Program (ASAP), Chair of the ED Safety Committee, SUPPORT U Program Coordinator, Workplace Violence Laison, and Chair of the ED Peer Support Team or Debrief Champions. This expert panel was chosen for their experience working in the ED, involvement in workplace violence matters at the medical center, and expertise in staff support throughout the institution.

Each expert received an introductory handout to provide context for the badge buddy (see Appendix B) along with the P.E.E.R.S. badge buddy tool (see Figure 1). In the email, a brief description of the project was provided. The expert review survey consisted of six free response questions about graphics, content, language and grammar, usability, recommendations, and a sixth question was added for any other comments not addressed in the survey (see Appendix C). All five experts completed and returned the survey through email, and then their responses were compiled.

## Expert Feedback Results

In the category of graphics, three of the five experts agreed that the badge buddy was aesthetically pleasing. The remaining two experts reported feedback regarding font size and clutter. One of them stated that the graphics “convey a warm tone”; however, they recommended

removing the icons from the left-hand side in order to accommodate a larger font. The second expert recommended, “decrease the amount of content on this as it is a bit busy.” Given the small size of a badge buddy, these suggestions prompted the removal of the icons, and the font size was increased.

The evaluation of content got a “yes” response from three experts with the fourth stating, “The content is excellent and highlights the major parts of the debriefing process.” There was feedback offered by the fifth expert who requested clarification about the definitions of peer support and debriefing being used in this project. They stated, “Also, you discussed peer support, are you describing formal or informal peer support? Could you provide your sources for the project regarding the structure of the debriefing and the guidelines for the peer responder.” The fifth expert also had concerns about the time limit on the intervention stating, “Putting a time limit on providing support to the second victim can be problematic. Do you have suggestions for your peers if they encounter situations where it takes more than 10 minutes?” With respect to the limited amount of information to be displayed on the badge buddy, these suggestions were opted out of being on the badge buddy; however, language was changed from “debrief” to “response.” Additionally, clarification on the informal nature of this discussion was added to the introductory handout to solidify that this response intervention was not a formal debrief or formal peer support intervention, nor would this response intervention serve as a substitute for either of these interventions. The word “informal” was inserted on the badge buddy near the title to make this apparent. Additional support resources were put on the back of the badge buddy for facilitators and participants to refer to should the response need to extend beyond its intentions.

The fifth expert also asked, “Do you have specific training that you are providing your nurses to lead these groups? Is this debriefing an evaluation of an event? Do you track your

events?” For this thesis, formulation of the tool was placed as a priority, and training staff would be a future action. The decision was made not to track events as this was not a clinical review but simply an opportunity for peers to discuss the event and support one another after the event and throughout the rest of the shift. Furthermore, documentation of the discussions may affect feelings of safety among participants and ability to express themselves openly.

For language and grammar, three experts offered feedback, while the other two had no recommendations. Of the three who provided feedback, one expert spotted a grammatical error, and this was fixed. The second expert made grammatical changes and various suggestions for tweaks in the language that promoted a softer and more therapeutic tone. For example, in the ground rules section, “Speak objectively,” the expert commented, “I think I know what you’re getting at here, but I think we actually want people to speak *subjectively* from their experience; maybe add ‘All feelings are welcome and are valid.’” Under the encourage safety section, the same reviewer changed the original statement from, “What is said in this debrief, must remain confidential,” to “Can we all agree to keep what is said in this debrief confidential?” The third reviewer commented, “Clarification of definition and content,” which was addressed in the content category previously.

In the category of usability, three experts reported that instructions were clear and easy to follow. Another expert agreed and commented, “quite usable for facilitators.” This expert had several comments about future training for this tool stating, “I’m assuming that there is/will be a training session for peer supporters to run through the process and discuss potential glitches/surprises that might need to be addressed (e.g., what to do when someone runs out of the room sobbing; how to field specific questions about confidentiality etc.) In the reactions/reflections part, it’s nice to remind the peer supporters to normalize the trauma

response(s) to help contextualize the experience of participants after the event." While this thesis revolved around development of the badge buddy, future steps would include details on training and acknowledging potential situations such as the ones mentioned by this expert. Another expert commented on this section stating, "Do you intend for the individuals to read from their badge? It is not recommended that Peer Responders read from a script as it can discourage the recipients from feeling safe." The script on the badge buddy was intended to serve as a guide for the facilitator to direct discussion and to standardize the response. Therefore, corrections were not made to this component of the badge buddy.

Under the recommendations and comments sections, one expert had no further recommendations. Two experts brought to light why the discussion of, "what could we have done better," was not included. The decision to exclude matters about improvement was made because the focus of the tool is to provide support to peers. Two experts mentioned the fact that debriefing is mandatory at this targeted hospital after a violent incident. One expert suggested making a reference to the debrief form attached to the policy somewhere on the card, and the other stated, "Just curious how/if that fits in with your project." In respect to the policy at the targeted facility, the decision to change the language from a debrief to a response intervention allowed there to be a separation between the two processes to eliminate confusion. Leaving the debriefing policy off the badge buddy and limiting the card to sources of support help keep support as the center of this card.

Two separate meetings were setup via Zoom with two of the experts after the feedback was received. Major changes were discussed with these experts, such as clarification of definitions between debriefing and peer support, and they both agreed that the word "response" was a better term for this project and the title of the badge buddy was changed. Another

important change that was discussed with one of the experts was the script on the badge buddy and concerns for safety of the participants. This reviewer was concerned that reading a script might come off “robotic” and stated that providing support to peers was really about listening, “especially for emotional debriefing.” The discussion of structuring conversation and standardization occurred, and it was agreed that the script was useful in this way. The time limit of the response was also another issue that needed to be talked about with this expert. She stated that boundaries for this intervention needed to be set, “This is what you are, and this is what you are not. Let people know it is only X amount of minutes long.” This feedback was noted and boundaries for this intervention were included in the handout and the word “informal” was added near the title on the badge buddy to ensure a distinction between this intervention and formal ones.

## Discussion

This applied project has shed light on the practice of debriefing in the ED. The ED is a special environment in that it is one of the most studied areas of workplace violence with predisposing risk factors, such as long wait times, frequent run-ins with patients experiencing acute alcohol and drug effects, 24-hour access, and high community traffic. Nurses exposed to these environments at work often suffer from psychological consequences that affect their well-being (Tadros & Kiefer, 2017). Additionally, nurses have been known to leave the job because of their experiences of violence in the workplace, impacting organizations and the profession as a whole. As the literature showed, nurses often see violence as being “inevitable” and “part of the job,” which may be affecting their abilities to cope with the effects of violence. This applied project was inspired by these associations of patient to nurse violence in an effort to bring action to supporting nurses in the aftermath of violent episodes through debriefing, PFA, and peer

connection. The motivation behind creating this tool was to be able to promote early, healthy processing, and acknowledgement of violent incidences to alleviate stressors, enhance a supportive nursing culture, and bring peers closer together.

After exploring the targeted institution's current support offerings through meetings and a class, the CISD and PFA frameworks were chosen as the foundation of this response tool. A search of the literature revealed multiple barriers to debriefing in the ED that needed to be addressed in the development of this tool. Main issues revolved around feasibility and included limited time (Spencer et al., 2019; Morrison & Joy, 2016; Sandhu et al., 2014), lack of trained people (Spencer et al., 2019; Ross-Adjie et al., 2007; Sandhu et al., 2014; Ugwu et al., 2020), and guidelines and policy (Theophilos et al., 2009; Ireland et al., 2008; Healy & Tyrrell, 2013, Ross-Adjie et al., 2007; Ugwu et al., 2020; Cudmore, 1996; Sandhu et al., 2014).

This tool was intended to be a low-resource intervention that could operate within the natural workflow of the ED in order to increase its usage. The workload in the ED was one of the most notable barriers to debriefing that was reported in several studies (Ugwu et al., 2020; Healy and Tyrrell 2013; Sandhu et al., 2014). The timely characteristic of the tool, allotting ten minutes for nurses to discuss an event may be more feasible, allowing them to find comfort in being able to transition between a violent event and returning to work or to the next patient without consuming too much time. To combat the reported lack of training and guidelines and offer standardization, the five-step acronym P.E.E.R.S. served as a user-friendly guide in which any nurse or staff member could lead the response. While this project did not include implementation of the tool, training on how to lead the response will be important in carrying out this response in the future.

Aside from feasibility, setting a therapeutic tone with emphasis on peer-based support for ED nurses was another key element incorporated into this tool. The fact that peers were often an intuitive source of support (Morrison & Joy, 2016) and informal peer-to-peer conversations were reported to be beneficial for coping after critical incidents (Pich et al., 2011; Morrison & Joy 2016; Cudmore, 1996; Ross-Adjie et al., 2007; Sandhu et al., 2014; Clark et al., 2019) made peers response the driving force behind this intervention. Also, incorporating ground rules into the response was crucial in creating and maintaining a therapeutic environment.

After the tool was evaluated by the expert panel, contributions from experts were applied. This resulted in a clarification of definitions that changed the tool's identification from a "debrief" to a "response" in order to avoid confusion and facilitate future implementation at the target institution. In addition, the word informal was added to the card to distinguish this intervention from formal interventions being offered by the institution. Ground rule language and language throughout the badge buddy was also altered to promote softer and more positive tones which highlighted the therapeutic nature of this tool.

**Limitations of Project**

Just like program A and program B at this institution, this tool is not intended to serve as a diagnostic evaluation or treatment for psychological disorders. This tool was an informal, guided discussion meant to serve nurses and other ED staff in the immediate post-violence period and was a bridge to more formal services if needed. While the time allotted to carry out a debrief may fit the workflow of the ED, nurses may desire more time to express themselves and process an event. The tool encouraged peer-to-peer support, and while peer support can be beneficial to nurses' coping, this environment may not be for everyone. A level of trust must be established for people to feel comfortable with expressing their true reactions and feelings

around an event knowing it will be kept confidential. Therefore, if people do not trust one another, the tool may not be as effective as a conversation piece between coworkers.

### Next Steps

The next step in this applied project would be to create an implementation plan. Due to barriers, such as the lack of adequately trained staff and guidelines to lead debriefs in the ED, a short training session with the ED Safety Committee would be needed. While this training would eventually need to be incorporated into ED staff meetings where most staff is in attendance, a smaller group to pilot the training session would be done first. The goal of this training would be to increase staff confidence and familiarity with using the tool so that they will feel more knowledgeable and comfortable initiating a response among their peers. Components of the training session would include information from the introductory handout (see Appendix B) as well as topics suggested from the expert panel, such as outlying scenarios that may be encountered during a response and answering any questions staff may have. Within this meeting, the opportunity to simulate a response within groups after video scenarios of violent events that might typically prompt a code gray would be provided. Feedback from the staff and leadership after the meeting would be invited and revisions made accordingly. Before rolling this project out any further, there may need to be approval from Risk Management, and badge buddy cards would need to be produced for all trained employees. Further research anticipated for this project would be to audit the number of responses done using the tool in over one month and asking for feedback regarding improvements needed and effectiveness in relation to the goals of this tool.

## Conclusion

Nurses are a vital part of the healthcare workforce, and they care for patients in some of their most vulnerable states. In their duties of performing care to patients, violence can often

occur from patient to nurse for a multitude of reasons. Though under-reported, healthcare workers are known to experience some of the highest rates of violence when compared to other professions (The Joint Commission, 2018). In order for nurses to continue to provide care, they too may need care, especially after being mistreated by others. Providing a space for nurses to express themselves, feel supported, and provide support to one another may be a key step in reducing the harmful effects of workplace violence to their careers and personal lives. Preservation of nurses' health should be a priority to organizations in order to retain a healthy workforce.

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## Appendix A

## Glossary of Terms

**Code Gray:** A hospital emergency code that informs staff of a violent or combative person with no observed weapon. When a code gray is initiated, members of the team including ED personnel closest to the location where the activity is occurring, and in-house security and police will respond to the event. Typically, the response involves interventions such as verbal de-escalation, or a more hands-on approach that results in the placement of a person in physical restraints, administration of chemical restraints, or both, to protect the safety of the patient and staff.

**Critical Incident:** An unexpected incident that occurs in which the coping mechanisms of those affected may be overwhelmed, resulting in threats to the well-being of those directly affected or who witnessed the event (Everly, Flannery, & Mitchell, 2000). Critical incidents can lead to negative sequalae in those who experience them (Everly et al., 2000).

**Critical Incident Stress Debriefing (CISD):** A supportive seven phase structured intervention for small, related groups after a critical incident that focuses on discussing the psychological and educational aspects of a traumatic event. The goals of CISD are to decrease stress, foster togetherness, normalize responses, strengthen performance, and promote recovery (Mitchell & Everly, 1997).

**Psychological First Aid (PFA):** A supportive framework for trained personnel who help others experiencing overwhelmingly stressful events (World Health Organization [WHO], 2011). The

framework is heavily based on social and psychological support, with concern for the uniqueness of individuals and human dignity (World Health Organization [WHO], 2011). Gispen and Wu (2018) explained PFA interventions in healthcare as being comparable to the quick actionable responses taken when a patient is physically deteriorating to prevent further deterioration. The core interventions of PFA include look, listen, link, and limits (Gispen & Wu, 2018).

**Types of Workplace Violence in healthcare:** There are four types of workplace violence that healthcare providers may encounter at work (American Nurses Association [ANA], n.d.):

1.) Criminal Intent: Violence committed is related to a crime in which the perpetrator and healthcare worker have no relationship to one another.

2.) Customer/Client: Violence committed by the perpetrator who is from the community in which the healthcare worker is providing healthcare services to.

3.) Worker-on-Worker: Violence committed by coworkers, also known as lateral or horizontal violence, that is often described as bullying.

4.) Personal Relationship: Violence committed at work in which the perpetrator is someone who the healthcare worker has a relationship with that is separate from work.

## Appendix B

## A Peer Response to Supporting Peers: A Guided Response Tool for Code Grays in the ED (P.E.E.R.S.)

**Why does this tool matter in the ED?**

Workplace violence events coupled with ineffective methods of coping in the aftermath of a critical incident can be detrimental to nurses' well-being, patient care, expenses involved in job turnover, and the overall work environment. Therefore, building a resilient nursing workforce equipped with the tools they need for coping and support may be essential to protecting this important workforce from the burdens of their experiences with workplace violence.

**What events trigger the use of this tool?**

This tool is to be used in the post-incident phase of a code gray.

**When should a response occur?**

A debrief should occur immediately after the resolution of a code gray event and when the safety of all is assured.

**Where should the response occur?**

Debriefing should take place on the unit in a place where the confidentiality of the patient and staff can be maintained. '

**How do I lead a guided response?**

Gather the team in the appropriate space. On the front of the card, there is a user-friendly acronym, P.E.E.R.S., that will walk staff through the post-event response.

**Who can lead a response?**

The anticipated plan for this tool is to provide a short training for all ED staff during staff meetings on how to use the tool. The goal is that any staff member would be able to lead the response using the badge buddy script.

**Who should be involved in the response?**

All involved staff and staff who witnessed the code gray event. Participation in the response is always voluntary.

**Additional support**

The 10-minute time frame for this informal response is an acknowledged limitation of this tool. Should any staff need support beyond this intervention, the back of the badge buddy lists several formal institutional options they can reach out to. This response is not a formal debrief or formal peer support intervention, nor does this response serve as a substitute for either of these interventions.

## Appendix C

## Expert Panel Review

*Please provide feedback after reviewing the P.E.E.R.S. badge buddy tool that I have created (you do not need to evaluate the introductory handout):*

1. **Graphics:** Is the badge buddy aesthetically pleasing, uncluttered, and font-sized appropriately?

2. **Content:** Does the content on the badge buddy make sense with the purpose of this project?

3. **Language and grammar:** Was the language used clear and purposeful? Did you notice any grammatical errors that need to be fixed or sentences that need to be rearranged?

4. **Ease of usability:** Did you find the badge buddy difficult to follow as a guide if you were the one using it to lead a debrief? Were instructions clear?

5. **Recommendations:** Do you have any recommendations that would make this tool better or more effective?

6. **Comments:** Any other comments not addressed in the questions above?

*Your time and feedback is valuable and highly appreciated. Thank you for your help.*

## Appendix D

## Example of P.E.E.R.S. Tool in Practice

After gathering all willing participants in a safe space, one facilitator will be needed to guide the discussion. The facilitator could be any trained staff member who chooses to participate in this role and in the discussion. The facilitator would then flip through their ID badge and find the P.E.E.R.S. card. The P.E.E.R.S. card would then be used by the facilitator to guide the group discussion surrounding the code gray event that had just occurred by following the instructions on the badge buddy and addressing each letter in the P.E.E.R.S. acronym in order and allowing for group responses. The facilitator can also take part in the discussion as well. An example of a discussion using this tool may proceed as follows:

**Facilitator: "**Welcome and thank you for being here. The purpose of this response is to provide a place to process violent incidents and see how we can best support one another. Before we begin, I will review the ground rules. Debriefing is voluntary, not mandatory, you can join when able to and leave when needed. We are here to listen to one another; not blame. This is a safe place and what is said will not be held against us. All feelings and ideas are welcome and valid. Respect one another."

**Facilitator:** "In order to keep this a safe place to share our ideas and responses to these challenging events with our peers, can we all agree to keep what is said in this response confidential?"

**All Participants and Facilitator:** Yes.

**Facilitator:** "Can anyone briefly explain the event that occurred to the group?"

**Participant 1:** I will. Our patient in Bed 12 became agitated when he did not get more water because he was on a fluid restriction and began throwing the furniture in the room at the staff and threatened to punch us if we came any closer. Mike called a code gray, the hospital police came within minutes and helped us get the patient in 4-point restraints and we medicated him with intramuscular shots.

**Facilitator:** "Does anyone want to share their initial reactions or responses towards the event?"

**Participant 2:** It was super scary. One of the chairs almost hit my leg.

**Participant 3:** Yeah, I felt scared too. I don't like thinking about any of us being hurt.

**Participant 4:** Same.

**Facilitator: "**Does anyone want to share what went well in the event?"

**Participant 1:** Mike was really quick on the code gray overhead announcement and that got us help quickly.

**Participant 2:** I think when Aaron closed the door, it was a smart move because it kept things from coming out of the door and kept us separated from the patient as he did not want us in there.

**Participant 3:** We had good teamwork and communication on who had what limb and when it was ok to release his limbs once all restraints were applied. I felt safe and like we had each other's backs.

**Facilitator:** I felt that as well.

**Facilitator:** "How can we help support each other while caring for this patient for the rest of this shift?"

**Participant 1:** I think it might be good to do a sweep of his room and remove all furniture or things that have the potential to be thrown.

**Participant 2:** Also, let's do two providers in the room for all patient care activities from here on out.

**Participant 3:** Those are good ideas.

**Facilitator:** "Does anyone need to step away for a few minutes before returning to work?"

**Participant 2:** Yes, I do. I'm going to get off the unit for a quick 5-minute walk to reset myself.

**Participants 3:** I am going to sip on my coffee and take a bite of my snack.

**Participant 1,4:** No

**Facilitator:** I don't feel I need to step away.

**Facilitator:** "Thank you for participating in this response. If you need more support, there is a list of resources on the back of this card. We are not alone."