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RESEARCH ARTICLE

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Exploring the experiences and perceptions of trainees undertaking a critical incident debrief training programme: A qualitative study

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Abstract

Rationale, aims and objectives: Critical incident debriefing is an occupational health tool for supporting healthcare workers following critical incidents. Demand for debriefing has increased following the Covid-19 pandemic. There is now a need for more trained debrief facilitators to meet demand, but there is a dearth of literature regarding how best to train facilitators. This study addressed this by exploring participant experiences of an online critical incident debrief training programme.

Methods: We conducted semi-structured interviews with 14 individuals who received a 5-day training programme based on the Critical Incident Stress Management model. Participants were recruited from a range of professional disciplines including psychology, nursing and human resources within one British healthcare system. Data were analysed using thematic analysis.

Results: The analysis produced three themes. *Managing trainee experiences and expectations* suggested that disciplinary heterogeneity in training groups supported inter-participant knowledge exchange. However, this variation also meant that training materials did not meet the learning

needs of all participants. *Modality of training* suggested that while online learning was acceptable for some, others experienced screen fatigue and found it hard to build rapport with other participants. *Systematic and organisational obstacles to training access and delivery* suggested that lack of managerial support and organisational mental health stigma may be barriers to accessing training.

Conclusion: A 5-day online CISM-based training programme was acceptable to participants. Organisations implementing critical incident debrief training may benefit from (1) offering both in-person and online training options, and (2) tailoring course materials according to the disciplinary make-up of groups.

KEYWORDS
critical incident stress management, healthcare workers, incident debriefing, qualitative methods, work-related stress

Highlights

- Since the outbreak of Covid-19 there has been an increase in demand for critical incident debriefings in the healthcare workforce.
- This study addresses the current lack of research examining the experiences of training staff in a critical incident stress management intervention.
- The training methods experienced were acceptable to participants
- Healthcare organisations implementing a similar training programme would benefit trainees by providing a blended and flexible learning environment.

1 | INTRODUCTION

In healthcare settings, critical incidents can be regarded as potentially traumatic events which cause strong emotional responses and which exceed the capacity of individuals' existing coping mechanisms.[1,2] These can include unexpected or sudden patient deaths, events involving violence or aggression and adverse events, where errors in care delivery cause patient harm.[3–5] Such events became more prevalent since the onset of the Covid-19 pandemic[6] and are a significant source of distress for healthcare workers. Exposure to these events can result in a range of detrimental outcomes for workers, including disillusionment, loss of enthusiasm, depression, anxiety and symptoms of post-traumatic stress disorder (PTSD).[7,8]

Critical incident debriefing is an occupational health tool which has long been used to support workers following critical incidents.[9,10] There have been three main approaches towards incident debriefing: Psychological Debriefing,[11] Critical Incident Stress Debriefing (CISD)[12] and Trauma Risk Management.[13] There are some

variations between these approaches, but all aim to draw groups of workers together in the immediate aftermath of a critical incident for a structured discussion. These approaches suggest that this discussion should be delivered by a trained facilitator and should draw together team members who were involved in a critical incident to reflect on their shared experience.[11–13]

There has been some controversy in the literature regarding the delivery of critical incident debriefs. This stems from a review which found that debriefs were not associated with reductions in PTSD[14] and which included one study suggesting that debriefing was in fact associated with greater risk of subsequent PTSD in trauma victims.[15] Following the reporting of these findings, debriefing has not been recommended by the National Institute of Health and Care Excellence (NICE) guidelines as a preventative treatment for PTSD.[16]

While recognising the validity of these findings, there are two important limitations to note. The first is that this review and the NICE analysis included studies which had used debriefing one-to-one with individuals who experienced personal traumas. This can be considered an 'off-label' use of debriefing, which is designed for use with groups of volunteers or professionals who have experienced shared traumatic events in the line of their work, rather than in their personal lives. Second, to discount debriefing on account of its inefficacy in preventing PTSD is to misconstrue the original intentions of the intervention, which were to normalise distress, activate peer support networks and enable catharsis.[17] Indeed, when considered in this context, recent evidence is supportive, indicating that debriefing appears to be associated with reductions in anxiety and problematic drinking after events.[10,18]

Reflecting its value as an occupational health tool, contemporary healthcare practitioners and researchers continue to recommend its use with teams following critical incidents.[2,9,19] These recommendations are based on consistent evidence suggesting that practitioners value facilitated team debrief discussions after incidents. For example, one study evaluated 104 debriefs delivered over a 2-year period in a critical care unit.[9] This study reported that over 80% of participants affirmed the benefits of these in helping them to cope with the traumatic event they had experienced and said they would recommend debriefs to other professionals.[9] In a survey of 39 emergency department staff, another study indicated that 76.2% would prefer to be offered critical incident debriefs, with this preference particularly pronounced among newly trained staff.[2] Similarly, in a qualitative study in emergency staff, it was found that optional critical incident debriefs were viewed positively by staff as an additional relief from work-related stress.[19]

The challenge observed by some practitioners is not whether debriefing should be used but instead that it is used on fewer occasions that it could be.[2,20,21] Barriers which have been identified include a lack of organisational policy for staff support after critical incidents and unsupportive management.[20,22] One frequently cited barrier is a lack of trained and educated facilitators,[21,23–25] however, there is a dearth of literature evaluating staff training approaches for debriefing. Due to this lack of research, it is unclear whether training is perceived as beneficial by practitioners, which aspects are most useful and how training approaches can be improved. Further research is needed to inform the development and delivery of future facilitator training programmes, to increase the availability of appropriately trained debrief facilitators.

The present study aimed to address this gap by conducting in-depth, qualitative interviews with participants who were trained as part of a programme for post-incident facilitators. In addition to training participants in facilitating team debriefs, this programme equipped facilitators to be peer-supporters more broadly who were competent to deliver psychological first aid. Participants were recruited from the UK National Health Service (NHS), social care and voluntary, community and social enterprise sectors and was supported by the regional Staff Mental Health and Wellbeing Hub. This Mental health and wellbeing hub is one of 40 similar hubs established in the UK, which were created as a response to the Covid-19 pandemic. The specific research questions investigated was:

1. What were participants' experiences and perceptions of a critical incident debrief training programme?

2 | METHODS

2.1 | Design

The current study employed a qualitative exploratory design, using in depth semi-structured interviews conducted via video platform Microsoft Teams. It was a nested qualitative study from a larger mixed methods project.[26] All quotes were pseudo-anonymised.

2.2 | Participants

An opportunistic sampling method was used to recruit participants who participated in one of three cohorts who received a debrief training programme. Despite the opportunistic nature of the sampling method, efforts were made to recruit from a range of disciplines, genders and age groups. The training was funded by the local Staff Mental Health and Wellbeing Hub but was provided by one of two independent, external providers. The debrief training programmes were held online (via video platforms, Microsoft Teams or Zoom) over 5 days (either consecutively or split over the weekend in 2 and 3 days sections) and trained participants in Critical Incident Stress Management (CISM), which is based on CISD[12] principles. Participants who completed the debrief training were asked to indicate if they were interested in participating in an in-depth follow up interview exploring their experiences of the training. Those who agreed to a follow-up interview were contacted via email by a researcher and provided with a participant information sheet. Interviews were conducted between October 2021 and February 2022 via video platform Microsoft Teams, approximately 1 month after completion of the debrief training. Informed consent was obtained from all participants via a recorded verbal statement of consent at the beginning of the interview, these statements were recorded and stored separately to the interview recordings.

2.3 | Data collection

Prior to commencing the interviews we collected participant demographics which included gender, ethnicity, age group (measured in 10 years age brackets), occupational group and sector and job role.

All interviews were conducted at the participant's convenience by a member of the research team (LP; who was trained in qualitative methods), who was not involved in delivering the debrief training programme. The semi-structured interviews followed an interview guide consisting of open-ended questions. Semi-structured interviews explored (1) experiences and perceptions of the debrief training and (2) the access and implementation of the training in a workplace setting (Table 1). Data collection ceased when saturation was achieved (Frances et al., 2010). Interviews were recorded using the MS Teams record function and transcribed verbatim.

2.4 | Analysis

A Thematic Analysis approach as described by Braun and Clarke (2006) was utilised to analyse the interview data. The first researcher (LP) transcribed the interviews and familiarised themselves with the data. This was achieved by repeatedly reading and listening to the interviews, which allowed for 'immersion in the data'.[27] Once familiarisation had occurred where the data could be read 'actively, analytically and critically', initial coding was conducted by the first researcher (LP).[28] A codebook was produced by the first researcher (LP) to accurately capture codes and their description in the text, this allowed for the management and formulation of codes into relevant categories. Key outcomes were formulated from the codes and refined into central themes that reflected participants opinions and

TABLE 1 Interview topics.

Interview topics	Key questions
Experiences and perceptions of training	- What was your overall perception of the training? - What worked well? - What could be improved? - Have you had any similar training previously? - How did this training contribute to your learning and overall professional development in relation to supporting staff after critical incidents? - Would you recommend this training to others undertaking your professional training?

Workplace setting and training access and implementation	- Have you had an opportunity to use the training?
	  - How was the training implemented?
	  - What was the effect of the training being implemented?
	  - If not used, what were the barriers?
	  - If used, what enabled its use?
	- How did you come to hear about the CISM training?
	- How did you find the process of accessing the training
	- Were you supported by your manager to access the training?

experiences regarding the debrief training. A second researcher (JJ) then checked a subset of interviews to test for validity in coding and the categorisation of codes using the devised codebook. The researchers (LP and JJ) then discussed the appropriateness of the development of codes, categories and proposed central themes. Once full agreement was reached regarding the central themes, researchers (LP, JJ) agreed on the suitability of subthemes and supporting statements.

2.5 | Academic rigour

The best way to achieve academic rigour is through clear, thoughtful and diligent planning of the research process and to apply ongoing researcher reflexivity. To achieve academic rigour in this study we ensured that the planning and development stage involved experts from the research field (JJ and CK) as well as clinical consultants (KH and NW). We selected the most appropriate research methods for our study, in depth semi-structured interviews that ensured the overall trustworthiness and transparency of the study.[29] Although an opportunistic sampling approach was adopted this was deemed to be the best approach as our target population was a closed group having been the attendees of a debrief training course, we therefore made attempts to include participants from a range of disciplines, genders and age groups. Data collection and analysis ran concurrently. Interviews were recorded and transcribed verbatim with the assistance of Microsoft Teams, although member checking was not required participants had access to their recording and transcript through the Microsoft Teams interview invite. We ensured confidentiality and privacy of our participants through pseudo-anonymising all transcripts and storing recordings separately. Coding was completed by one researcher (LP) and crosschecked by a second researcher (JJ) at different time points throughout the analysis process, after initial coding and completion of coding and categorisation of codes. A codebook was produced by the first researcher (LP) and checked for validity within the codes and categories by the second researcher (JJ). The utilisation of a codebook enables a more focused and rigorous approach to the continued analysis of raw data during successive re-reads by multiple researchers.[30] Two researchers (LP and JJ) then discussed and approved the overarching themes and subsequent subthemes. An additional application of academic rigour was applied through the use of direct participant quotes to highlight credibility in the presentation and accuracy of reporting.[31]

3 | RESULTS

Fourteen in-depth semi-structured interviews took place with debrief training participants (10 women and 4 men) approximately 1 month after the completion of their training. Interviews averaged 35 min (range = 26–46 min). Data collection ceased at the point of data saturation, whereby the research team deemed no new themes were emerging from the data. Of the 14 participants, 12 were NHS staff, 1 was from a VSCE organisation and 1 was from the social care sector. Their mode age category was 31–40 (n = 6). Participants were from a range of different health professional roles (see Table 2).

In total from the interviews 15 codes were identified which were formulated into six categories prior to being regrouped into three key themes (see Table 3). The three overarching themes included: (1) Managing trainee experiences and expectations, (2) Modality of training, and (3) Systematic and organisational obstacles to training access and delivery.

3.1 | Theme 1: Managing trainee experiences and expectations

3.1.1 | Diversity in trainees' professional backgrounds

Despite the disciplinary diversity of participants, many voiced finding the training valuable and applicable to their role.

> I felt overall that it was, um, really useful training I enjoyed the five days that we did, and I think that it was very useful and something that I liked about it was that it was very applicable. So I felt like I could use it. Um, it gave you lots of kind of practical advice for how to use the information.
>
> [P1].

> I really enjoyed the training. Um, that in terms of it, it's really relevant to my role in terms of staff well-being and it was a definite area within [organisation name] that we were looking to explore further.
>
> [P7].

The diverse background of trainees attending the debrief training was considered to have both a positive and negative impact on the training experience by the learners. For some trainees, the inclusion of staff from different organisational and expertise backgrounds was helpful for gaining new insights and considerations for future interactions within a diverse healthcare workforce.

> So it was quite nice welcome surprise that it was people from a range of different backgrounds and working areas. So I think it made the day better 'cause everyone could draw from their different experiences.
>
> [P5].

> I think having different people from across the sector. Was really helpful, so previously a lot of training courses I've been on have been quite NHS focused in NHS setting and so it was nice to have some voluntary sector and charity colleagues as well.
>
> [P7].

However for other trainees, especially those from a psychology or mental health background, the diversity in professional backgrounds also had a negative impact on their experience. They felt that having such a wide range of

TABLE 2 Participant characteristics.

	Participant ($n = 14$)
Participant gender	
Male	4
Female	10
Participant age group	
21–30	2
31–40	6
41–50	1
51–60	4
61–70	0
71–80	1
Ethnicity group	
White British	13
White European	1
Job role categories	
Clinical psychologist	3
Psychotherapist	1
Labour ward coordinator	1
Specialist nurse	1
HR partner	1
Resuscitation officer	1
Deputy director of people and OD	1
CEO	1
Pastoral and emotional support services	1
Clinical operation manager	1
Project manager	1
Mental health practitioner	1
Participants' work sector	
NHS	12
Voluntary	1
Social care	1

professional backgrounds meant that the training was more generic than originally anticipated. This led some trainees to believe that certain aspects of the training were unnecessary for them and their professional experience or that they learnt little to no new information on some days.

> The4 first few days are quite slide heavy, but he [instructor] introduced himself, it was covering stuff that I think going in as completely no knowledge you'd need, where some of the stuff I'd come across

TABLE 3 Codes, categories and themes.

Code	Category	Related theme
Participant backgrounds	Participant suitability	Theme 1: Managing trainee experiences and expectations
Training time	Managing expectations	Theme 1: Managing trainee experiences and expectations
Applicable to participant job role	Participant suitability	Theme 1: Managing trainee experiences and expectations
Training expectations	Managing expectations	Theme 1: Managing trainee experiences and expectations
In person training	Online training experience	Theme 2: Modality of training
Developing a connection with other trainees	Online training experience	Theme 2: Modality of training
Online training	Online training experience	Theme 2: Modality of training
Facilitator involvement	Experience of training staff	Theme 2: Modality of training
Lack of delivery staff	Experience of training staff	Theme 2: Modality of training
Screen fatigue	Online training experience	Theme 2: Modality of training
Training barriers–capacity	Ability to access training	Theme 3: Systematic and organisational obstacles to training access and delivery
Training barriers–attitudes and support	Ability to access training	Theme 3: Systematic and organisational obstacles to training access and delivery
Attitudes and support for training course	Ability to access training	Theme 3: Systematic and organisational obstacles to training access and delivery
Barriers to delivering training–attitudes	Ability to deliver training	Theme 3: Systematic and organisational obstacles to training access and delivery
Barriers to delivering training–capacity	Ability to deliver training	Theme 3: Systematic and organisational obstacles to training access and delivery

> previously, so some of it for me personally, like I'd come across some of this stuff from my academic history, but I understand not everyone would have done so.
>
> [P13].

> I'm not sure whether it could be geared to.. It's difficult, but I'm not sure whether it could be geared to particular professionals, as in the two days of the piercer part [SIC], it was pretty much stuff that obviously I know, but it was good to go through it with everybody else and share, so there's like a downside of it, not really gaining any new information.
>
> [P2].

One participant expressed this view from the opposing end; they were from a non-clinical background and felt there should be remedial sessions for colleagues from a similar background so that they could be better informed prior to the core aspects of the course starting.

> I think in terms of the course that we did, it was really helpful having all those different perspectives together. But it might have been helpful to have a kind of remedial sort of class on that side to it. And I mean, I appreciate as well that the model isn't about trying to become an expert in a form of coping, but just to have a kind of base vocabulary established maybe before the training begins would have been helpful for me.
>
> [P11].

3.1.2 | Trainees' expectations

A number of interviews highlighted the importance for trainees to be fully aware and understand the content and relevance of the training to their profession or background. For some the training highlighted a disconnect between the information they were provided before commencing the course and what they actually learned.

> It would have been helpful to have a clear breakdown of what the course was gonna cover because it wasn't just focused on CISM, so there was quite a lot on the kind of health and safety and systems background, and there was quite a lot of focus on PFA.
>
> [P9].

> I mean, I guess it's probably just honestly, in that description at the beginning, that this is actually what debrief is, and this is where we would like you to kind of deploy that debrief rather than you know halfway in the course finding out that's what it's. That's how it's designed as well. So probably a little bit more information at the beginning.
>
> [P6].

3.2 | Theme 2: Modality of training

3.2.1 | Online delivery and screen fatigue

During the COVID -19 pandemic many education and training courses were shifted online, leading to video platform fatigue. The debrief training programme was no different as several trainees expressed a weariness towards online delivery. These trainees indicated that a return to face-to-face training methods would be an improvement in delivery, especially when covering sensitive material. A key aspect of face-to-face training that the participants missed was the potential improvement it offered in developing bonds between trainees. They expressed that face-to-face training would also help to increase empathy in the situational training aspects of the course such as role play.

> I think that was the thing about the zoom that because the topic was just so emotive for people, but then you haven't got that connection with people like that physical connection. Not that we'd be cuddling each other or whatever, but they talk about it don't they? Their evidence about zoom, that you're always sort of searching for that eye contact, that physical connection with people and that didn't exist.
>
> [P10].

> Virtual training is tough, particularly with this type of training when you, when part of it is about empathy and that rapport building and it's hard to do it over a screen.
>
> [P7].

Despite trainees expressing a weariness for online training, a number of participants acknowledged that the training was well put together and that their overall experience was not significantly diminished due to the online modality.

> I think it was really well put together. It's all online. And I don't think that's obviously how they planned it. But I thought it was really interactive and it wasn't necessarily held back by kind of being online, so I think they overcame that really well.
>
> [P6].

> I think if we did, if it had been back-to-back five days [online training], I think it would have been quite tricky. But generally you know, I don't think it was hindered by doing it online.
>
> [P12].

Crucially, the online modality was generally considered an acceptable and engaging delivery model which enabled them to learn the intended skillset and gave them the confidence to implement it.

> Yeah, I know it was really helpful. Um, it kind of, I came away feeling relatively confident about delivering debriefings to staff so I learnt new things in the training. Um yeah it was really it was good.
>
> [P12].

A few of the participants have also been able to implement and deliver the debrief intervention in their organisation. For these participants they indicated that the online delivery was problematic for the same reasons as it was for attendance, primarily that it impacted the ability to build a connection.

> But the problem that we had is a couple of the girls got quite upset following it [CISM debrief] and we couldn't go speak to them after it, which as per the training you should check in with each individual one to one and have coffee.
>
> [P5].

3.2.2 | The importance of the facilitator

Several trainees highlighted in their interviews the significance and impact the facilitator had on their training experience, which they indicated as being especially pertinent with online training. The facilitator was key in helping to motivate, bond together and encourage the trainees throughout their learning experience. For the trainees their facilitators had the potential to impact their training experience in both a positive and negative way.

> I thought [facilitator's name] who ran it, was very knowledgeable. Um, and the experiences that she brought out about herself going through debriefs and what she experienced was really valid. And it made you think about what it would be like to debrief somebody as well.
>
> [P6].

> We did still manage by the end of the week to kind of form as a group, and I think that was down to [facilitator's name] and her facilitation skills and she still managed to get us to bond as a group, which virtually is really difficult to do.
>
> [P7].

For some trainees there were not enough facilitators available to run the training. These trainees expressed a desire for a second or third facilitator to clarify the training purpose and to solidify why they have undertaken this type of training.

> I think actually because of the amount of people that were on it, another facilitator would have been helpful, because obviously one is delivering, it would be good to have another backup kind of person to go around and just clarify stuff.
>
> [P2]

> There wasn't a facilitator in the room with us when we're having those discussions. We were not necessarily guided in the right way, if that makes sense. Although the facilitator did keep popping in, but they weren't there all the time.
>
> [P3].

3.3 | Theme 3: Systematic and organisational obstacles to training access and delivery

3.3.1 | Availability, workload and capacity

The interviews highlighted that for some trainees the key issues of concern in accessing training was their ability to attend a 5-day course due to their workload, availability and managerial support to take this time away from their work schedule. For some trainees, their manager's encouragement and support for the course was instrumental in them attending the training.

> So I told them about it. Um, and I told my matron. First of all, she thought it was a really good idea. So did the head of Midwifery, um? But then there is a bit… because it was over five days. They didn't know who's gonna give me all the study leave for it. So that became a bit of an issue. Um, because again during COVID they were cancelling leave.
>
> [P5].

> Yes, it was very much supported. And yes, I think it was something that I wasn't sure when I first saw the offer. I wasn't sure whether it was relevant to my role or not because my role is brand-new and evolving and things like that. Um but yeah, so they were very supportive in me accessing that.
>
> [P1].

3.3.2 | Attitudes and organisational support

Some trainees suggested there were negative attitudes towards debrief training which may be due to perceptions that healthcare staff should just 'keep going' or 'carry on'. A stigma around healthcare staff needing or accessing support is perpetuated by these attitudes.

> I think it's new, so with anything that is new, people are always a bit resistant to it. And [clinical role] definitely have a um, persona of just keep going and carrying on in. In some respects they have to because it's really busy.
>
> [P5].

> We're very good in the NHS at pretending we're OK, um, and you know that some of our colleagues who have been through really traumatic things throughout the pandemic or just generally in their in their role it's our colleagues in the emergency department who deal with trauma every day… And so there is absolute potential for trauma there. But if you have a conversation with them, Oh well. It's just part of the job. It's what we do. And so I think that's probably a barrier.
>
> [P7].

The trainees also indicated that negative organisational attitudes could make it challenging to deliver debrief conversations. This was suggested to be a particular issue for clinical staff as their time and attitudes may be difficult to change.

> I think um, getting senior colleagues on board like the [senior doctor role] and senior management [in department name] to get on board and to allow staff to have the time to have these reflections and this process to happen will be quite difficult again. Time constraints, money constraints, things like that.
>
> [P5].

> It's just the main barrier would be. Uh…. Time and attitude….Can you be bothered?
>
> [P8].

4 | DISCUSSION

The present study investigated trainees' experiences of participating in a critical incident debrief training programme, which aimed to equip participants to facilitate post-incident discussions, provide psychological first aid and act as peer-supporters. The analysis produced three themes: (1) *Managing trainee experiences and expectations*, which highlighted the need to provide accurate training information to participants before participation and to consider variation in participants' pre-existing knowledge; (2) *Modality of training*, which emphasised the importance of having an engaging facilitator but also recognising variation in preferences for online vs. in-person training; and (3) *Systematic and organisational obstacles to training access and delivery*. This final theme suggested that while the length of the training (5 days) may be a barrier to participation for some professionals, this can be overcome when managerial support is in place. It also captured how negative cultural attitudes towards mental health support may be a barrier to both participating in the training and delivering the debriefs in practice afterwards.

This is the first qualitative investigation evaluating experiences of participants who have received a critical incident debrief training programme. The present study extends the current knowledge base in two main ways. First, these findings add novel information to a mixed evidence base regarding the value of critical incident debriefing as a practice. This literature has demonstrated that debriefing should not be used with individuals who have experienced personal traumas[17] and should not be regarded as a PTSD prevention measure.[10,17] However, it is also now clear that when used with groups of emergency responders or health workers, it is valued by participants for its support in helping them to cope and the relief from stress that it provides.[9,19] This evidence base has also indicated that debriefing may be associated with reductions in anxiety and substance misuse.[18] The present study extends this literature by suggesting that in addition to valuing receiving debriefs, participants value being trained in debriefing. At 5 days, the course was longer than most professional occupational training courses for other non-clinical skills, such as unexpected news delivery,[32] but participants did not raise this as a concern. Indeed, one participant expressed a desire for additional sessions which would have increased the length of the training. Instead, suggestions for change focused on the nature of the content of the training, the modality of delivery and the number of facilitators who were provided to support learning. These findings further emphasise the perceived value that practitioners place upon the practice of critical incident debriefing. When considered in light of the wider

literature, it appears that evaluating interventions in individuals or solely on the basis of PTSD outcomes may be a reductionist approach which misses wider perceived psychological benefits of this practice.

Second, these findings add to a burgeoning literature investigating experiences of online learning in healthcare workers. A systematic review of randomised controlled trials conducted prior to the Covid-19 pandemic indicated that online learning is as effective for clinical skills training as in-person training.[33] Expanding on this, a systematic review of qualitative studies also conducted prior to the pandemic indicated that healthcare professionals appreciated online learning for its flexibility, but found that the role of the tutor in engaging learners became particularly salient in online settings.[34] Since these studies were published however, the onset of the Covid-19 pandemic necessitated a significant increase in the delivery of online learning for healthcare workers and a shift towards the use of video-platforms such as Zoom and Teams,[35] which may have impacted learners' experiences. In line with pre-pandemic research findings, our study highlighted the importance of the facilitator in engaging participants and suggested that having a higher degree of facilitator input may be important in online settings. Our findings add to this literature by suggesting that extra considerations may be needed for emotive clinical training on topics such as debriefing, where participants may feel that emotional connection is particularly important. Participants also reported experiencing 'zoom fatigue' and viewed it as beneficial to have the training days spread out, rather than delivered in a block.

4.1 | Recommendations

Organisations looking to train healthcare workers in critical incident debriefing should consider (1) the length of the training course; (2) the modality of delivery; (3) the skill mix of healthcare professionals they train and (4) the credentials and skills of the facilitator. In the present study, participants found a 5-day training course an acceptable length. While shorter durations may be accessible to more practitioners, participants generally felt the length of the course was appropriate. Instead, they highlighted the importance of having managerial supporting in being able to take this time out from their clinical schedule.

In terms of modality, some participants expressed a preference for in-person delivery but others found online delivery acceptable. Online delivery can also enhance accessibility as some practitioners will find that the reduction in their travel time enhances flexibility.[34] Organisations may benefit from offering the option of both modalities to learners to meet preferences of different groups. If offering only online versions, the course should be broken into day-long modules which are spread over a few weeks and facilitator support should be enhanced, either by keeping training cohorts small or by increasing the number of facilitators who are delivering each course.

When considering who should receive critical incident debriefing training, there are advantages to including both professionally homogenous and heterogenous cohorts. Homogenous cohorts will have a similar background knowledge and role; as such, the facilitator can tailor the course information to their existing knowledge base to ensure that necessary novel information is presented and pre-existing knowledge is not repeated. However, heterogeneous cohorts allow for inter-participant knowledge exchange and could support wider team building. Organisations should consider which approach may best benefit their organisational priorities.

The role of the facilitator becomes particularly important in online learning. Facilitators should be chosen who are knowledgeable and experienced in debriefing, engaging and able to build rapport with learners over video platforms.

4.2 | Strengths and limitations

The study benefited from the use of a qualitative interview method, which enabled participants' experiences of the training to be explored in-depth. It also benefited from the inclusion of participants from a wide range of

disciplinary backgrounds who were able to bring a diversity of perspectives to the dataset. The study was limited by a lack of ethnic diversity in participants, as only White participants were able to be recruited. Lack of ethnic diversity is a common problem in health research, and future research in this area should aim to address this using strategies such as increasing the diversity of their research team and offering support to potential participants in the form of transportation or financial assistance.[36]

5 | CONCLUSIONS

Interest in critical incident debriefing interventions has increased following the onset of the Covid-19 pandemic, but the delivery of these conversations is often hindered by a lack of trained facilitators.[24,25] The present study interviewed participants in a 5-day training programme based on the CISM model and found that this was acceptable to participants. Organisations looking to provide CISD to their staff may benefit from employing a similar training programme. In implementing this, they should consider offering both in-person and online training options to participants and should increase the facilitator-to-learner ratio when training is delivered online. Our recommendation for future research would be a follow up of CISM trainee's experiences in implementing the CISM model in their workplace.

AUTHOR CONTRIBUTION

The authors confirm contribution to the paper as follows: study conception and design: Kerry Hinsby, Nigel Wainwright, Judith Johnson and Chris Keyworth; data collection: Lucy Pointon, Jenny Bates, Lucie Moores; analysis and interpretation of results: Lucy Pointon and Judith Johnson; draft manuscript preparation: Led by Lucy Pointon and Judith Johnson, with all authors providing critical feedback, reviewing and approving the final version.

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CONFLICT OF INTEREST STATEMENT

The authors report no competing interests.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS STATEMENT

The study was reviewed and approved by the School of Psychology, University of Leeds ethics committee (Ref: PSYC-277; Approval date: 08/06/2021).

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