Critical Event Debriefing: Impacts on Clinical Practice and Implications for Oncology Nurses

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BACKGROUND: The complexity of caring for patients with cancer has a direct impact on oncology nurses. When a patient with cancer experiences a critical health event, oncology nurses may have concerns about their ability to provide high-quality care for patients in the current healthcare environment. These concerns can negatively affect nurses' emotional well-being and lead to compassion fatigue and burnout.

OBJECTIVES: This article aims to examine critical event debriefing and identify ways oncology nurses can implement a critical event debriefing framework into their clinical practice.

METHODS: A literature search was conducted in CINAHL® and PubMed® databases for articles related to critical event debriefing and compassion fatigue and burnout among oncology nurses. A case study demonstrates the use of critical event debriefing on an oncology unit.

FINDINGS: Critical event debriefing frameworks can enhance teamwork, help initiate process improvements, and offer psychological support to improve emotional well-being. Additional research is needed about the use of critical event debriefing as a solution to compassion fatigue and burnout among oncology nurses.

KEYWORDS
debriefing; critical event; compassion fatigue; burnout; oncology; nursing

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ONCOLOGY CARE IS INCREASING IN COMPLEXITY because of a multitude of factors. Patients with cancer are being offered a wider range of treatments with higher levels of intensity, often at older ages when multiple comorbidities are present and at later stages of disease (Ferreyro & Munshi, 2019). However, this treatment model has led to new and more severe complications (Ferreyro & Munshi, 2019; Schellongowski et al., 2016). Patients experiencing complications related to cancer account for about four million emergency department visits per year in the United States. Of those visits, about one-third lead to a hospital admission (Hsu et al., 2018). Patients with cancer also use more time and resources in the emergency department because of their higher acuity levels on presentation (Hsu et al., 2018). Patients with hematologic malignancies or solid tumors frequently require intensive care to manage complications from the disease or its treatment, such as organ failure from an infiltrating tumor or organ toxicity from a cancer drug (Schellongowski et al., 2016). In the current healthcare system, the emergency department is pressured to limit overcrowding by efficiently transferring patients to inpatient units (Hammer et al., 2022), and the intensive care unit must carefully evaluate potential admissions before accepting them from inpatient units (Ferreyro & Munshi, 2019; Schellongowski et al., 2016). This can lead to oncology units being filled with high-acuity patients.

Oncology nurses, like all healthcare providers, face a great deal of stress. Data show that healthcare providers who specialize in oncology face even greater degrees of stress than those who work in other specialties, which may increase their risk of burnout (Gribben & Semple, 2021). Burnout occurs when an individual experiences low energy, low personal accomplishment, and negative feelings about their job (World Health Organization, 2019). When work-related stress becomes so constant that nurses start to experience undesirable consequences, such as burnout, fear, or insomnia, it can lead to compassion fatigue (Algamdi, 2022). While experiencing compassion fatigue and burnout, oncology nurses are no longer getting pleasure out of being a service provider, which has a negative impact on their emotional well-being (Algamdi, 2022).

The heightened level of stress in oncology can be largely attributed to the widespread nursing shortage and the many challenges nurses manage with their workload when caring for complex, high-acuity patients (Gribben & Semple, 2021). Oncology nurses also assist with the emotional challenges faced by patients, including fear of the unknown, bad news about a diagnosis, and the ever-present need to make complicated decisions (Gribben

& Semple, 2021). In addition, because of the nature of oncology as a rapidly evolving field, oncology nurses continuously educate themselves to keep abreast of clinical updates (Gribben & Semple, 2021). They do this while also providing compassionate, holistic care to patients who are experiencing a great deal of pain and can be at high risk for experiencing a critical or traumatic event. To cope with these heavy and numerous burdens, oncology nurses require evidence-based approaches. One approach is to routinely conduct debriefing sessions after critical events.

Clinical debriefing is a way for the healthcare team to review and process a critical event that just occurred (Toews et al., 2021). Common critical events in patients with cancer are most often related to adverse effects of cancer therapies, new symptoms of a previously undiagnosed malignancy, progression of a known disease, or disease recurrence (Gould Rothberg et al., 2022). The critical events that occur because of patient complications are usually acute respiratory failure, sepsis requiring vasopressor support, or cardiac arrest (Bruckel et al., 2017; Schellongowski et al., 2016). Of note, about 14% of all in-hospital cardiac arrests occur in patients with advanced cancer (Bruckel et al., 2017). The American Heart Association Guidelines for CPR and Emergency Cardiovascular Care recommend critical event debriefing for healthcare providers involved in a resuscitation attempt to provide support, review team performance, and discover areas for improvement (Berg et al., 2020; Panchal et al., 2020).

Purpose

The purpose of this article is to summarize the literature about the role of clinical debriefing after critical events and outline a framework for oncology nurses to implement critical event debriefing into their clinical practice. In addition, a case study illustrates the use of debriefing on an oncology unit.

Methods

A review of the literature was performed using CINAHL® and PubMed® databases. The following key search terms were used: *debriefing*, *critical event*, *oncology*, *nursing*, *compassion fatigue*, and *burnout*. Studies published in English from 2012 to 2022 were included. Because clinical debriefing can occur in all areas of the hospital, the settings and populations considered for inclusion were any hospital department serving any patient population. Studies focusing on clinical debriefing that occurred outside of the hospital, such as with EMTs or paramedics, were excluded.

Findings

In total, 16 studies were identified that focused on the impacts of debriefing after critical events, and 5 of these studies described specific debriefing frameworks. Four studies focused on compassion fatigue and burnout among oncology nurses. No studies were found that focused on debriefing after critical events to prevent compassion fatigue or burnout in oncology nurses. The details of the included studies are presented in Table 1.

"Debriefing provides oncology nurses with tools to build personal resilience and a more stable workforce."

Many researchers who study the process of debriefing after critical events focus specifically on in-hospital cardiac arrest and how debriefing after the event affects patient outcomes (e.g., return of spontaneous circulation, patient survival), as well as the quality of future resuscitation attempts (e.g., efficiency of interventions, chest compression quality) (Anderson et al., 2021; Couper et al., 2015, 2016; Malik et al., 2020). Other potential effects of debriefing that are often studied include adherence to American Heart Association guidelines, awareness of the need to update or change established protocols or equipment, and emotional support for staff (Coggins et al., 2020; Gilmartin et al., 2020; Hunt et al., 2018; Kam et al., 2022; Spencer et al., 2019).

Debriefing Frameworks

Critical event debriefing frameworks are usually multistep processes, with a leader who guides the discussion similar to a team leader during a code. Establishing a leader to facilitate the conversation and providing them with a script or visual aids were reported as the most effective approaches to critical event debriefing (Hale et al., 2020; Sawyer et al., 2016; Tannenbaum & Cerasoli, 2013). When led by a facilitator and approached using a well-developed structure, debriefing can improve healthcare team performance by about 25% (Tannenbaum & Cerasoli, 2013).

Although there is an abundance of literature on the use of debriefing frameworks in simulation, research on such frameworks in the clinical setting is less common (Coggins et al., 2020; Sawyer et al., 2016). This may be because clinical debriefing has to be tailored to the healthcare providers involved, the event itself, and the amount of time available to conduct a debriefing (Schmidt & Haglund, 2017), which can make some institutions hesitant to investigate the use of debriefing.

A few debriefing frameworks have been developed specifically for real-world situations and can be widely used. STOP5 is a debriefing framework that enables healthcare workers to have a structured dialogue immediately following a critical event (Walker et al., 2020) (see Figure 1). This framework is highly

TABLE 1.
LITERATURE REVIEW: CRITICAL EVENT DEBRIEFING (N = 16)

STUDY	DESIGN, SAMPLE, AND PURPOSE	OUTCOME MEASURES	FINDINGS
Anderson et al., 2021	A descriptive, qualitative analysis of 129 staff interviews to identify best practices for IHCA resuscitation training and education	Best practices were determined by analyzing interview data from the 9 top-performing hospitals in AHA's Get With The Guidelines®–Resuscitation registry.	The following 4 themes were identified in top-performing hospitals: clear communication (prioritized debriefing, institutional reviews of events, and continual education); engagement; consistency; and responsive leadership.
Berg et al., 2020	An evidence review (systematic review, scoping review, and evidence updates) to update part 7 of the AHA Guidelines for CPR and Emergency Cardiovascular Care, which outlines recommendations across the spectrum of care for cardiac arrest	Each recommendation was assigned a level of evidence (measured by quantity, relevance, and consistency of the evidence) and class of recommendation (measured by level of evidence classification and by systems, economic, and ethical factors).	The 2020 update to part 7 of the AHA Guidelines for CPR and Emergency Cardiovascular Care emphasizes clinical debriefing as a quality improvement strategy.
Coggins et al., 2020	A single-center, prospective, observational study of 71 clinical debriefings to examine the similarities and differences between simulation debriefing and clinical debriefing	The primary outcome was to determine discussion topics during clinical debriefing using content analysis; secondary outcomes included length, start time, number of staff involved, designation of roles during debriefing, Plus-Delta discussions, and recommendations for improvement.	12 discussion domains (e.g., communication) were identified; 61.5%–84.1% of the topics discussed aligned with simulation debriefing discussion domains; 49 of the completed clinical debriefing forms reported on quality assurance (e.g., equipment failure or deficit), which generated multiple practice changes.
Couper et al., 2015	A 2-phase, prospective cohort study of 1,395 patients who experienced a cardiac arrest across 3 hospitals to examine the effects of audiovisual feedback (provided by a defibrillator) with or without postevent debriefing on CPR quality and patient outcomes	The primary outcome was return of spontaneous circulation (persisting for > 20 minutes); secondary outcomes included survival to discharge, neurologic status at discharge (measured by CPC score), chest compression depth, chest compression rate, poor chest compression release, and pauses during resuscitation.	Audiovisual feedback, with or without debriefing, did not improve primary or secondary outcomes; return of spontaneous circulation and CPR quality improved for all 3 hospitals from phase 1 to phase 2 of the study (believed to be because of external factors).
Couper et al., 2016	A prospective cohort study of 1,198 cardiac arrest events across 3 hospitals to examine the effectiveness and deliverability of different debriefing approaches following cardiac arrests	The primary outcome of CPR quality following debriefing was measured by chest compression depth (mm); secondary outcomes were chest compression rate, poor chest compression release, pauses during resuscitation, return of spontaneous circulation, survival to discharge, neurologic status at discharge (measured by CPC), and deliverability of the debriefing intervention (measured by number of debriefings, number of staff in attendance, and time required to complete).	The debriefing interventions were found to be deliverable; 343 debriefs occurred, with an average of 13 (SD = 5) attendees per debriefing and lasting for a total of 10–16.5 hours per month; debriefing interventions did not lead to any significant improvement in CPR quality or patient outcomes.
Gilmartin et al., 2020	A quality improvement report of 16 debriefings during a 6-month period to implement a debriefing tool as a quality improvement initiative at a single emergency department	The primary outcome of debriefing occurring after every cardiac arrest in the emergency department was measured by comparing the number of debriefings to the number of cardiac arrests; the secondary outcome was the implementation of quality improvement strategies based on suggestions from debriefings; qualitative feedback was obtained via a participant survey to assess length of debriefing, psychological effects of debriefing, and effects of debriefing on clinical practice.	16 debriefings occurred, representing 42% of the cardiac arrests; multiple quality improvement changes were made; survey data showed that 95% of respondents reported that the debriefing was "just right" regarding time required to complete; 90% of respondents reported that the debriefing benefited their mental well-being; and 100% of respondents reported that their clinical practice improved or changed.
Hale et al., 2020	A systematic review to identify postresuscitation debriefing frameworks used in emergency or other acute care departments	Included studies met the following criteria: (a) The study included a debriefing framework; (b) the study described the debriefing framework in detail; and (c) the debriefing framework described must be appropriate for clinical debriefing (not solely simulation debriefing).	The following debriefing frameworks were analyzed across 6 studies: DISCERN, INFO, PCP, REFLECT, PediRes-Q, and CCHS; all frameworks highlighted the importance of a facilitator, and all used a physical tool or form; patient care improved with CCHS, healthcare team functioning improved with PCP, and quality of debriefing improved with DISCERN, INFO, PediRes-Q, and REFLECT.

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TABLE 1. *(CONTINUED)*
LITERATURE REVIEW: CRITICAL EVENT DEBRIEFING (N = 16)

STUDY	DESIGN, SAMPLE, AND PURPOSE	OUTCOME MEASURES	FINDINGS
Hunt et al., 2018	A prospective, observational, single-center study of 93 pediatric patients with a total of 105 cardiac arrest events to evaluate chest compression quality and simultaneously create a resuscitation quality bundle based on clinical debriefings that took place following cardiac arrest events	The primary outcome of chest compression quality was measured using 60-second recordings of chest compressions from the defibrillator used during each cardiac arrest event; recurring themes were identified from information gathered during debriefing, which led to development of the resuscitation quality bundle.	The resuscitation quality bundle was associated with increased adherence to AHA Guidelines for CPR and Emergency Cardiovascular Care; adherence to optimal chest compression rates increased; results for chest compression fraction and depth were mixed.
Kam et al., 2022	A prospective crossover study based on staff survey responses to examine the usefulness of 2 postresuscitation debriefing tools: DISCERN and PCP	The primary outcome of debriefing tool usefulness was measured using survey responses received from staff based on personal-, situational-, environmental-, and team-based factors; secondary outcomes included feedback during debriefing (type, quality, subject matter of the feedback) and effects on quality improvement and patient safety.	No significant differences in ease of use were identified; the average time for PCP was 18.1 minutes, and the average time for DISCERN was 11.1 minutes; increased emotional support was reported by 65.2% of survey respondents for PCP and by 50% of survey respondents for DISCERN; 61.2% of respondents reported that PCP strongly supported education, and 56.7% reported the same for DISCERN; no significant differences in team-based support or quality improvement were noted.
Malik et al., 2020	A national survey of hospitals participating in the AHA's Get With The Guidelines–Resuscitation registry (N = 193 hospitals and N = 44,477 IHCA events) to identify whether higher rates of post-IHCA debriefing were associated with more timely CPR interventions or improved patient outcomes	Timeliness of CPR interventions (epinephrine, defibrillation) was measured using the proportion of times the intervention was delivered within AHA guidelines (epinephrine: ≤ 5 minutes; defibrillation: ≤ 2 minutes); patient outcomes were measured by evaluating return of spontaneous circulation, survival to discharge, and favorable neurologic status (measured by CPC score) rates.	There was no association between debriefing frequency (i.e., rarely, occasionally, or frequently) and timely CPR interventions (epinephrine, defibrillation) or patient outcomes.
Panchal et al., 2020	An evidence review (systematic review, scoping review, and evidence updates) to update part 3 of the AHA Guidelines for CPR and Emergency Cardiovascular Care, which provides recommendations for managing cardiac arrests in adults	Each recommendation was assigned a level of evidence (measured by quantity, relevance, and consistency of the evidence) and class of recommendation (measured by level of evidence classification and by systems, economic, and ethical factors).	On the topic of debriefing, the 2020 update to part 3 recommends team debriefing following a cardiac arrest event to improve performance in future resuscitation attempts and discuss the stress experienced.
Sawyer et al., 2016	A literature review, including descriptive reports, experimental studies, systematic reviews, and meta-analyses, to examine the extent of the literature on healthcare debriefing simulations	Studies were selected using the following search terms: *debrief** and *simul**; no additional criteria were discussed.	Debriefing is essential for learning in any simulation exercise; having an effective facilitator is more important than selecting the right debriefing method because methods can be used in most simulation contexts; knowledge of simulation debriefing continues to grow, but more research is needed to expand the knowledge base of clinical debriefing.
Schmidt & Haglund, 2017	A case study illustrating the effects of compassion fatigue on nurses and the use of debriefing in the prevention of compassion fatigue	The primary outcome was to showcase how compassion fatigue affects nurses and how debriefing can assist in preventing compassion fatigue.	The selection of a debriefing method should be based on the healthcare population and the amount of time available for debriefing; debriefing can provide emotional support, help to identify signs of compassion fatigue, decrease staff turnover, and improve patient–provider interactions.
Spencer et al., 2019	A single-center, cross-sectional study of 414 staff members who responded to a 33-question survey and 302 staff members who completed a PTSD screen to evaluate post-IHCA debriefing practices and the impact of IHCA on psychological well-being of healthcare staff	Debriefing practices were measured by staff responses ("yes" or "no") to questions about their debriefing experiences; the Trauma Screening Questionnaire was used to measure psychological well-being associated with involvement in an IHCA.	Regarding debriefing, 72.4% of staff reported feeling better supported, 69% reported having the ability to address questions about the event, 63.8% reported a better understanding of the clinical causes of the arrest, and 62.1% reported that it was a way to develop learning; regarding psychological impacts of IHCA, 9.6% of staff screened positive for PTSD.

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TABLE 1. *(CONTINUED)*
LITERATURE REVIEW: CRITICAL EVENT DEBRIEFING (N = 16)

STUDY	DESIGN, SAMPLE, AND PURPOSE	OUTCOME MEASURES	FINDINGS
Tannenbaum & Cerasoli, 2013	A meta-analysis of 31 studies to examine the effectiveness of debriefing	Included studies met the following criteria: (a) Performance measures were implemented before and after debriefing; (b) effect sizes were able to be calculated; (c) the debriefing included self-learning, reflection about a specific event, and multiple sources of data, and the intent was improvement rather than punitive; and (d) staff performance was the primary outcome.	Debriefing can improve healthcare team performance by about 25%; clinical debriefing is particularly effective when it follows a structure and is led by a facilitator.
Walker et al., 2020	A quality improvement analysis to develop the STOP5 debriefing framework in a single emergency department to promote quality improvement, improve patient care, and facilitate teamwork; staff surveys were administered at baseline (n = 40 respondents), 6 months (n = 30 respondents), and 18 months (n = 41 respondents).	The primary outcome of staff satisfaction with the debriefing framework was measured using a Likert-type scale questionnaire; secondary outcomes (system, process, and equipment improvements) were measured based on actual practice changes that were implemented as a result of the STOP5 debriefing framework.	At 6 months, 90% of survey respondents rated STOP5 as "good," "very good," or "excellent"; 100% of respondents rated STOP5 as "good," "very good," or "excellent" at 18 months; 10 practice changes were initiated following the implementation of STOP5.

AHA—American Heart Association; CCHS—Christiana Care Health System; CPC—Cerebral Performance Category; DISCERN—Debriefing In Situ Conversation after Emergent Resuscitation Now; IHCA—in-hospital cardiac arrest; INFO—Immediate, Not for personal assessment, Fast facilitated feedback, and Opportunity to support and ask questions; PCP—Post-Code Pause; PediRes-Q—Pediatric Resuscitation Quality Collaborative; PTSD—post-traumatic stress disorder; REFLECT—Review the event, Encourage team participation, Focused feedback, Listen to each other, Emphasize key points, Communicate clearly, and Transform the future; STOP5—STOP for 5 minutes

rated by its users and has been shown to help initiate practice changes to improve quality (Walker et al., 2020). In addition, the STOP5 framework is a mnemonic, which makes it easy for anyone to use and does not require specialized training for use. It calls on staff involved in the event to stop for five minutes to summarize what happened, discuss things that went well and opportunities for improvement, and point to future actions that will help ensure those improvements can be attained (Walker et al., 2020). Gilmartin et al. (2020) studied a similar debriefing framework called the hot debriefing tool, which was effective in helping staff feel a sense of psychological well-being following a critical event and identify areas for improvement in their handling of critical events. All users of the hot debriefing tool reported that their clinical practice had improved after participating in a hot debrief, which is a debriefing that occurs immediately following a critical event (Gilmartin et al., 2020). Another debriefing model, the Post-Code Pause, was found to be effective at identifying areas for improvement and addressing stress or psychological trauma that can result from being involved in a critical health event (Hale et al., 2020; Kam et al., 2022).

Debriefing After Critical Events

Although published literature evaluating the impact of debriefing on patient outcomes or CPR quality is limited (Couper et al., 2015, 2016; Malik et al., 2020), there is quite a bit of evidence to support the practice of critical event debriefing to enhance staff satisfaction, performance, and well-being. Staff who are involved in a debriefing feel more supported by their colleagues, appreciate having the opportunity to address questions that come up after an incident, and think of debriefing as a meaningful learning experience that enables them to better understand the clinical picture (Spencer et al., 2019). In addition to providing needed emotional support, debriefing also allows for the identification of gaps in care or deficiencies in standard operating procedures and highlights areas for quality improvement at the individual, group, and system levels (Coggins et al., 2020; Gilmartin et al., 2020; Kam et al., 2022). Debriefings that are led by a facilitator, include all staff members involved in the critical event, and focus on personal challenges experienced by staff during the event have been found to increase adherence to established CPR guidelines from the American Heart Association (Hunt et al., 2018).

Of note, debriefing sessions are easy to implement, are relatively inexpensive, and do not take much time to complete, with the average session lasting 5–18 minutes (Couper et al., 2016; Kam et al., 2022; Tannenbaum & Cerasoli, 2013). In addition, among hospitals with the best resuscitation performance records, healthcare staff acknowledge that critical event debriefing is a top priority (Anderson et al., 2021). Anderson et al. (2021) also acknowledged a general preference for a coordinated, interprofessional approach to the debriefing process instead of the asynchronous, departmentally stratified approach that is often used and believed to be less effective in improving teamwork. In the latter approach, each discipline debriefs separately, and they

FIGURE 1.
STOP5: A FRAMEWORK TO GUIDE CRITICAL EVENT DEBRIEFING

FACILITATOR INTRODUCTION

Thank the team and ask, "Is everyone OK?" If "yes," then continue with the debriefing by first stating the following:

- "We are going to have a 5-minute team debriefing."
- "The purpose is to improve quality of patient care; it is not a blaming session."
- "Your participation is welcomed but not compulsory."
- "All information discussed during this debriefing is confidential."

STOP5 FRAMEWORK

- S: summary of the case
- T: things that went well
- O: opportunities to improve
- P: points to action and responsibilities

STOP5—STOP for 5 minutes

Note. From "STOP5: A Hot Debrief Model for Resuscitation Cases in the Emergency Department" by C.A. Walker et al., 2020, *Clinical and Experimental Emergency Medicine, 7*(4), p. 261 (https://doi.org/10.15441/ceem.19.086). Copyright 2020 by the Korean Society of Emergency Medicine, licensed under CC BY-NC 4.0 DEED (https://creativecommons.org/licenses/by-nc/4.0).

infrequently debrief immediately after a critical event because of other clinical responsibilities (Anderson et al., 2021).

Debriefing Applications for Clinical Oncology Critical Events

The number of patients with cancer with critical illness has increased because novel cancer treatments are being selected for a greater number of patients, including older adult patients and patients with poor functional status (Ferreyro & Munshi, 2019). Because of the rapid advances in treatment options, caring for patients who are critically ill is rarely straightforward and requires providers to have an expansive knowledge base and be prepared for adverse outcomes, such as respiratory failure and cardiac arrest (Bruckel et al., 2017; Ferreyro & Munshi, 2019). Adverse outcomes among patients in the oncologic and hematologic populations can be particularly challenging for healthcare providers because survival rates for these patients are lower than those for the general patient population (Bruckel et al., 2017; Ferreyro & Munshi, 2019). With formal debriefing, staff can gain a better understanding of the situation, evaluate and respond to the varied emotions they may be experiencing, and have better support as they return to patient care (American Association of Nurse Anesthesiology, 2014).

There is a substantial lack of research on the topic of critical event debriefing in oncology settings. However, there is a growing body of evidence focusing on the high prevalence of compassion fatigue and burnout among oncology nurses (Algamdi, 2022; Ortega-Campos et al., 2020). Nurses who care for patients with cancer are continually exposed to emotionally challenging situations, which can lead to the development of compassion fatigue and burnout (Ortega-Campos et al., 2020). Oncology nurses report experiencing compassion fatigue more often than compassion satisfaction (Algamdi, 2022). An exceptionally heavy workload, staffing shortages, continual exposure to profound distress, and high patient acuity all contribute to oncology nurse burnout (Gribben & Semple, 2021).

When a critical event such as a cardiac arrest takes place, nurses have expressed that there is a need for reassurance, validation, and education about the event to establish a shared understanding of what happened (Clark & McLean, 2018). This can be accomplished through formal debriefing. When nurses debrief following an emotionally challenging critical event, a significantly distressing experience can turn into a positive learning experience (Clark & McLean, 2018). Compassion fatigue and burnout can be reduced when nurses have the opportunity to gain a sense of clarity regarding their thoughts and emotions (Ortega-Campos et al., 2020), and critical event debriefing can provide such an opportunity. Figure 2 presents a case study to demonstrate the challenges faced by oncology nurses and how the use of clinical debriefing after critical events can help to mitigate the negative effects of those challenges.

Discussion

Although data on debriefing in oncology practice are limited, the strong foundation for debriefing in health care can be readily applied to clinical oncology. Clinical oncology settings, some of the most complex settings in any healthcare institution, need ways to reduce nurse burnout and promote psychological and emotional wellness to retain nursing staff (Gribben & Semple, 2021). Emotional well-being is frequently cited as a positive outcome of critical event debriefing (Gilmartin et al., 2020; Kam et al., 2022; Schmidt & Haglund, 2017).

Oncology nurses are responsible for safely managing the unique needs of their patients while also closely and continuously monitoring for signs of deterioration. Therefore, when a critical event involving a patient with cancer occurs, critical event debriefing is needed to examine all the moving pieces and make sense of what happened. Debriefing provides opportunities to ask questions and learn from the experience (Spencer et al., 2019). The knowledge gained from critical event debriefing can be used during future high-intensity situations (Schmidt & Haglund, 2017). Critical event debriefing also offers an opportunity to create meaningful practice changes that can improve clinical practice (Gilmartin et al., 2020). In addition, debriefing provides oncology nurses with tools to build personal resilience and a more stable workforce—two key components for combating burnout (Gribben & Semple, 2021).

IMPLICATIONS FOR PRACTICE

- Implement a formal debriefing after critical events to improve oncology nurses' emotional well-being, teamwork, and workflow processes.
- Designate one individual as a facilitator to lead the debriefing and use a script or visual aids to effectively guide the conversation.
- Educate oncology nurses about the use of critical or traumatic event debriefing to better understand the event that occurred and the feelings that follow, which can improve emotional well-being.

Institutions can implement a formal debriefing framework to use following critical or traumatic events for minimal cost, time, and education. Important components to include when debriefing are as follows: Each debriefing has a leader, such as the unit charge nurse; participants in the debriefing include any staff member involved in the event; and the debriefing is structured. Debriefing can last from 5 to 20 minutes. This practice change can be approached using the Model for Improvement, a quality improvement framework used by many healthcare institutions because of its simplicity and high utility (Institute for Healthcare Improvement, n.d.). This framework helps to establish goals for a quality improvement project and determine ways to measure whether the practice change has been successful in achieving those goals (Institute for Healthcare Improvement, n.d.). The nursing team implementing the change decides on a goal (e.g., improving emotional well-being), develops a way to measure whether this goal was achieved (e.g., a postimplementation staff survey to assess improvements in emotional well-being after three months of regular use of the critical event debriefing tool), and begins using the selected clinical debriefing tool after any critical event occurs (see Figure 3). Using the information obtained from postimplementation surveys, the nursing team can decide whether the debriefing tool has been successful in achieving the predetermined goals or whether it needs to be adjusted.

Implications for Practice and Research

The positive effects of clinical debriefing on emotional well-being, teamwork, and process enhancement indicate that it plays

FIGURE 2.
CASE STUDY OF A CRITICAL EVENT DEBRIEFING ON AN ONCOLOGY UNIT

Mr. Johnson, a 58-year-old man, was admitted to the oncology unit for altered mental status. He was recently diagnosed with melanoma, with metastasis to his lymph nodes and brain. His hospital course was complicated by nausea, a stage II pressure injury on his sacrum, and a fall. His mental status improved with corticosteroids, and he was working with physical therapy to regain his strength so that he could return home with his wife and continue outpatient treatment for melanoma.

On the morning before discharge, Mr. Johnson reported new feelings of anxiety and fatigue. His nurse assessed him and informed the provider. His vital signs were within normal limits. It was determined that his symptoms were likely because of deconditioning from prolonged hospitalization and emotional concerns about the strain that his upcoming discharge might put on his wife. The provider ordered a case management consultation to help coordinate the discharge plan and arrange outpatient resources. Mr. Johnson's nurse continued with her shift, taking care of 4 other patients with hematologic cancer.

That afternoon, Mr. Johnson became significantly short of breath, and he called his nurse into the room. Mr. Johnson was found to be in acute distress, and he quickly deteriorated and experienced a sudden cardiac arrest. Nursing staff initiated a code and began basic life support, and the unit code cart was brought to the bedside. While waiting for the code team to arrive, it was noted that there was no backboard in the room or on the code cart. Multiple staff members began talking at once, with many of them shouting because of the increased noise in the room and the added stress from realizing essential equipment was missing. The code team arrived at the same time as Mr. Johnson's wife, who was returning from lunch. As the healthcare team worked to resuscitate Mr. Johnson, his wife was given no explanation about the events she was witnessing. Ultimately, Mr. Johnson was resuscitated and taken to the intensive care unit. Nursing staff helped his wife pack up their belongings and accompanied her to the intensive care unit, attempting to provide emotional support and reassurance that she would receive more information soon.

Following Mr. Johnson's resuscitation, the oncology unit charge nurse obtained the STOP5 (STOP for 5 minutes) debrief framework from the charge nurse's desk. The oncology unit charge nurse gathered staff members—the nurses and patient care assistants who were involved in Mr. Johnson's resuscitation, the members of the code team who were still present on the unit, and the chaplain—in the break room to hold a critical event debriefing. Staff who were not directly involved in the code remained on the unit to provide patient care. The debriefing led staff through a discussion of the event, giving everyone an opportunity to note what went well and what could have gone better and encouraging staff to develop solutions for improvement. In a follow-up survey, staff reported that when the debriefing was over they were able to return to work feeling that they had a better understanding of the potential causes of Mr. Johnson's cardiac arrest and felt supported by their colleagues. Staff also reported feeling empowered to look into practice changes to improve care and help prevent similar issues in the future. Mr. Johnson's nurse and the chaplain verbalized concerns about the trauma experienced by the patient's wife, so they developed a plan to ensure family members are better supported during a critical event. Another nurse was particularly bothered by the missing backboard and started taking steps to fix equipment issues. Debriefing had a positive impact on the emotional well-being of the staff, and no staff members reported that this event contributed to any feelings of compassion fatigue or burnout. All staff reported a readiness to continue providing care to their other patients.

FIGURE 3.
CHECKLIST FOR IMPLEMENTING CRITICAL EVENT DEBRIEFING INTO CLINICAL PRACTICE

- Identify the need for the practice change.
- Identify the goal(s) of the practice change.
- Develop a way to measure the success of the practice (e.g., survey, audit).
- Choose a debriefing framework to use (e.g., STOP5 debrief framework).
- Educate department staff about the upcoming practice change.
- Following every critical or traumatic event, hold a debriefing session.
  - ☐ A leader will begin the debriefing using the selected framework to guide them.
  - ☐ All staff involved in the event will attend the debriefing (as able).
  - ☐ Staff not involved in the event will remain available on the unit to provide necessary care for other patients.
- Evaluate results from the measurement tool to determine whether the practice change has been successful in achieving goals. This evaluation will guide the decision-making process regarding whether to establish the practice as standard of care or alter it and continue measuring outcomes.

Note. Based on information from Institute for Healthcare Improvement, n.d.

an important role in oncology nursing to improve clinical practice. More research is needed about critical event debriefing in oncology settings to evaluate how debriefing can most effectively improve emotional well-being and reduce problems such as compassion fatigue and burnout. Critical event debriefing frameworks have been shown to be effective and easy to implement, but their use has not been studied on hematology or oncology units specifically. Future studies are needed on compassion fatigue and burnout among oncology nurses that focus on clinical debriefing as a means to reduce these potential adverse effects and keep oncology nurses engaged in the care of patients with cancer.

Conclusion

As the treatment landscape evolves and patients live longer with cancer, oncology nursing will continue to be a challenging specialty. Meeting these challenges with adequate protective measures can ensure that oncology nurses feel supported to perform their jobs at a high level and maintain their emotional well-being by preventing adverse outcomes such as compassion fatigue or burnout. Debriefing after a patient experiences a critical or traumatic event offers many protective measures for nurses, such as better emotional support, enhanced teamwork, and continual opportunities to improve their practice environment.

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REFERENCES

Algamdi, M. (2022). Prevalence of oncology nurses' compassion satisfaction and compassion fatigue: Systematic review and meta-analysis. *Nursing Open, 9*(1), 44–56. https://doi.org/10.1002/nop2.1070

American Association of Nurse Anesthesiology. (2014). *Guidelines for critical incident stress management*. https://issuu.com/aanapublishing/docs/3_-_guidelines_for_critical_incident_stress_manage?fr=sZWQ2MzU2NDAxMjU

Anderson, T.M., Secrest, K., Krein, S.L., Schildhouse, R., Guetterman, T.C., Harrod, M., . . . Nallamothu, B.K. (2021). Best practices for education and training of resuscitation teams for in-hospital cardiac arrest. *Circulation: Cardiovascular Quality and Outcomes, 14*(12), e008587. https://doi.org/10.1161/CIRCOUTCOMES.121.008587

Berg, K.M., Cheng, A., Panchal, A.R., Topjian, A.A., Aziz, K., Bhanji, F., . . . Lavonas, E.J. (2020). Part 7: Systems of care: 2020 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. *Circulation, 142*(16, Suppl. 2), S580–S604. https://doi.org/10.1161/CIR.0000000000000899

Bruckel, J.T., Wong, S.L., Chan, P.S., Bradley, S.M., & Nallamothu, B.K. (2017). Patterns of resuscitation care and survival after in-hospital cardiac arrest in patients with advanced cancer. *Journal of Oncology Practice, 13*(10), e821–e830. https://10.1200/JOP.2016.020404

Clark, R., & McLean, C. (2018). The professional and personal debriefing needs of ward based nurses after involvement in a cardiac arrest: An explorative qualitative pilot study. *Intensive and Critical Care Nursing, 47*, 78–84. https://doi.org/10.1016/j.iccn.2018.03.009

Coggins, A., De Los Santos, A., Zaklama, R., & Murphy, M. (2020). Interdisciplinary clinical debriefing in the emergency department: An observational study of learning topics and outcomes. *BMC Emergency Medicine, 20*(1), 79. https://doi.org/10.1186/s12873-020-00370-7

Couper, K., Kimani, P.K., Abella, B.S., Chilwan, M., Cooke, M.W., Davies, R.P., . . . Perkins, G.D. (2015). The system-wide effect of real-time audiovisual feedback and postevent debriefing for in-hospital cardiac arrest: The cardiopulmonary resuscitation quality improvement initiative. *Critical Care Medicine, 43*(11), 2321–2331. https://10.1097/CCM.0000000000001202

Couper, K., Kimani, P.K., Davies, R.P., Baker, A., Davies, M., Husselbee, N., . . . Perkins, G.D. (2016). An evaluation of three methods of in-hospital cardiac arrest educational debriefing: The cardiopulmonary resuscitation debriefing study. *Resuscitation, 105*, 130–137. https://doi.org/10.1016/j.resuscitation.2016.05.005

Ferreyro, B.L., & Munshi, L. (2019). Acute respiratory failure in the oncologic patient: New era, new issues. In J.-L. Vincent (Ed.), *Annual update in intensive care and emergency medicine 2019* (pp. 31–45). Springer. https://doi.org/10.1007/978-3-030-06067-1_3

Gilmartin, S., Martin, L., Kenny, S., Callanan, I., & Salter, N. (2020). Promoting hot debriefing in an emergency department. *BMJ Open Quality, 9*(3), e000913. https://10.1136/bmjoq-2020-000913

Gould Rothberg, B.E., Quest, T.E., Yeung, S.-C.J., Pelosof, L.C., Gerber, D.E., Seltzer, J.A., . . . Kyriacou, D.N. (2022). Oncologic emergencies and urgencies: A comprehensive review. *CA: A Cancer Journal for Clinicians, 72*(6), 570–593. https://doi.org/10.3322/caac.21727

Gribben, L., & Semple, C.J. (2021). Factors contributing to burnout and work–life balance in adult oncology nursing: An integrative review. *European Journal of Oncology Nursing, 50*, 101887. https://doi.org/10.1016/j.ejon.2020.101887

Hale, S.J., Parker, M.J., Cupido, C., & Kam, A.J. (2020). Applications of postresuscitation debriefing frameworks in emergency settings: A systematic review. *Academic Emergency Medicine Education and Training, 4*(3), 223–230. https://10.1002/aet2.10444

Hammer, C., DePrez, B., White, J., Lewis, L., Straughen, S., & Buchheit, R. (2022). Enhancing hospital-wide patient flow to reduce emergency department crowding and boarding. *Journal of Emergency Nursing, 48*(5), 603–609. https://doi.org/10.1016/j.jen.2022.06.002

Hsu, J., Donnelly, J.P., Moore, J.X., Meneses, K., Williams, G., & Wang, H.E. (2018). National characteristics of emergency department visits by patients with cancer in the United States. *American Journal of Emergency Medicine, 36*(11), 2038–2043. https://doi.org/10.1016/j.ajem.2018.03.025

Hunt, E.A., Jeffers, J., McNamara, L., Newton, H., Ford, K., Bernier, M., . . . Duval-Arnould, J. (2018). Improved cardiopulmonary resuscitation performance with CODE ACES^2: A resuscitation quality bundle. *Journal of the American Heart Association, 7*(24), e009860. https://doi.org/10.1161/JAHA.118.009860

Institute for Healthcare Improvement. (n.d.). *How to improve: Model for improvement.* https://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

Kam, A.J., Gonsalves, C.L., Nordlund, S.V., Hale, S.J., Twiss, J., Cupido, C., . . . Parker, M.J. (2022). Implementation and facilitation of post-resuscitation debriefing: A comparative crossover study of two post-resuscitation debriefing frameworks. *BMC Emergency Medicine, 22*(1), 152. https://doi.org/10.1186/s12873-022-00707-4

Malik, A.O., Nallamothu, B.K., Trumpower, B., Kennedy, M., Krein, S.L., Chinnakondepalli, K.M., . . . Chan, P.S. (2020). Association between hospital debriefing practices with adherence to resuscitation process measures and outcomes for in-hospital cardiac arrest. *Circulation: Cardiovascular Quality and Outcomes, 13*(11), e006695. https://10.1161/CIRCOUTCOMES.120.006695

Ortega-Campos, E., Vargas-Román, K., Velando-Soriano, A., Suleiman-Martos, N., Cañadas-de la Fuente, G.A., Albendín-García, L., & Gómez-Urquiza, J.L. (2020). Compassion fatigue, compassion satisfaction, and burnout in oncology nurses: A systematic review and meta-analysis. *Sustainability, 12*(1), 72. https://doi.org/10.3390/su12010072

Panchal, A.R., Bartos, J.A., Cabañas, J.G., Donnino, M.W., Drennan, I.R., Hirsch, K.G., . . . Berg, K.M. (2020). Part 3: Adult basic and advanced life support: 2020 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. *Circulation, 142*(16, Suppl. 2), S366–S468. https://doi.org/10.1161/CIR.0000000000000916

Sawyer, T., Eppich, W., Brett-Fleegler, M., Grant, V., & Cheng, A. (2016). More than one way to debrief: A critical review of healthcare simulation debriefing methods. *Simulation in Healthcare, 11*(3), 209–217. https://doi.org/10.1097/sih.0000000000000148

Schellongowski, P., Sperr, W.R., Wohlfarth, P., Knoebl, P., Rabitsch, W., Watzke, H.H., Staudinger, T. (2016). Critically ill patients with cancer: Chances and limitations of intensive care medicine—A narrative review. *European Society for Medical Oncology Open, 1*(5), e000018. https://doi.org/10.1136/esmoopen-2015-000018

Schmidt, M., & Haglund, K. (2017). Debrief in emergency departments to improve compassion fatigue and promote resiliency. *Journal of Trauma Nursing, 24*(5), 317–322. https://10.1097/JTN.0000000000000315

Spencer, S.A., Nolan, J.P., Osborn, M., & Georgiou, A. (2019). The presence of psychological trauma symptoms in resuscitation providers and an exploration of debriefing practices. *Resuscitation, 142*, 175–181. https://doi.org/10.1016/j.resuscitation.2019.06.280

Tannenbaum, S.I., & Cerasoli, C.P. (2013). Do team and individual debriefs enhance performance? A meta-analysis. *Human Factors, 55*(1), 231–245. https://doi.org/10.1177/0018720812448394

Toews, A.J., Martin, D.E., & Chernomas, W.M. (2021). Clinical debriefing: A concept analysis. *Journal of Clinical Nursing, 30*(11–12), 1491–1501. https://doi.org/10.1111/jocn.15636

Walker, C.A., McGregor, L., Taylor, C., & Robinson, S. (2020). STOP5: A hot debrief model for resuscitation cases in the emergency department. *Clinical and Experimental Emergency Medicine, 7*(4), 259–266. https://doi.org/10.15441/ceem.19.086

World Health Organization. (2019). QD85 burnout. In *International statistical classification of diseases and related health problems* (11th ed.). https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/129180281

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QUESTIONS FOR DISCUSSION

USE THIS ARTICLE FOR JOURNAL CLUB

Journal club programs can help to increase your ability to evaluate the literature and translate those research findings to clinical practice, education, administration, and research. Use the following questions to start the discussion at your next journal club meeting.

- In the past month, how many critical events did you experience? How many of those did you think about after leaving work? How many of those critical events included a formal debriefing?
- Which critical event debriefing framework most appeals to you? Why?
- Does your institution use a critical event debriefing framework? If not, what practical next steps can you implement to begin using a critical event debriefing framework?

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