CVH-480e
Rev. 5/18

Staff Debriefing Form

(Required after every restraint/seclusion episode)

Date: _____ **Time**: _____ **Unit**: _____ **Patient(s) MPI #** _____

Check One: ☐ **Seclusion** ☐ **Restraint** ☐ **Both**

Staff in attendance at debriefing:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Specific questions to answer while reviewing the episode in detail:

1. **What was happening before the episode of seclusion or restraint?**
   a. **Patient Behavior:** ☐ Assaultive/Threatening towards Staff ☐ Assaultive/Threatening towards Co-Patient ☐ Agitated/Yelling/Screaming/Banging/Posturing/Escalating ☐ Self-Harm ☐ Refusing to Take Medication ☐ Responding to Internal Stimuli ☐ Ingestion of Foreign Objects
   ☐ Other: _____
   b. **Milieu**: ☐ Quiet/Normal Activities ☐ Busy/Noisy ☐ Pre-Meal/Meal Time ☐ Change of Shift
   ☐ Other: _____
2. **What non-physical intervention techniques were used?** ☐ Redirection ☐ PRNs ☐ Comfort/Blue Room ☐ Headset ☐ Personal Preference ☐ Talk with Staff ☐ De-escalation Attempt,
   ☐ Other: _____
   What happened as a result? ☐ PRNs given ☐ PRNs not effective in 15 minutes ☐ PRNs offered and refused ☐ Staff Assault ☐ Agitation ☐ Blue Room ☐ Intervention not effective ☐ Restraint ☐ Patient uncooperative
3. **Was the physical intervention technique effective?** ☐ Yes ☐ No
   Was the technique the least restrictive one possible, given the situation? ☐ Yes ☐ No
   Was the technique done correctly? ☐ Yes ☐ No
   Is more training required? ☐ Yes ☐ No
   Comments: ☐ Staff acted promptly and effectively ☐ Patient requested restraint ☐ Fit of restraint
   ☐ Other: _____
4. **How did you feel before, during, and after the confrontation?**
   ☐ Same ☐ Good Teamwork/Communication ☐ Confident ☐ Okay/Satisfied/Calm ☐ Tense/Frustrated ☐ In Control ☐ Concerned for Patient/Staff Safety
   ☐ Other: _____

This form <u>IS NOT</u> to be filed in the patient's medical record

5. **Did sufficient staff respond?** ☐ Yes ☐ No
   Was the team leader identified? ☐ Yes ☐ No
   Did the team leader direct the activities of those present? ☐ Yes ☐ No
   Was communication from the team leader clear? ☐ Yes ☐ No
   Was staff functioning as an effective team? ☐ Yes ☐ No
   Comments: ☐ Patient ambulated self ☐ Staff worked together
   ☐ Other: _____
6. **Were other patients removed from the area?** ☐ Yes ☐ No
7. **If the situation re-occurs, would you do anything differently?** ☐ Yes ☐ No
   Comments: ☐ Use different restraint ☐ Other: _____
8. **Are there any recommendations for the future?** ☐ Yes ☐ No
   Please note any staffing, training, equipment or environmental problems that have been identified in the debriefing that should be addressed.
   Comments: ☐ Restraint cuffs too large ☐ Bed too low ☐ Use different restraint
   ☐ Other: _____

Section 9 is only required when the patient is placed in <u>Four Point Restraints</u>.

9. **Restraint Review by Charge Nurse and Nursing Supervisor** (*Please review each of these areas and document accordingly*)

	Yes	No	N/A
1. **Non-slip pad is in place between the mattress and the bedframe**	☐	☐	
2. **Restraint is applied consistent with CSS Techniques**	☐	☐	
3. **Wedge is properly placed at head of bed**	☐	☐	
4. **Face Shield applied and used appropriately**	☐	☐	☐
5. **Patient is properly and safely placed on the bed**	☐	☐	
6. **There is no impeded access between the patient and the staff (*no closed doors*)**	☐	☐	
7. **Documentation is complete and reflect the actual staff who conducted the Continuous Observations**	☐	☐	

_____	_____	_____	_____ AM/PM
Charge Nurse Signature	Print Name	Date	Time
_____	_____	_____	_____ AM/PM
RN Supervisor Signature	Print Name	Date	Time

This form <u>IS NOT</u> to be filed in the patient's medical record