CVH-480d **CONNECTICUT VALLEY HOSPITAL** Patient Name: _____
New 5/18 **Seclusion/Restraint - PATIENT DEBRIEFING**

MPI#: _____ *Print or Addressograph Imprint*

[ ] General Psychiatry Division
[ ] Addiction Services Division Unit: _____

1. Is there anything staff could have done to assist you with regaining control prior to going into Seclusion and/or Restraint? ☐ Yes ☐ No

Comments*:* _____

_____

2. Is there anything you could have done to better communicate to staff that you were beginning to feel "out of control"? ☐ Yes ☐ No

Comments*:* _____

_____

3. Did staff offer alternatives to help you regain control that you identified as Personal Safety Preferences?
☐ Yes ☐ No ☐ I don't know

Comments*:* _____

_____

4. Do you know why staff determined that you needed to be in Seclusion and/or Restraints?
☐ Yes ☐ No

Comments*:* _____

_____

5. In your estimation, was the length of time spent in Seclusion and/or Restraint the right amount?
☐ Yes ☐ No

6. While you were in Seclusion and/or Restraints:
Were you scared? ☐ Yes ☐ No Did you feel safe? ☐ Yes ☐ No
Did you feel anxious? ☐ Yes ☐ No Were you angry? ☐ Yes ☐ No

Other Comments*:* _____

_____

7. How do you feel regarding the care that was provided to you?
Were your needs met? ☐ Yes ☐ No
Were you treated with respect? ☐ Yes ☐ No
Was your privacy maintained? ☐ Yes ☐ No

8. Were you hurt as a result of Seclusion and/or Restraint? ☐ Yes ☐ No

9. How could we have made re-entry (your return to the unit, group, and your peers) easier for you?

Comments*:* _____

_____

10. Is there anything you would do if faced with the same situation again?

Comments*:* _____

_____

Completed by: Staff Signature/Title: _____ Print Name _____

Date _____ Time: _____AM/PM

Distribution: Original – Medical Record **SEND COPY to Division Director's Office**

File in Progress Note section following the corresponding "Discontinuation" portion of Part II "Observation & Care of the Patient"