Thriving in Health

Critical Incident Response Model Toolkit

Peninsula Health

Thriving in Health

FBG

Supported by WorkSafe Victoria WorkWell

Contents

The resource was created in collaboration with FBG Group, as part of the Thriving in Health project. The Thriving in Health project is supported by WorkSafe's WorkWell Mental Health Improvement Fund. The information in this resource is not intended as a substitute for workplace specific health and safety measures. Information contained in this resource was considered best practice as at March 2023.

The context

This toolkit came about as part of the Thriving in Health project, supported by WorkSafe Victoria's WorkWell Mental Health Improvement Fund.

FBG Group partnered with Peninsula Health to develop a best-practice model to strengthen the organisational response to critical incidents. This strategy is one of the number of strategies within the Thriving in Health project, aimed at protecting and promoting the mental health and wellbeing of healthcare workers by removing and reducing work-related psychosocial hazards.

Creating mentally healthy workplaces

Employers have a legal responsibility under the *Occupational Health and Safety Act* (2004) to provide and maintain so far as reasonably practicable a working environment that is safe and without risk to physical and psychological health. This involves managing the risks posed by hazards, including work-related psychosocial hazards, so far as is reasonably practicable.

Psychosocial factors are elements that impact employees' psychological responses to work and work conditions. Psychosocial hazards are anything in the design or management of work that increases the risk of work-related stress[1]. It is well recognised that healthcare workers can be exposed to many potentially traumatic events (PTE) through the nature of their work. Violent or traumatic events are one type of psychosocial hazard, which can be experienced directly (i.e., critical incidents), indirectly (i.e., vicariously experienced) and cumulatively (i.e., a build-up of repeated exposure to PTEs and other stressors).

While managing psychosocial risks is the law, it also makes good business sense. Workplaces that do not manage risks have been found to experience greater absenteeism, greater presenteeism, reduced performance and increased compensation claims[2]. Furthermore, workplaces that do not consider psychosocial risks can exacerbate mental health symptoms experienced by staff[3].

1. SafeWork Australia (2022). Managing psychosocial hazards at work. Code of Practice. https://www.safeworkaustralia.gov.au/doc/model-code-practice-managing-psychosocial-hazards-work
2. Productivity Commission. (2020). Mental Health (No. 95). https://www.pc.gov.au/inquiries/completed/mental-health/report#:~:text=The%20Productivity%20Commission's%20Mental%20Health%20Inquiry%20presents%20a%20long%2Dterm,of%20children%20and%20young%20people.
3. Harvey, S. B., Joyce. S., Tan, L., Johnson, A., Nguyen, H., Modini, M., Growth, M. (2014). Developing a mentally healthy workplace: A review of the literature. National Mental Health Commission and the Mentally Healthy Workplace Alliance. https://www.headsup.org.au/docs/default-source/resources/developing-a-mentally-healthy-workplace_final-november-2014.pdf?sfvrsn=8

Getting started with the evidence

Healthcare workers can face many potentially traumatic events (PTEs) through work. A PTE is a term commonly used to describe incidents, or series of incidents that have the potential to threaten the physical safety or psychological wellbeing of an individual or group. A 'critical incident' is a common type of PTE in the healthcare sector.

In healthcare settings, critical incidents may include, but are not limited to:

work-related violence and aggression, including code greys and code blacks

clinical events involving death, including those of children or the sudden death of a patient

disasters and major events with large scale casualties.

Critical incidents are often defined synonymously with an adverse clinical event. Research over the last two decades strongly suggests that we move away from this black and white categorisation, as what might be impactful for one person, might not be for another. By only looking after the mental health and wellbeing of staff after a clinical or critical incident, we inhibit appropriate attention towards other factors which contribute to poor mental health outcomes at work. Many organisations have also made a key assumption that the event itself is the cause of any psychological harm that one might experience and that exposure to such incident will lead to distress and trauma. However, this isn't true. Research tells us that multiple interacting factors influence how any one person responds in the hours, days, weeks, months or years following a critical incident or PTE[4].

We cannot take a one-size-fits-all approach

For a long time, organisations have taken an event-centred, organisation-led approach when responding to critical incidents. This has often involved a rapid on-site response immediately following the incident, with multiple personnel including professional counsellors conducting mandated one-on-one and group psychological debriefing. This approach tends to be a one-size-fits-all and the problems with this are:

- it assumes all individuals respond to the same event in the same way
- it assumes that the event was confronting, challenging or upsetting for everyone
- it neglects to consider the range of other experiences and unique needs that individuals bring
- it forgoes choice for how recovery occurs
- it can expose others to additional trauma or PTEs.

4. McNally, R. J., Bryant, R. A., & Ehlers, A. (2003). Does early psychological intervention promote recovery from post traumatic stress? *Psychological Science in the Public Interest, 4*(2), 45-79. doi: 10.1111/1529-1006.01421

- it can result in one individual or a small group of individuals having the skills to respond,
- it is often implemented as if there is a belief that all parties involved have been impacted in the same or similar way and have the same or similar psychological needs,
- it neglects to consider the surrounding systems of work that can impact an individual.

When we respond to critical incidents as if they are inherently traumatic, we fail to control or reduce the risk of harm associated with the event as far as reasonably practicable.

For further details read the Thriving in Health: Critical Incident Responses in Healthcare White Paper

Exposure can be cumulative

The experience of PTEs can be cumulative. **Cumulative distress (or cumulative trauma) can develop over the course of one's work** through repeated direct or indirect exposure to critical incidents and other types of PTEs. The impact of exposure can be exacerbated or mitigated by the surrounding systems of work, as well as an organisation's response to PTEs.

Case study

A nurse is exposed to verbal aggression from several patients and their family members.

There's a lot going on and they're not sure if it's a big enough concern to raise with their manager. Feeling distressed and unsettled is just part of the job, right?

Logging an incident about this unacceptable behaviour can be time consuming and the process can be confusing. However repeated exposure to this type of behaviour over time can have a cumulative impact on mental health.

Most of us will recover... naturally

Research has shown that many people recover from critical incidents through the use of non-professional supports such as family, friends and one's own mental health strategies and resources. This process is called natural recovery. Research indicates that some organisational responses can interfere with natural recovery. Although the majority of people want support from their organisation, they do not always feel their organisation has adequately supported them following a critical incident or exposure to PTEs. Where support is provided by the organisation, it can be perceived by frontline staff to be unorganised, unstructured and unsystematic. The gap between current practice and research findings, as well as feedback from those often exposed to critical incidents, makes a strong case to change the way organisations respond to these PTEs.

A note on group *psychological* debriefing

While it may seem beneficial to gather impacted staff in a safe, non-judgemental space to reflect, process and share experiences and feelings after a critical incident, research tells us that it can have the opposite effect[5]. The World Health Organisation[5] suggests that group psychological debriefing "should not be used for people exposed recently to a traumatic event as an intervention to reduce the risk of post-traumatic stress, anxiety or depressive symptoms".

This is not to say we shouldn't bring teams together. Running an information session or an operational review (where relevant) that treats the event or exposure as an opportunity for learning and development can be beneficial.

5. World Health Organisation. (2012). Psychological debriefing in people exposed to a recent traumatic event. https://cdn.who.int/media/docs/default-source/mental-health/mhgap/other-significant-emotional-and-medical-unexplained-somatic-complaints/psychological-debriefing-in-people-exposed-to-a-recent-traumatic-event.pdf?sfvrsn=8bb5f0cb_0

CREATING A MENTALLY HEALTHY WORKPLACE WITH A CONSISTENT CRITICAL INCIDENT RESPONSE

Critical incident management involves preparation, prevention and response

A prevention-focused critical incident response recognises that most people exposed to these PTEs, or series of PTEs, do not go on to experience psychological injury. When the critical incident response takes a person-centred focus including an individuals' experience of the incident, the surrounding workplace factors and one's personal factors, staff can be provided with the support they need, when they need it. Unfortunately it is not always possible to prevent a critical incident from occurring in the first place. We can, however, reduce risk factors associated with critical incidents and prevent psychological injury.

A preventative approach to managing critical incidents involves three key domains:

PREPARING managers and staff with the capabilities to manage the response in a way that removes or reduces work-related risk factors before harm is caused. This involves:

- developing capability to implement a contemporary, coordinated and consistent approach
- raising awareness of normal responses to PTEs
- clarifying roles and responsibilities for managing PTEs.

PREVENTING psychological harm through exposures to PTEs by:

- providing a stepped care approach to supporting staff
- providing choice in how recovery occurs
- building awareness of the shared responsibility to mental health and wellbeing.

SUPPORTING those who are impacted by the PTEs and/or surrounding systems of work by:

- providing access to the right supports at the right time
- taking a person-centred focus.

UNDERSTANDING YOUR BASELINE POINT

Maturing your organisation's mindset

A preventative approach requires more than just a new set of actions. It must be combined with a new mindset underpinned by the last two decades of research. This mindset must shift from focusing specifically on the critical incident, i.e., just responding to those who have experienced a clinically defined 'critical incident', to one that is proactive and recognises that individuals have a range of experiences, i.e., recognising that many factors can influence mental health and wellbeing at work. WorkWell uses the cultural maturity model developed by Frankal & Leonard[6] as a guiding framework for measuring changes in workplace attitudes and behaviours. Many healthcare organisations may naturally have a mix of reactive and proactive elements embedded with the critical incident response.

6. Frankal, A., & Leonard, M. (2018). A systematic framework for the delivery of safe, highly reliable care and habitual operational excellence. Health Catalyst. https://www.healthcatalyst.com/learn/webinars/systematic-framework-to-deliver-safe-reliable-care-and-operational-excellence

Reactive responses may look like:

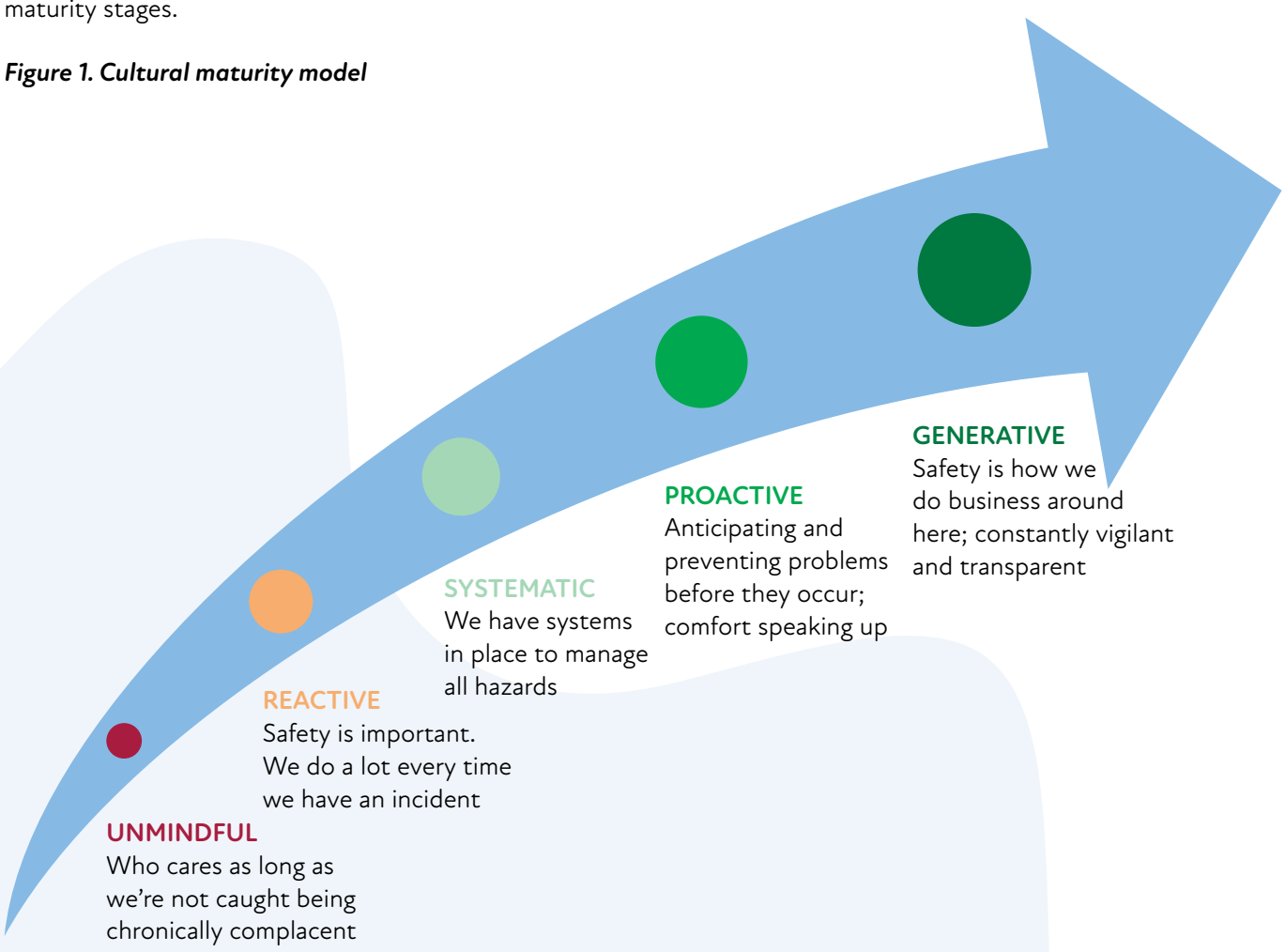
- rapidly providing on-site response immediately following the incident, with multiple personnel including professional counsellors conducting one-on-one and group debriefing
- providing and encouraging participation in group psychological debriefing
- providing 'one off' support and returning to regular operations
- Assuming that everyone will respond in a similar way
- Encouraging time away from the workplace for those involved with or impacted from an incident
- Taking a narrow focus and applying supports after critical events that do not take into account everyday workplace stressors
- Initiating a response after a formal 'critical incident' has been declared.

Proactive responses may look like:

- monitoring staff in an ongoing manner
- facilitating personal choice about how recovery occurs and what support is required
- being ready to support staff who may be showing signs of impact, regardless of exposure to PTEs
- recognising that staff may be impacted by incidents that do not meet the definition of 'critical'
- activating a critical incident response when signs of impact are noticed, not only if an official critical incident has occurred
- providing ongoing communication to staff about how their wellbeing is being supported
- preparing a timely response to support staff who may be impacted.

Consider where your organisation may spend most time operating. It's not uncommon to have elements across the maturity stages.

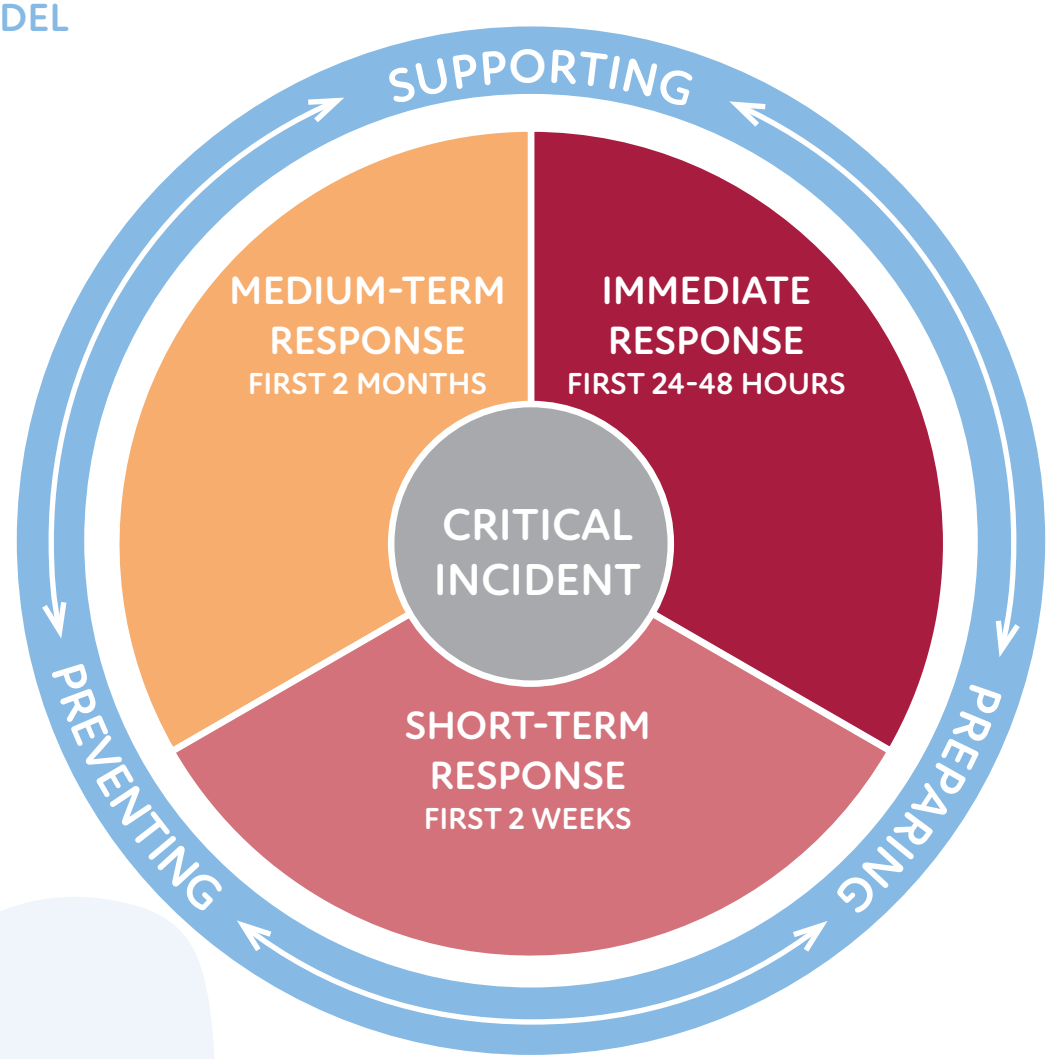
Figure 1. Cultural maturity model



Preventative approaches to critical incident responses: a model

The Critical Incident Response Model can help healthcare organisations take a consistent approach to supporting the mental health and wellbeing of staff in the long-term.

THE MODEL



IMMEDIATE RESPONSE

FIRST 24-48 HOURS

Ensure the immediate safety of affected staff members and assign a response leader to promote natural recovery.

SHORT-TERM RESPONSE

FIRST 2 WEEKS

Provide ongoing support to staff in line with a stepped care approach to support natural recovery.

MEDIUM-TERM RESPONSE

FIRST 2 MONTHS

Continue to monitor the wellbeing of staff after the incident.

THE APPROACH

Key elements	What this means in practice
Expects most people to be resilient and/or recover in the short-term	Rather than mandate counselling or debriefing in the initial aftermath, managers are best placed to watch and observe their staff for signs of how they're responding.
Understands that mental ill-health is the product of many factors and staff wellbeing should be an ongoing concern	A number of personal and work-related factors can build to influence how individuals experience incidents. What might be impactful for one person might not be for another. Recognising that an incident has occurred can show staff that they are seen, but it is not assumed that they will be impacted.
Facilitates personal choice in how recovery occurs	Support people to connect with the services and social support they feel best suits them and not suggest that coming together in a group format to debrief on how they are feeling is the best way.
Responds to those who need help at the right time and in the right way	Facilitate a tailored, **stepped care approach** to critical incident response management.
Understands the important role of immediate line managers in supporting staff following a critical incident or PTE	People leaders have a responsibility for looking after their staff all the time, not just when a critical incident occurs. Line managers are often best placed to understand their staff, notice any changes and assist with accessing appropriate supports in a timely manner. Leaders play a key role in creating environments where it is ok to speak up and seek support.

What is a stepped care model of support for critical incidents?

The stepped care model incorporates 3 levels of interventions:

LEVEL 1:
The availability of immediate support and monitoring for all exposed to the critical incident, such as psychological first aid delivered by managers, supervisors or peer supports. Support should be initiated by those who want help rather than being mandated.

LEVEL 2:
Brief-focused interventions for those who do not 'bounce back' and continue to experience mild mental health symptoms. This should be delivered by psychologists or other trained mental health professionals, not managers themselves.

LEVEL 3:
Referral to evidence-based treatment for the minority of people who develop and maintain compromised mental health, such as a condition that resembles post-traumatic stress disorder. These interventions are delivered by trauma specialists such as psychologists or psychiatrists.

ALIGNING THE FOUNDATIONS IN YOUR WORKPLACE

To mature the organisational response to critical incidents, the following architecture are recommended.

Architecture	Details	Questions to ask
Define accountabilities	Ensure the accountabilities of managing and responding to critical incidents are clear to all. This includes response leaders, staff and Work Health Safety (WHS) and Human Resources (HR) teams as appropriate. Key roles include: **RESPONSE LEADER:** • Use psychological first aid to support staff following a critical incident. • Take charge for determining how staff will be supported following a critical incident, from the first few hours to first few months. • Plan for, review and revise supports for staff. • Monitor staff wellbeing in the short-, medium- and long-term following a critical incident and apply a stepped care approach to supporting staff. **STAFF:** • Take reasonable steps to look after their mental health and wellbeing. • Initiate the support they need in a timely manner. • Take reasonable steps to look after the mental health and wellbeing of their colleagues. **WHS AND HR TEAMS:** • Provide governance to process. • Ensure resourcing of mental health and wellbeing supports for staff and managers. • Maintain recency of policies, procedures and processes. • Determine training needs for managers and staff, • Ensure Employee Assistance Program provider is fit for purpose. • Ensure appropriate prevention plans and/or risk registers are in place and reviewed on an appropriate, regular basis.	• Are accountabilities clear to everyone? • Are these defined in policies and procedures? • How are these accountabilities explained in onboarding and ongoing training?

Architecture	Details	Questions to ask
Develop capability	Ensuring those accountable and responsible for the critical incident response are clear what a best-practice critical incident response involves, what to expect and feel confident to apply their skills. **FOR MANAGERS THIS INCLUDES:** • understanding the evidence behind best-practice incident management • understanding the principles of psychological first aid • assessing risk and identifying those showing signs of impact • ability to facilitate operational debriefs that avoid group psychological debriefing • ability to have wellbeing conversations with staff • awareness of supports and resources available internal and external within the organisation • role modelling self-care. **FOR EMPLOYEES THIS INCLUDES:** • understanding the evidence behind best-practice incident management • awareness of what a proactive approach to critical incident management looks like • awareness of what normal responses to the exposure to PTEs looks like • responsibility for looking after own mental health and wellbeing • responsibility for supporting mental health and wellbeing of others • Awareness of supports and resources.	• What training do managers and staff receive? • What is the current level of awareness of what to expect with a critical incident response? • Do staff and managers know where to get support? • Do managers feel confident to facilitate group debriefs that avoid venting emotions? • Do managers know who the response leaders will likely be in their work area? • Are staff aware of the role they have in supporting the mental health and wellbeing of their colleagues?
Align policies and procedures	The organisational response to critical incidents is clearly defined and aligned with expectations for supporting mental health and wellbeing in the workplace. Related policies and procedures may include: • Mental health and wellbeing policy and procedure • Critical incident response policy and procedure • Emergency management policy and procedure • Leave policy and procedure • Injury management policy and procedure • Occupational violence and aggression policy and procedure.	• Do policies and procedures define a how critical incidents and PTEs should be managed? • Is there consistency across all related policies and procedures? • Are these policies and procedures easily accessible?

Architecture	Details	Questions to ask
Educate organisational supports	Ensure organisationally endorsed supports are aligned with an evidence-informed response to ensure a consistent approach to supporting staff. Ensure supports are accessible and managers understand when and how they can be used for best effect. Supports to consider may include: • experts such as in-house and external psychologists, counsellors • employee Assistance Program providers, including the Manager Assist function • peer support programs • HR and Work Health & Safety representatives • intranet pages • information and supports for family and friends • community organisations.	• Does the EAP respond in an evidence-informed, preventative manner? • Is the Manager Assist functionable to provide coaching support to response leaders? • Are managers aware of the range of support options available to staff?
Communicate consistently	Communication is consistent and is aligned with the principles of the model. Messaging is clear and consistent across all levels of the organisation and staff and stakeholders are informed about the most effective responses. Communication empowers individual choice to recovery.	• Is the approach to managing critical incidents communicated in a consistent way by managers and key stakeholders? • Are staff aware of what they can expect following a critical incident?
Guide, don't dictate	The response is principle-based rather than a prescriptive processes. This: • enables managers to put actions in place that suit the varied needs by incident and by person, and • guides managers to execute key parts of the process safely, e.g., facilitating critical incident information sessions, undertaking risk assessment, providing psychological first aid.	• Does the response allow flexibility depending on the incident, number of recent incidents and different individual needs? • Are critical incident response leaders supported to plan for response depending on the circumstances of the event(s)?
Apply methodologies	Methods of engaging with staff are founded on the basis of: • psychological first aid • stepped care approach.	• Is the approach to managing staff mental health and wellbeing embedded with the principles of psychological first aid? • Can a stepped care approach be taken where the right support is provided for the individual at the right time?
Implement a timely approach	Timing of the response should consider: • the early hours and days after a critical incident or PTE • the normal responses in the initial hours, days and weeks after a critical incident or PTE • ongoing monitoring and response to individual needs (irrespective of when the critical incident occurred) as the months and years transpire.	• Do response leaders understand best practices in the days, weeks, months following a critical incident or PTE? • Are response leaders ready to support staff showing signs of impact?

KEY PRINCIPLES OF THE NEW MODEL – 'PREVENT'

Provide person-centred responses

Rather than focusing on the critical incident as the central player in a critical incident response, better outcomes are more likely when impacted individuals are the centre of the response. When the individual is in focus, those assisting them in recovery not only take note of their unique response to the PTE but also understand that many other factors – in addition to or instead of – the critical incident, could influence their mental health. Those who adopt a person-centred approach understand that the mental health of an individual is enduring and an ongoing concern.

Regularly observe

Managers do not need to be diagnosticians to ensure that staff do not fall through the cracks. Instead they need fundamental skills in observation and knowledge of the right questions to ask to ensure they can guide staff to the right supports at the right time. Observation should extend beyond the immediate hours and days after a critical incident. Staff mental health is not just the outcome of a critical incident. It can be impacted by multiple variables acting together and the manifestations can appear at any time. Observation does not end when the immediate dust settles from one critical incident.

Educate with evidence

The critical incident response presents managers with an opportunity to educate staff about the actions that best align with good mental health outcomes following exposure to PTEs. This education process is critical to embed one's own capability and confidence to drive a path toward recovery and resilience.

View long-term health and wellbeing

Organisations have typically taken a short-term view when responding to critical incidents based on an assumption that immediate expert-led support mitigates poor mental health outcomes. However, whilst well meaning, rapid responses risk creating poor mental health outcomes. Organisations need to take a longer-term view – well before and well after the critical incident – being proactive to build mentally healthy and resilient staff.

Empower with communication

Rather than communicating one-size-fits-all messages, communication in the aftermath of a critical incident should explain the established critical incident response framework and empower individuals to use their knowledge and skills to find their own pathway to maintain or build their mental health, leaning into the organisational supports as required.

Nurture natural recovery

Rather than an organisation-led response, it may be more effective for organisations to focus on enabling agency amongst those impacted. This means placing greater trust in managers and employees to take action to protect their mental health. This reduces the likelihood of interfering in the natural recovery process as those impacted are free to determine what support they need and when.

Tailor supports

If individuals respond differently to critical incidents and follow different recovery pathways, the logical conclusion is that they have different needs, different degrees of need, at different times. This may mean providing limited assistance to the majority who are recovering naturally and implementing a stepped care approach which considers each person's varying degrees and duration of symptoms over time, assisting each person to receive the right type and level of support at the right time for them.

Putting the model into practice

Reviewed literature and developed white paper
Conducted a comprehensive investigation of national and international research and best-practice models relating to critical incident management in high intensity environments. Developed a white paper synthesising these findings.

Conducted consultations
Consulted broadly across the Victorian Healthcare sector including frontline workers, senior leaders and key stakeholders. Sought to understood current critical incident responses and the priorities of different stakeholders.

Developed response model and guide
To support healthcare organisations to take a consistent, evidence-informed, prevention-focused approach to promote mentally healthy systems of work, prepare for managing risks and respond to impacted staff from potentially traumatic critical incidents.

Piloted the model with two organisations
Partnered with two healthcare organisations to trial the Critical Incident Response Model. This involved forming steering committees, reviewing policies and procedures, delivering training to staff and managers and providing ongoing support for response leaders.

Evaluated the pilots
Involved collecting pre-pilot, post-training and post-pilot data to compare implementation against intended outcomes. Involved conducting surveys, focus groups and individual interviews with staff and managers from pilot wards.

Finalised the model
Incorporated key learnings from the pilot process to consolidate the model and put it forward for implementation by healthcare organisations.

CASE STUDY: PILOTING THE CRITICAL INCIDENT RESPONSE MODEL

Background:
After identifying possible risks to worker mental health from exposure to potentially traumatic events, a large health service engaged with mental health experts to pilot the Thriving in Health Critical Incident Response Model.

Step 1:
Workplace mental health experts facilitated an introductory workshop with key health service stakeholders to outline the proposed Critical Incident Response Model and methodology for implementation, and compare the proposed model with existing practice. Stakeholders invited to the workshop included:

- those with governance and accountability for critical incident response across the health service
- managers with responsibility for leading critical incident response on the ground (targeting managers from a targeted pilot ward/department).

Step 2:

Using a checklist provided by workplace mental health experts, the health service identified opportunities to enhance their current organisational critical incident response in line with the proposed model's architectural points and key best-practice principles. Opportunities included reviewing, editing, updating or creating, policies, procedures and guidelines. Examples of documents for review included:

- critical incident response management procedures
- clinical incident response management procedures
- work-related violence policies
- leave policies
- mental health and wellbeing procedures
- supervision frameworks.

Step 3:

An implementation plan was developed to create conditions for an effective pilot in an area of the health service (e.g. ward/unit/department). The plan included:

- education for key leaders to introduce the model and approach to implementation
- training for managers and staff, supported through a dedicated communication plan
- application of updated policies, procedures and guidance material to practice
- identification of the tools to be used to measure and evaluate the pilot.

Step 4:

Training was delivered to managers and staff by mental health experts, using the safest platform available (e.g. facilitated face-to-face on-site). Pre and post surveys were used to capture the impact of training on staff skills and knowledge.

Step 5:

The Thriving in Health Critical Incident Response Model was applied when an incident occurred on the target ward/unit. In line with organisational emergency management protocols, the dedicated response leader used guidance material and contacted the workplace mental health experts for critical incident management advice and support (i.e. resembling that of a 'manager assist' function). Recognising the need to maintain the response leader role across a rotating shift work roster, ongoing response leaders were identified and created a plan for ongoing implementation of the response model over the coming weeks and months.

Step 6:

An operational review was conducted two weeks after the incident, led by the relevant ward director and included the work health and safety team and other stakeholders across the service (e.g. work-related violence team).

Step 7:

Staff were monitored for signs of impact for the following few months, recognising the cumulative impacts of fatigue, staff shortages and the general residue effects of the COVID-19 pandemic.

Step 8:

Managers and staff were invited to participate in an evaluation of the pilot, with learnings informing an organisational approach to expanding the pilot across the business.

WHAT DID WE LEARN?

- Many organisations may be already aligned in key elements of the approach, however, there may be inconsistency in the way that the response occurs as a result of:
  - type of incident
  - timing of incident
  - operating nature of the ward/work area
  - manager experience/specialty
  - organisation-wide processes or recommendations provided (e.g., immediate on-site visit by EAP provider)
  - staff expectations and request for group psychological debriefing.
- Individuals can experience the same incident differently and while an incident may not be considered 'critical' (e.g., no clinical code is called), it can still be impactful for staff (e.g., the death of a long-standing patient).
- Staff often appreciate receiving some notice that an incident has occurred as it acknowledges the challenging nature of work.
- Coming together to review the operational elements of an incident in a non-judgemental way can be a useful exercise to increase staff confidence and feelings of safety as it can provide a space to discuss the approaches that may best work for supporting patients.
- The act of bringing ward/area managers together in the form of training or group setting can be a useful way to clarify likely roles in responding to PTEs and thus increase consistency in the response.
- Managers can lean on one another for guidance and advice while leading the response.
- In-person training can encourage conversation and healthy debate to operationalise the response for a specific work area/ward. Virtual training can be more accessible for some, depending on the operational environment.
- On-demand resources, such as quick-reference guides and learning bytes (e.g., e-learns), can be helpful tools for a quick reference after an incident has occurred.
- There is a shared responsibility for supporting one another following an incident. Staff can take steps to look after their own mental health and wellbeing and look after that of their colleagues by avoiding sharing sensitive or potentially traumatic information about the incident.
- Training focused on the evidence, theory and process behind leading practice critical incident responses can increase knowledge, skills and confidence of managers and staff to apply a preventative and planned set of actions.
- Training on vicarious trauma can be well received by staff and can contribute to the understanding of a shared responsibility of mitigating risk by sharing potentially traumatic details of an event.

Getting started: a guide to implementation

THE INFRASTRUCTURE

1. Understand where to start

- Determine your organisation's cultural maturity.
- Assess what resources you have available within the organisation and where additional expert support may be required.
- Identify who you can approach for support.

2. Enlist the help of others

- Create a working group within your organisation to build confidence within leadership teams.

3. Familiarise your working group with the evidence

- Read the Thriving in Health White Paper.

4. Conduct a needs analysis across the organisation to determine:

- What are current practices?
- What is working well?
- What is the aspired practice?
- How does this match up against the key architecture?
- How is this supported in related policies and procedures?
- What is the current capability within the organisation?
- Identify the supports and initiatives that can be leveraged and map out any anticipated barriers.

5. Review policies & procedures to align them with best practice

6. Ensure the Employee Assistance Program is aligned in methodology and approach

7. Identify an implementation area and work with area manager

8. Provide training to managers and staff

9. Educate key stakeholders, including:

- unions
- organisation executives
- medico-legal stakeholders.

10. Review and revise process

11. Expand to other areas

Tip! Pilot the response with one area within your organisation. Start small, enlist local support and build it out from there.

A guide for response leaders: the model in action

IN THE HOURS AND DAYS AFTER A POTENTIALLY TRAUMATIC INCIDENT: SUGGESTED ACTIONS

The focus of this phase is for the response leader(s) to activate their role and ensure the immediate safety of affected staff members using the principles of psychological first aid.

Not all of these steps have to be completed on the same shift in which the incident occurred.

The initial steps involved in responding to the immediate needs of staff are aligned to the principles of psychological first aid. While some staff may show immediate signs of distress, this does not mean they will continue to be impacted. Nor does it mean that those who may show no immediate signs of distress will continue to be okay. It's important that a response leader begins to create a plan for supporting those who may start to show signs of impact.

Depending on the time or type of incident, the typical response leader(s) may not be available. The leader who holds the current responsibility for ensuring staff mental health and wellbeing (e.g., a shift manager) may initiate the response, then determine if it would be appropriate to handover the role to a response leader who may be better placed to look out for staff in the longer term. This hand over could occur when next practical (e.g., the following Monday if the incident occurred on a weekend, for instance).

Some of the actions may be implemented in the first couple of hours to couple of days. If the response leader role is handed over, the initial leader must communicate the completed and outstanding actions. Depending on the operational nature of the work area, it may be more efficient to conduct an informal 'information session' while staff are still on shift.

The timing of actions should be based on the judgment of the response and in consultation with other key internal and/or external stakeholders.

A note on bringing staff together

It is still important for managers and even senior managers to acknowledge that the incident has occurred. This could involve bringing impacted staff together to provide a **Critical Incident Information Session**. This type of session is intended to:

- provide basic factual details of the event

- acknowledge idiosyncratic responses to critical incidents and avoid generalisations

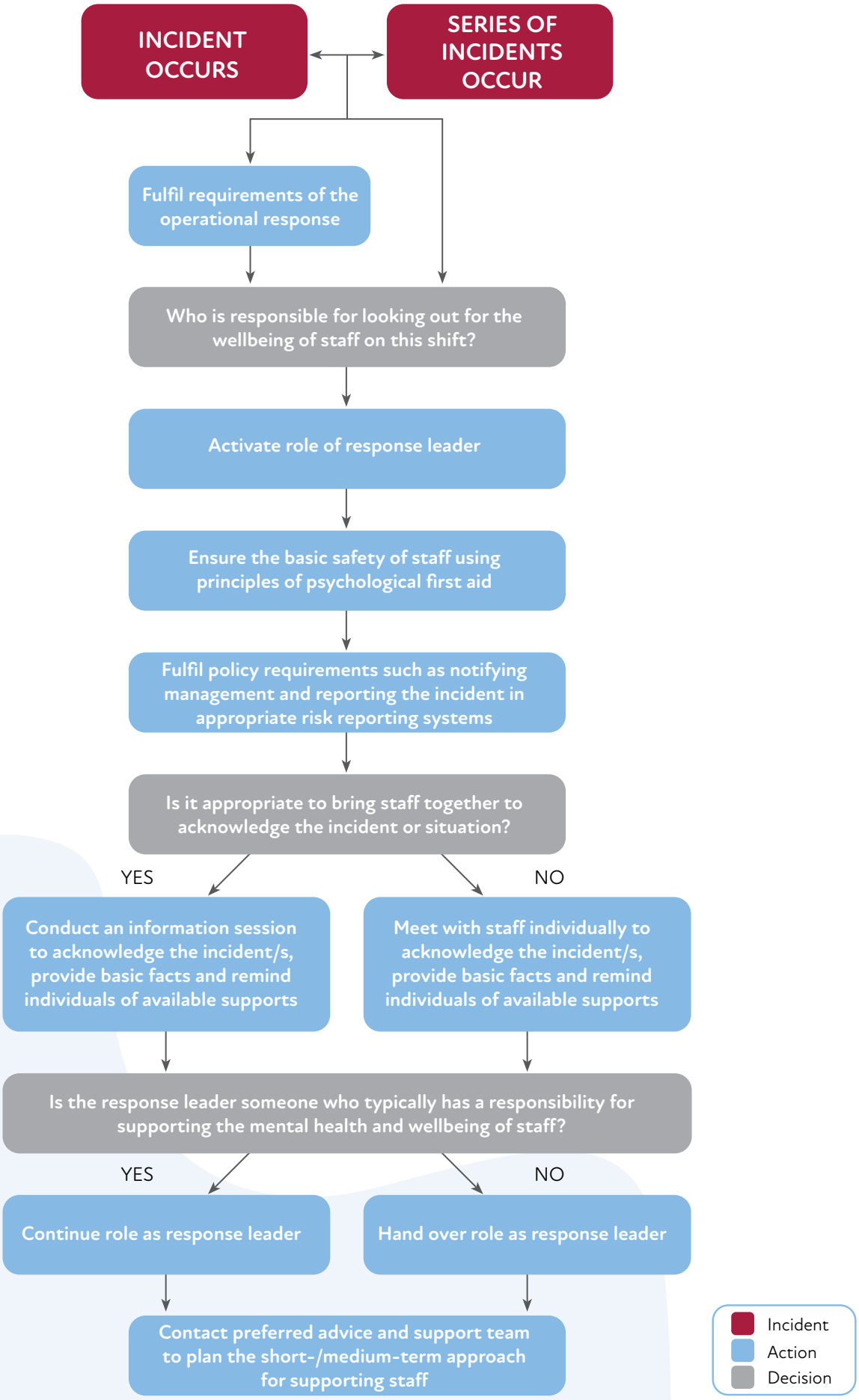
- educate staff on the best ways to support one another

- address any immediate safety needs

- and ensure staff have the details of available supports and services so they are empowered to find their own path to recovery and lean on organisational supports as required.

Note: These sessions should not stray into the arena of emotional or psychological debriefing.

IN THE HOURS AND DAYS AFTER A POTENTIALLY TRAUMATIC INCIDENT: SUGGESTED ACTION PLAN



THE FIRST FEW WEEKS AFTER A POTENTIALLY TRAUMATIC INCIDENT: SUGGESTED ACTIONS

The focus of this phase is to support natural recovery by providing a stepped care approach.

Supporting staff wellbeing

Staff will learn to expect more 1:1 check-in conversations in the weeks following an incident. It's common for staff to report feeling some levels of distress or impact in the following weeks. For many, these will dissipate over time through natural recovery processes. Where these experiences persist and/or staff are seen to be having difficulty managing tasks or coping with presenting issues, they should be assisted to identify the right support options for them.

While having these wellbeing conversations, keep in mind:

- Many factors, not just the incident/s, can influence how the individual is impacted.

- What has worked well for someone else might not work well for everyone.

- What has previously worked well for the individual may be a good starting point.

- A number of different resources may be appropriate: e.g., self-care plans, EAP, private mental health professional, time with trusted family or friends, clinical supervision, etc.

Operational reviews

It may be appropriate to conduct an **operational and/or clinical review** of the incident.

Key principles of an operational review include:

- focusing solely on the operational or clinical elements of the event

- understanding the learnings, implications for service delivery, and recommendations for improvement or change in practice or systems

- following up with any agreed upon changes

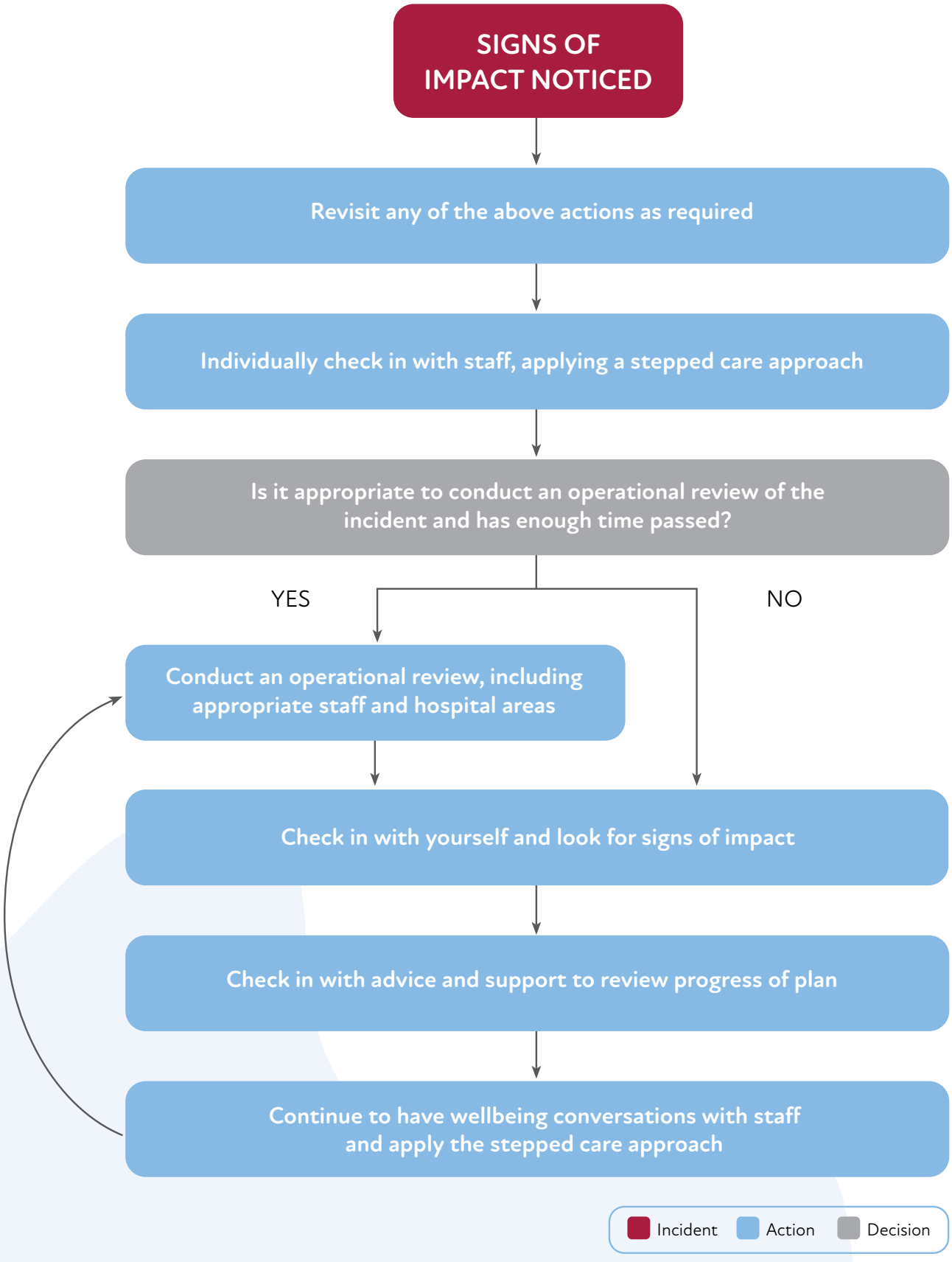
- conducting the review at the appropriate time, after enough time has passed to avoid heightened emotions

- bringing the right people in for the conversation – the review should be coordinated and may involve including other operational areas of the organisation

- avoiding venting or sharing of emotions.

As above, the timing of actions should be based on the judgment of the response leader and in consultation with other key internal and/or external stakeholders. Keep in mind that impacts from exposure to PTEs can be delayed. It's never too late to implement the response; take notice of your staff and consider if they need support. Contact your 'advice and support team' (e.g., Manager Assist) if you are questioning whether you should create a plan for supporting staff. Hint: it could be weeks later that you become aware of how impactful an incident was for staff.

THE FIRST FEW WEEKS AFTER A POTENTIALLY TRAUMATIC INCIDENT: SUGGESTED ACTION PLAN



THE FOLLOWING WEEKS AND MONTHS AFTER A POTENTIALLY TRAUMATIC INCIDENT: SUGGESTED ACTIONS

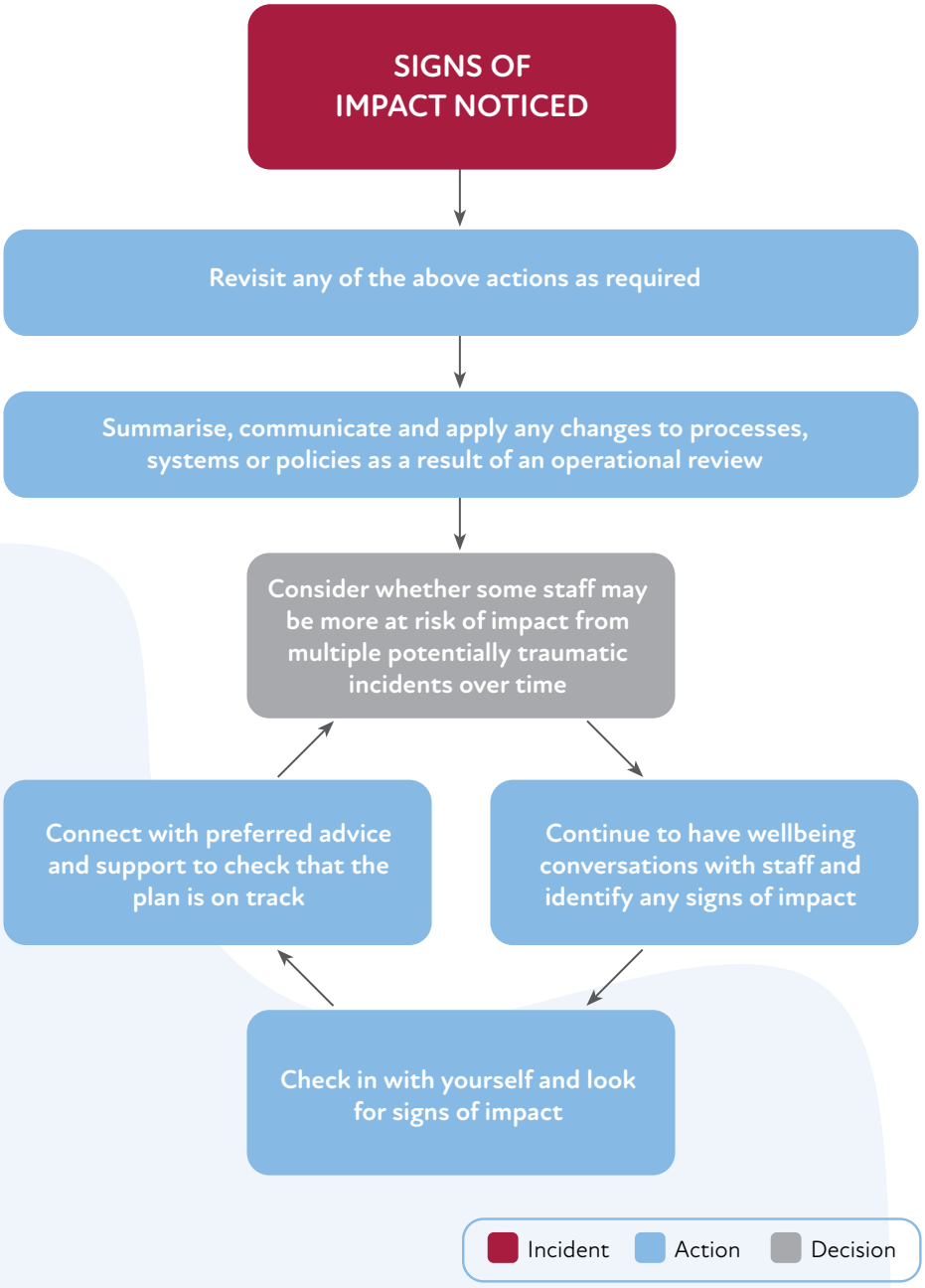
The focus of this phase is to continue to monitor the wellbeing of staff after the incident and any other potentially impactful factors.

A response leader should continue to identify staff who might need additional support. A response leader may like to continue to consult with their advice team (e.g., Manager Assist or colleagues) to review how staff are tracking and determine if additional action needs to be taken. It's important to continue to consider the range of other factors that might impact on stress levels or interfere with the usual recovery process.

If any changes are decided in the operational review, ensure these are communicated to all staff.

You may notice staff begin or continue to talk about the incident/s or other challenging events within the workplace. Response leaders may wish to refer to the advice team for support in managing this and determine which activities may need to be revisited.

As above, the timing of actions should be based on the judgment of the response leader and in consultation with other key internal and/or external stakeholders.



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