Managing people

Support for staff when things go wrong

The patient had come to the OR for joint replacement surgery. Though she had a complicated medical history, there was no reason to believe she would have serious problems. But during the surgery, things went wrong, and despite everyone’s efforts, the patient died.

It hit the team hard, including the veteran surgeon. Death in the OR is unusual, particularly during routine orthopedic surgery. The team, which included novice nursing staff who had not experienced a death in their professional lives, found themselves providing postmortem care, guided by a nurse manager.

But in a busy trauma center, there’s little time to reflect. Team members are expected to move on. Still, days later, they may not be able to get the case out of their minds. They may ask themselves, “Is there anything I could have done differently?” Usually, they suffer in silence.

This time it was different. OR leaders pulled together a group meeting to offer peer support.

“We went to every member who was involved in the surgery and offered them the opportunity to be part of a debriefing session,” says Barbara DiTullio, RN, BSN, MA, assistant nurse manager in the ORs at Brigham & Women’s Hospital, Boston. Participation was voluntary. Team members were assured the session was confidential and was not a root cause analysis.

“We were giving them a chance to be together, share their feelings, and see if they could do some healing together,” she says.

Developing the program

For several months, a task force at Brigham had been developing a peer support program for the OR. A core group had been trained, and even though they weren’t ready to pilot the program, the time had come.

The debriefing took place on a Wednesday morning when in-services are held. At first, team members were wary. But after being reassured, the entire team came together, including the surgeon. The session helped resolve some feelings, says DiTullio, and “people were able to walk away feeling better than when they went in.”

About 6 to 8 debriefings have been held since the first one about 2 1/2 years ago. One took place after a long and difficult surgery for a patient who had an invasive sarcoma and needed a hemipelvectomy. The patient seemed to be coming through well. But as the incision was closed, she suddenly went into cardiac arrest. Despite all efforts, resuscitation failed. The team was devastated, DiTullio says.

A debriefing was held 1 1/2 hours later. This time, no one hesitated.

“Every single member of the team came, including the surgeons, anesthesiologists, and residents. People have really embraced the idea,” she notes.

Critical incident training

Peer support is now a regular part of Brigham’s OR. A core group of OR personnel were trained and carry a beeper.

“We let people know that if a critical incident happens, and people need support, that is what this beeper is for,” says DiTullio. Support is also provided one on one.

The core group, which includes surgeons, anesthesiologists, and nurses, attend-
ed 2-day critical incident training, paid for by the hospital and provided by the same
group that trains Boston’s police and firefighters.

The official term is a “critical incident stress debriefing,” a structured discussion
that is part of a model developed by the International Critical Incident Stress
Foundation (www.icisf.org).

When a serious incident happens, a member of the core group calls the team
members involved. This includes incidents that happen on weekends.

“We touch base and say, ‘I heard you were involved in this case. How are you
doing?’” DiTullio says.

A group debriefing may be held, or team members may meet individually with
a trained peer. They are always paired with a peer from the same discipline.

Leanne Espindle, RN, MSN, an OR assistant nurse manager who participated in
the first debriefing and several since, says the debriefings have become a valuable
experience for staff and physicians alike. Like many OR personnel, she says she’d
learned to “shake off” difficult situations, but she’s found that even veterans can
carry around “big feelings” afterward.

The debriefings give physicians and staff a chance to piece together the event and
gain a better understanding of what happened. She thinks the staff also benefits
from hearing from physicians about how they interacted with the family, which pro-
vides a perspective beyond the OR.

“It ends up being powerful,” DiTullio notes. “Just sharing the experience with the
others involved has a healing power.”

She finds the debriefings have made a big difference in morale.

“People feel like it’s not just a job—someone cares about you,” DiTullio says.

Now that peer support is established in the OR, the hospital plans to roll it out
for the emergency department and women’s and children’s services.

Support in a small hospital

There are ways managers can provide peer support, even in smaller facilities that
don’t have Brigham’s resources.

DiTullio suggests first defining which categories of personnel will be trained and
how to provide the training. Training might be provided by the hospital social work-
er or an employee assistance person. Or a manager might be able to identify a local
resource who could provide critical incident training.

She emphasizes that debriefings must be confidential and completely separate
from a root cause analysis or investigation.

Though the training provides helpful skills, in DiTullio’s mind, debriefings are
“really just about being human—it’s caring enough to ask somebody how they are
doing. It is reaching out and taking that extra step.”

She finds the peer support program has added a new dimension to her life as a
manager.

“It changes your philosophy about how you see your staff and how you care for
them,” she says. “It really is caring for the caregiver.

“In retrospect, we can’t believe we used to have these critical incidents, and noth-
ing was done to support people.”

Support group for clinicians, families

The idea for the peer support program grew out of the experience of a Brigham
anesthesiologist, Frederick Van Pelt, MD, and his patient, Linda Kenney, who went
on to found MITSS—Medically Induced Trauma Support Services, a Boston-based
nonprofit that provides support for clinicians, patients, and families who have
been through an unexpected outcome from medical care (www.mitss.org).

Dr Van Pelt was Kenney’s anesthesiologist for a total ankle replacement several
years ago. Shortly after he administered the nerve block, Kenney began to show
confusion, had a seizure, and went into cardiac arrest. A resuscitation effort wasn’t
working. She was taken to a cardiac OR, which had been prepared for another
patient, and placed on cardiopulmonary bypass. She woke up later in the ICU, wondering what had happened.

She was told she had had a bad reaction to anesthesia, but her questions went unanswered. Meanwhile, Dr Van Pelt was in distress. He wanted to reach out to Kenney and her family, but the hospital and his colleagues discouraged him. He says he felt surrounded by “a wall of silence.”

Finally, he decided to write Kenney a letter. Six months later they talked on the phone. They say the conversation opened a path to healing for both of them, which led them to found MITSS. The organization provides phone support nationally and support groups in the Boston area.

Read more about MITSS in the editorial in the April 2007 OR Manager.