

Program Development

Coordinating a Multiple Casualty Critical Incident Stress Management (CISM) Response Within a Medical/Surgical Hospital Setting

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ABSTRACT: *The medical/surgical hospital environment presents numerous challenges to a Critical Incident Stress Management (CISM) Team Coordinator responsible for implementing a psychological crisis intervention. Often this person is responsible for managing a response to a large in-house multiple-casualty incident, sometimes involving fatalities. Many mental health professionals have not had the opportunity to work in a medical/surgical healthcare facility and consequently are not familiar with the environment (and agency culture) that exists within these employment settings. This article will review important factors to be considered during the initial assessment of a critical incident in a hospital setting, logistical concerns that are unique to this setting, and the subsequent planning of the Critical Incident Stress Management Team crisis management response. [International Journal of Emergency Mental Health, 2001 3(1), 27-34].*

KEY WORDS: Mass casualty incident, hospital shooting, crisis intervention team coordination, response planning, Critical Incident Stress Management (CISM), crisis intervention.

The first-responder(s) to a multiple-casualty hospital incident will face unique challenges not present in other large events. The first and most important difference will be the fact that ambulances generally do not remove victims in a Medical/Surgical environment (Med/Surg) to other facilities; instead, in-house staff will respond to treat the wounded. Having an understanding of such "Code Blue" responses and other aspects of the hospital environment will be crucial to properly assessing the impact of the incident and planning the Critical Incident Stress Management (CISM) team's crisis intervention response. This article will address these issues and is based on "lessons learned" by the author while coordinating a CISM team's crisis intervention response to a multiple fatality incident in a Med/Surg hospital setting.

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Gaining Access and Initiating the Assessment

The First-Responder's Arrival On-Scene

As a contracted responder arriving on-scene, you may be confronted with two obstacles to gaining access to the facility.

First, many local clinicians may have already inundated the healthcare facility with offers of assistance, making it easy for the contracted responder to be turned away. The first responder from the contracted CISM team should arrive with the name, department and phone number of the in-house staff member authorized to contract for the team's services. Having this information will facilitate the first responder gaining access to the facility and initiating the assessment.

Second, depending on the time of arrival, there may be limited access permitted by law enforcement personnel while they complete their processing of the crime scene(s). Not only may entry be denied to the CISM responder, but also the hospital staff may be prohibited from walking to the

responder's location and providing escort back to his or her office. Consequently, the first responder at the scene should anticipate the possibility of some initial delay; but this should not postpone the response to the scene unless the team has been instructed to delay its response.

Providing Initial CISM Services

Ideally, directly impacted staff will be provided the opportunity to participate in a defusing¹ prior to departing for the day. Unfortunately, they frequently are released from duty before the CISM team has arrived. Regardless, on a multiple casualty incident, the first responder (responsible for assessing the agency's needs) should arrive, if possible, with at least two other team members to handle any immediate crisis intervention needs. It will also be preferable if the CISM responders have access to off-scene support personnel who can activate additional CISM trained clinicians/peer support personnel as needed. The off-scene support personnel should be kept updated (at least every 2 hours) on all new assessment information. They should be provided with updated contact information, including how to contact the Incident Command Center, the agency's fax number, the names and contact information of administrative personnel who are involved in making administrative decisions, and any other pertinent information.

Initial Briefing and Assessment of Support Needs

During the initial briefing, the first responder should obtain the names of those injured and/or deceased and their respective departments. If there are surviving injured, ascertain their current condition (if known) and their current location within the hospital (Emergency Room (ER), Operating Room (OR), Intensive Care Unit (ICU), regular patient room, etc.). Inquiries should be made to determine whether or not the families have been notified, if any of them are currently at the hospital and if not, when they are expected to arrive? Determine if the Department of Social Services is able to greet and assist the arriving families or if the CISM team will need to do so? When asking these questions, the hospital may express concerns about maintaining the confidentiality of this information, especially in relation to the media. They should be re-assured of the confidential nature of all information provided to the team.

The Walk-Through

Walking through the scene (before it is cleaned up) can

be traumatic and should be avoided when it is not necessary for an intervention team member's role. However, it is very important for the completion of the assessment phase that the CISM Team Coordinator (and, if different, the first-responder responsible for the initial assessment) be given a tour of the crime scene so that accurate assessment can be made of which staff and which departments are likely to be the most severely impacted. During the Walk-Through, obtain the following information:

1) Location of each wounded or deceased victim (whether visitor or staff member).

2) Was a "code blue" called for any of victims? If there was more than one victim for whom a code was called, was there adequate coverage for all the responses? If not, which code was not adequately covered and who was able to respond to it? Which departments were involved?

3) Were any pronounced dead at the scene and if so, how long did the body remain on scene? Were arriving relief staff exposed to the crime scenes with bodies still present? (Note: the processing of the crime scene(s) may still be ongoing at the time of the walk-through and bodies may not have been removed at this time.)

4) Where were the injured transported and which departments received them?

5) Did any of the victims expire while in those departments? If so, were they visitors or employees? If employees, how long were they employed at the facility, which departments did they work in and how well were they liked?

6) While visiting each location where someone was wounded or killed, determine:

a. Which departments are immediately adjacent to each location?

b. Which patient rooms are adjacent to any of the crime scenes, if any? Were patients in their rooms at the time of the incident? Did they have visitors?

c. Was staff from other departments visiting the areas at the time of the incident (such as to make copies at the copier machine, picking up medications at the pharmacy, delivering mail, etc.)?

7) Finally, check on the emotional status and location of the PBX operators. They will have been handling an overwhelming number of phone calls from people outside the hospital and may need additional breaks, defusing, debriefing and/or other additional support.

Because the staff member who guides the intervention

team members through the scene may not have time to wait while information is gathered, ask only the questions that are required to identify the most severely impacted employees. Later, when access to the area is easier, return and fill in missing information. The Outreach Team (discussed later under “Response Planning”) can also be used to accomplish this task.

Additional information that will be needed includes the shifts on which each department operates. Some will be on regular weekday business hours, some may be on 12-hour shifts (typically 7 a.m. to 7 p.m. and 7 p.m. to 7 a.m.) with four days off each week, some may be on overlapping eight hour shifts that run around the clock (possibly 6:45 a.m. to 3:15 p.m., 2:45 p.m. to 11:15 p.m. and 10:45 p.m. to 7:15 a.m.) and still others may work a ten-hour shift four days per week.

Finally, there may be one or more departments with staff members who do not speak English or for whom English is a second language. Determine the need to provide Critical Incident Stress Debriefing (CISD) and other crisis intervention services in these other languages and which departments will need these services.

A Word about “Code Blue”

Normally a “Code Blue” is announced using the overhead public address system to activate in-house personnel when a patient goes into cardiac arrest. It may also be called when additional emergency medical support services are needed to provide acute care for a deteriorating patient. Nursing personnel (including possibly a Unit Secretary or Ward Clerk) will respond with the “crash cart” which contains items needed to restore a patient’s airway, breathing and/or circulation (heart function), including tubes for intubation, an “ambu bag”, oxygen, cardiac defibrillator, medications and other related supplies. Additional support personnel will also arrive from other departments: Electrocardiogram (EKG), Respiratory Therapy, Pharmacy, Medical Residents, the patient’s physician (if in the house at the time), Security, the Nursing Supervisor, transporters, the hospital chaplain and any others whose services are needed. During an in-house incident that involves staff members, these responders will arrive and be confronted with the need to treat an injured or dying co-worker. If a “Code Blue” was called during the incident, the CISM team should expect that any of these responders may have been impacted by the experience and they should be included in debriefings specifically designated for caregivers.

Having accumulated all of this information, it is now possible to assess/predict roughly how many employees and which departments are likely to be the most severely affected. Although many employees may be impacted in multiple ways, the circles of impact can be roughly delineated as follows:

1) Those who were witnesses — including employees, patients and visitors. These individuals may have been missed targets of the perpetrator, direct visual witnesses, or in the general proximity, but not in direct line-of-sight of the incident.

2) Those involved in providing immediate emergency medical treatment to the victims.

3) Those caring for seriously and/or critically injured patients whose condition may be unstable and/or are not expected to survive.

4) Those involved in caring for victims (including employees, patients or patients’ family members) who were not seriously injured.

5) Those who, as co-workers, are also close friends or family members of the victim(s).

6) Those who are long-term co-workers of the victim(s), but not close friends.

7) Those who are co-workers of the victim(s) but for a shorter period of time.

With the above information, the CISM Team Coordinator can begin planning the response. There will, however, be some additional information that will need to be collected on the next day.

Additional Assessment Tasks on the Second Day

Early on the second day, the CISM team will need to obtain, through the Human Resources Department (or from Department Heads), a list of the following:

1) Names and phone numbers of employees who were scheduled to work the day after the incident, but did not show up. (This can also be requested of Department Heads in their daily briefing.)

2) Names and phone numbers of employees who are scheduled off but were present on the day of the incident.

3) Language spoken by each individual, if not English.

The Telephone Outreach team (described below) will use these lists to make sure that these employees receive any needed support services.

Logistical Concerns

Communications - Hazards of Cell Phone Use

Unfortunately the radio frequencies used by cell phones cause interference with the medical telemetry used to transmit a monitored patient's vital signs (heart rate, blood pressure, and respiratory rate) back to the Nurse's station. For this reason, their use is currently prohibited in Medical/Surgical hospitals.

On June 8, 2000, the Federal Communications Commission (FCC) set aside three sections of radio bandwidth (608-614 MHz, 1395-1400 MHz and 1429-1432MHz) for use specifically on medical telemetry equipment in order to eliminate this problem (Federal Communications Commission, 2000). Unfortunately, it will take several years for these changes to be incorporated into new equipment and for older equipment to be replaced or updated. Consequently, for the immediate future, alternate communications will have to be used by the CISM team to stay in touch with the Team Coordinator and with each other. These options include:

- **Beepers:** The Team Coordinator should maintain a list of all team members' pager numbers. Keep in mind that any team member whose pager is combined with his/her cell phone will NOT be able to use it.

- **House Phones:** House phones are generally very readily accessible throughout the hospital and can be used by team members to call the Incident Command Center or each other. Team members should be provided with the telephone extension(s) for the Incident Command Center and beeper numbers of on-scene team members.

- **Overhead Public Address System:** Generally, calling the operator by dialing "0", identifying yourself and requesting that a specific team member be paged will be sufficient to utilize this system. This system will only work if the other team member is monitoring it. Additionally, this system should be used sparingly as the PBX operators will be overwhelmed with other incident-related calls.

- **Business Band Handheld Radios:** Another option is to supply key members of the team with programmable handheld business band radios that have the CTCSS code squelch. This feature, when activated, causes the radio to send transmissions with an additional code. This feature allows a business band radio, when set to one of the codes, to open its speaker ONLY when it "hears" transmissions that contain that code. The effect (of setting all radios used

by the team to the same code) is to screen out transmissions by other nearby businesses using the same frequency. Keep in mind that this feature is NOT the same as encryption and ALL transmissions can be heard by anyone with another business band radio (either un-coded or set to the same code) or a scanner. No confidential information should EVER be transmitted via radio. A license is also required by the FCC to operate these radios, but a CISM team can obtain a single commercial license that will cover all of the radios. (For more information, call the FCC at 1-800-418-3673 or visit the FCC's website and download the required forms (600, 159, 1070Z and PR 5000) from <http://www.fcc.gov/formpage.html> ("CallCtr CallCtr", 2000).

Planning the CISM Response

The structure of the CISM Team response will vary according to the severity of the incident and the extent to which staff are impacted.

Initial Defusing or Demobilization

If possible, arrange for a defusing (or demobilization) of staff involved in the incident prior to their release from duties for the day. Include the hospital's administration in the FACT stage so that accurate and updated information regarding the details of the incident can be provided. This will help to reduce the development and propagation of rumors among employees.

Initial Meeting with Administration

As soon as possible (and preferably on the day of the incident), arrange a meeting with the hospital administrator in order to establish a collaborative relationship between the hospital and the CISM team. The support of this individual for the overall operation and staff participation in it will be crucial to its success. The goals of this meeting are:

- 1) Explain that the CISM team's response on the first full workday following the day of the incident will be based on the assessment of the scene and the estimate of how many staff members may have been affected. This assessment may change as staff arrive for work and a more accurate determination can be made of the emotional impact of the incident. At that time a decision will be made to expand or reduce that level of response, if appropriate. (Note: Plan to have some team members on standby in the event the operation needs to be expanded.)

2)Based on the current assessment, explain the types of services that appear to be needed for the following day and how the hospital administration can assist with the response.

3)Ask the administrator(s) to designate an “agency liaison” to assist the CISM team with securing rooms for debriefings, department head briefing meetings, the drop-in center and individual sessions, announcing schedule and room changes, arranging for team lunches and/or snacks, arranging snacks for debriefing rooms, setting up signage and other needed tasks. This person should be someone who is minimally impacted by the incident and sufficiently knowledgeable of the hospital’s internal workings to be able to carry out these tasks.

4)Arrange for a room that can be used as a “command center” and team member staging area. This will help to reduce the level of chaos within the staff offices used initially by the first-responders. Two Incident Coordinators will actually be needed to cover the day and evening shifts.

5)An Incident Update Bulletin Board can be set up to aid in rumor control; designate a location and the person responsible for updating it. This board can also be used to provide updated information on how to access the team’s (or other follow-up) services.

6)Designate a time for the caregiver’s debriefing groups (or this can be left for discussion with the department heads). Explain the importance of restricting attendance to only emergency caregivers involved in the incident for the first couple of days and the consequent need for additional patient care coverage to relieve staff attending these “caregiver’s” debriefings.

7)Arrange a meeting of department heads — explain the need for a show of administrative support for staff participation.

8)Go over the format of the initial department head meeting (see below).

9)Confidentiality: Review the limits of confidentiality vis-à-vis staff debriefing sessions. If identifying information is to be collected for the purpose of generating statistics about services provided, the administration needs to understand the confidentiality of that raw data. Any disagreement regarding the confidentiality of this information should be resolved before any data is collected.

10)Determine whether or not the hospital would like the team to be available to see hospital patients; and if so what will be the procedure for seeing them?

Initial Meeting with Department Heads & Administration

The following tasks may be handled in this meeting:

1) Defusing of Administrators and Department Heads: Provide a defusing, time permitting.

2) Rumor Control: To help control rumors, arrange for a bulletin board where staff can get updates. Include a question box where employees can ask for verification of information.

3) CISM Services Plan: Review CISM services planned for the next day: times, tentative locations, how to access additional services for their staff, location of Incident Command Center, and how the staff will be advised of room and/or time changes.

4) Confidentiality: Review the limits of confidentiality vis-à-vis staff debriefing sessions and any data collected for statistical purposes.

5) Security Issues: Encourage the administrative staff to begin thinking about security issues and stress that this will be a primary concern of employees when they return to work. Most specifically, they will be asking what is being done to prevent a re-occurrence. Encourage a well thought out response rather than a reactive one.

6) Daily Briefing of Administrators and Department Heads: These meetings will provide an opportunity for the Incident Coordinator, Administration and Department Heads to exchange information, including updates on the condition of hospitalized survivors, any new information relative to the police investigation, funeral and memorial service plans, CISM services provided to date, planned changes in the level of services provided as the response winds down, CISM needs not yet addressed and any other concerns.

7) Debriefing of Administrators and Department Heads: After the initial crisis period has subsided, schedule a debriefing of department heads. Explain the rationale for debriefing them as a separate group later in the response:

a. Due to their supervisory positions, they will need to suppress their emotions to stay focused on their jobs of directing the work of others (which may make them less open to the debriefing process if done at this time).

b. They may need to discuss concerns that would be inappropriate to discuss with subordinates.

c. Finally, in some employment cultures, the presence of supervisors in debriefings of subordinates may inhibit the latter’s freedom of expression such that they don’t participate fully in the debriefing process. Since it is possible that some

administrative staff may choose to attend some of those debriefings, it would be helpful to explain in the initial meeting with department heads that the CISM team members will be having them step outside briefly to allow the group to be polled regarding their comfort level in having administrative staff present. The Team will observe confidentiality regarding the identity of any staff member who expresses his or her preference to have an administrator excluded from the group.

Planning the Response to start the first full day after the Incident:

Below is a list of services that can be set up as part of the team's response:

• **Team Members on Standby for Crisis Intervention (1:1):** Once the location of the Command Center is identified and announced to hospital staff and department heads, a stream of individuals (in need of crisis intervention) may begin to appear at the door. The Team Coordinator should remain in that capacity and refer these individuals to team members waiting in the staging area. Two team members (possibly more, depending on the size and severity of the incident) should be designated for these individual sessions.

• **Drop-in Center:** While providing relief nurses may allow regular Nursing staff to attend one or more debriefings, their patient care responsibilities may prevent them from taking full advantage of the services provided. Consequently, it will be helpful to them if a "Drop-in Center" is set up in an empty patient room that is central to all the patient care areas. This will allow Nurses additional opportunities for ventilation and support as they use their break time to visit the center. The Drop-in Center should be staffed with at least one team member during its hours of operation. Additional team members (for 1:1 sessions) may also be stationed here, as this site will also receive individuals in need of crisis intervention. Peer debriefers with a background in Nursing are an excellent choice for staffing this location.

• **Caregivers' (Debriefing) Groups:** During the first one or two days, the focus of these debriefing groups should be on those who provided direct care to casualties. If possible, arrange with (or encourage) the administration to schedule registry staff and/or local hospital mutual aide to relieve nursing staff for the purpose of attending these groups. And be sure the administration understands the time required to properly conduct a debriefing and schedules relief staff accordingly. These services may also need to be provided

in a language other than English.

• **Individual Sessions/Crisis Intervention:** Whereas the Team Coordinator may be temporarily drawn into providing brief support while an employee is waiting for a free team member to provide Crisis Intervention services, the Team Coordinator should not be expected to fulfill this role. These services may also need to be provided in a language other than English.

• **In-House Outreach Teams:** Outreach teams (consisting of two CISM team members) can be used very effectively by having them make "rounds" throughout the hospital. On their first round, they should be instructed to introduce themselves to Department Heads (or each unit's current supervisor or charge nurse) and let them know that they will be floating throughout the hospital and will check back with them periodically to see how their staff are doing. As needed, they can provide individual sessions and/or debriefings for small groups. The Incident Coordinator should be kept advised if the team's activities will take them out of service. It is also advisable to have some members of the CISM Outreach team remain for at least part of the Night Shift so that their needs are also addressed.

• **In-House Outreach Team Coordinator:** It can be very helpful to have Outreach Teams consisting of two licensed CISM team members. To reduce the supervisory responsibilities of the Incident Coordinator, it will be helpful to designate one member as the roving supervisor. This person should be in regular contact with the Incident Coordinator, providing updates as needed.

• **Telephone Outreach:** Due to the varied work schedules characteristic of this type of setting, a number of people, who were involved in the incident, may be taking their usual days off beginning the day after the incident. A few others may simply have difficulties returning to work. The Telephone Outreach team should be given a list of these staff members (including phone numbers and language spoken) to call at home. The calls can be used to advise them of the services available at work, provide telephone defusing (if time allows), assess the impact of the incident and the need for additional services. Utilize translators for non-English speaking employees.

• **Home Outreach Visits:** If a staff member is having difficulty returning to work, arrangements can be made for a CISM team member to visit that person (and his or her family, if needed) at home. It can also be helpful to have the same team member available to meet the staff member when he or

she returns to work.

• **Agency Liaison (a hospital staff person):** Early in the incident response, the Incident Coordinator should have the Hospital Administration designate a minimally impacted staff member to act as a Liaison between the Hospital and the CISM team. He or she can be of great assistance to the team by arranging for group rooms and daily briefing meetings, signage, team lunches and snacks, broadcasting room changes and other necessary information to staff and/or department heads, and any other task that requires knowledge of the hospital's internal workings.

• **Department Debriefings:** As the response to the incident progresses, there may be some departments that need to be debriefed separately, either because scheduling does not allow them to attend the main debriefing sessions or they may prefer to debrief as a separate group. In these cases, it will be helpful to schedule a debriefing right in the department through the department head.

• **Patient Contacts:** Unfortunately, it is possible that patient rooms may be immediately adjacent to (one or more of) the incident scene(s). Debriefing patients who were emotionally impacted by the incident should NOT be done without a doctor's order. In some cases, temporary privileges may have to be granted by the hospital before a team member may see one of the hospital's patients. After obtaining administrative support, a letter can be placed on the chart of each affected patient, advising the doctor that the patient has been exposed to the traumatic event, educating him/her about the symptoms of traumatic stress, and providing instructions on how to order debriefing services for a patient whose condition is stable enough to tolerate it.

• **Patient's family and other visitors:** At the discretion of the hospital, the team may be called to see family members of affected patients and/or other visitors who were in the hospital at the time of the incident. If these individuals need additional support, they can be referred to a local clinician who accepts reimbursement from the Victims/Witness Program. It will be helpful to obtain a list of these clinicians from the local program office early in the incident response and keep it in the Incident Command office so that referrals can be easily provided.

Closing Down the Operation:

• **Releasing CISM Team members:** As the need for CISM team services declines, members of the team will be released from duty. In choosing which staff to release first,

consider the overall hours and exposure each has had as well as their hours of availability for additional assignment. Determine the current needs of the operation, and retain team members according to availability to meet the current need, balancing their need for time off.

• **Making Recommendations for Follow-up:** Determine what resources are available to the hospital for assessing employee need for additional follow-up and/or referral to Workman's Compensation. This may include an Employee Assistance Program or staff from the Department of Social Services.

• **Final Meeting with Administration:** This meeting is used to officially transfer the responsibility for follow-up care to the Hospital Administration and other designated individuals. If the Incident Commander is not familiar with workman's compensation, it will be helpful to have an individual in attendance who is familiar and who can answer any questions posed by the administration. Recommendations may also need to be made regarding arrangements for a Workplace Violence Risk Assessment to be done throughout the hospital. Administrative staff may also have questions about how to deal with areas of the hospital that are reminders of the trauma for some staff members.

Conclusion

Coordinating a CISM team's response to this type of incident is an enormous responsibility and a very stressful experience. It is hoped that by sharing these "lessons learned," CISM-trained clinicians will be better prepared to respond in the event of another similar incident. The unique characteristics of each event will also require that CISM team coordinators be flexible and creative in adapting their team's response.

With the increasing incidence of workplace violence, it is also becoming more likely that the healthcare industry will occasionally experience such an event. Hospital administrators and their employees need to be prepared for this possibility. In addition to utilizing risk assessment services to evaluate their work environment, the commonly used "code gray" (which alerts available staff to respond because assistance is needed to contain a behaviorally out-of-control individual) needs to be augmented with a new code (and appropriate response policy) that designates the involvement of a lethal weapon. Without this new code,

unsuspecting employees responding to the designated location may find themselves directly confronting an armed and lethally dangerous assailant. Clearly, the lives of hospital employees (in both medical and psychiatric facilities) will be at greater risk until these protective measures have been developed and implemented. Please, if you work in one of these healthcare settings and your employer has not yet implemented this change, encourage them to do so. Your life

and those of your co-workers will be safer for it.

Notes

1. If there have been employee fatalities, the line of duty death protocol for the day of the death (Mitchell and Everly, 1997, pg. 201) may be more appropriate.

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