

Critical Incident Stress Management from an RN Perspective

By Eddie Blacklock

I went to work in Alice Springs twelve months after the tragic air balloon crash that killed the thirteen people on board. Because of Alice Springs geographical isolation emergency service workers there were stretched to the limits of their capabilities. They also provided a lot of education to a broad range of health professionals about Critical Incident Stress Management (CISM) for some time after the event. In 1991 I was fortunate enough to be working in a family community centre as an RN mental health counsellor under the guidance of an American psychologist Rose Boehm whom I am eternally indebted to for the education she provided on CISM and for the learning opportunities that were presented to me to put those skills into practice.

After my contract in Alice Springs was completed I left for employment at the largest private multispecialty hospital in Queensland as a Clinical Nurse Consultant in charge of their Acute Mental Health Unit. In the first twelve months there, I became aware of how much emotional trauma RNs and other health professionals in the general environment managed on a routine basis but without any structured support. I formed alliances with the hospital's nurse counselling and chaplaincy services and shared my Critical Incident Stress Management experiences from my time spent in Alice Springs. All agreed about its need within the hospital community and its adaptability to the nursing / medical environment. The hospital executive approved our starting an educational program that was extended throughout the hospital complex. We also engaged the services of a CISM academic from the University of Queensland who held a number of workshops for a core group of personnel about the philosophy of CISM and its practical application to the culture of the hospital we

worked within. That core group then went out into all wards and departments holding mini-education sessions at clinical handovers about the proposed CISM Team and calling for volunteers as peer support personnel. A hospital policy and procedure was then drawn up outlining who the key players were in the CISM Team and how to contact them in an emergency.

The Team was officially launched in 1993. Both medical and nursing staff availed themselves of the CISM Team's services and some typical emergency calls came from staff on the intensive care unit, especially when there was the death of a young person that staff had invested considerable time with; staff on oncology wards who managed end of life scenarios with both patients and their families; staff at the breast screening clinic from having to tell outpatients some emotionally challenging information; and staff from the maternity unit which, while generally seen as a celebratory environment, can at times have things can go very wrong. The atypical calls came from a very public suicide, the collapse of a surgeon in theatre during an operation, the cultural clash of a grieving process from a large extended Islander family on a busy thoracic unit and calls from the emergency department following traumatic admission issues from both the patients and their family members.

These incidents are not peculiar to the hospital concerned and any medical or nursing professional would recognise them as the routine business of any large busy metropolitan hospital. Unfortunately CISM's are not a regular feature of hospitals and given the universal shortage of nursing staff, it is my argument that hospital management need to be looking at strategies to retain their current staff and attract a future generation of nurses. One of the best strategies in keeping health professional's happy and content is to make them feel safe by providing emotional support for when they are confronted with emotionally challenging situations. Accumulated grief

issues, poor patient management, extended sick leave and professional burnout are the price management will have to pay for failing to do so.

While Jeffrey Mitchell and his colleagues originally designed the Critical Incident Stress Debriefing Model for emergency service personnel it is my contention that medical and nursing staff is also confronted with routine emotional trauma. Mitchell's model is effective for the identification and management of emotionally charged situations and I am indebted to him and his colleagues for its creation. We found it to be very user friendly and I believe can be adapted to a broad range of work cultures. It is also cost effective as the only financial outlay we had was the education sessions received from the CISM academic. What it does require though is a strong commitment from some key hospital personnel who need to be available at short notice. This requires hospital management to recognise the necessary mobility in the roles of these key staff members.

The CISMT has both a symbolic and practical value to employers and employees. Health professionals within an acute hospital environment have the opportunity if they wish to avail themselves routinely of structured emotional support. They are also aware that hospital management care enough about them to sanction the CISMT. Conversely, hospital management have the knowledge they are providing psychological support to a broad range of their health professional employees for a minimal cost. With the need internationally to attract and retain health professionals the time has never been more opportune for CISMT's to become a regular feature in acute hospital environments.

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