

Creating Violence Free and Coercion Free  
Service Environments for the Reduction of  
Seclusion and Restraint

***Debriefing Activities***  
A Core Strategy ©  
A Tertiary Prevention Tool

Module created by Goetz & Huckshorn, 2003



## Definition of Debriefing

- A stepwise tool designed to:
  - rigorously analyze a critical event,
  - examine what occurred and
  - facilitate an improved outcome next time (manage events better or avoid event).

*(Scholtes et al, 1998)*

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## Debriefing Questions

- Debriefing answers these questions:
  - Who was involved?
  - What happened?
  - Where did it happen?
  - ***Why did it happen?***
  - ***What contributed to it happening***
  - ***What did we learn?***

*(Cook et al, 2002; Hardenstine, 2001)*

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## Debriefing Goals

- 1) To prevent the future use of seclusion and restraint.
  - Assist the individual and staff in identifying what led to the incident and what could have been done differently.
  - Determine if all alternatives to seclusion and restraint were considered; meet regulatory requirements.

*(Ibid)*

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## Debriefing Goals

- 2) To reverse or minimize the negative effects of the use of seclusion and restraint.
  - Evaluate the physical and emotional impact on all involved individuals
  - Identify need for (and provide) counseling or support for the individuals (and staff) involved for any trauma that may have resulted (or emerged) from the incident.

*(Massachusetts DMH, 2001; Huckshorn, 2001; Cook et al, 2002; Hardenstine, 2001; Goetz, 2000)*

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## Debriefing Goals

- 3) To address organizational problems and make appropriate changes.
  - Determine what organizational triggers may exist that increase the risk of conflict and seclusion and restraint use.
  - Recommend changes to the organization's philosophy, policies and procedures, environments of care, treatment approaches, staff education and training.

*(Ibid)* 6

## Know the process you wish to change

- The events leading to the use of seclusion or restraint can be broken down into steps
- A review of each discrete step leads to a more thorough analysis
- Questions emerge throughout the stepwise process that clarify what occurred
- Makes the point that there are multiple opportunities for effective interventions

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## Understanding The S/R Process (See Debriefing P & P Guide)

- Step 1: Had a treatment environment been created where conflict was minimized (or not)?
- Step 2: Could the trigger for conflict (disease, personal need, environmental) have been prevented (or not)?
- Step 3: Did staff notice and respond to events (or not)?

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## The S/R Process

- Step 4: Did staff choose an effective intervention (or not)?
- Step 5: If the intervention was unsuccessful was another chosen (or not)?
- Step 6: Did staff order S/R/invol. meds only in response to imminent danger (or not)?
- Step 7: Was S/R applied safely (or not)?

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## The S/R Process

- Step 8: Was the individual monitored safely (or not)?
- Step 9: Was individual released ASAP (or not)?
- Step 10: Did post-event activities occur (or not)?
- Step 11: Did learning occur and was it integrated into the tx plan and practice (or not)?

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## Suggest two types of Debriefing for inpatient settings

- Immediate “post acute event” debriefing that occurs on unit following event
- Formal debriefing the next working day

*(Ibid)*

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## Post Acute Event Debriefing

- Done immediately following event (on unit)
  - Safety, security
  - Direct care staff health (often do not recognize injury)
  - Emotions of all involved persons
- Goal: Return to pre-crisis milieu
- Goal: Gather and communicate event facts to administration, unit staff, family

*(Ibid)*

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## Post Acute Event Debriefing

- Goal: Assure that documentation is accurate, complete and meets requirements
- Goal: Begin to evaluate the need for emotional support up to actual trauma treatment
  - Individual (victim)
  - Witnesses/observers
  - Staff involved (EAP)

*(Ibid)*

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## Post Acute Event Debriefing

- Who should be present?
  - At a minimum:
    - Key individuals involved, including staff who participated in the event
    - Supervisor (on site)

*(Huckshorn, 2001; Goetz, 2000)*

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## Emergency Services

- Psychiatric Emergency Service settings will need to adapt debriefing activities
- If an ER service wants to reduce use, debriefing is a critical activity to discover what happened and to prevent use in the future
- ER staff must take the time to analyze events, that day or the next
- Best is to invite QI or other non-ER staff to facilitate this process

*(Stefan, 2006)*

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## Formal Debriefing

- Occurs 1-2 days later
- Led by senior manager, not involved in event, trained in process.
- Set context: Explain situation, purpose of meeting

*(Huckshorn, 2001; Goetz, 2000)*

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## Formal Debriefing

- Includes a broader group of people
  - Mandatory attendance by clinical lead, other treatment members, executive staff representative (champion), consumer advocates
  - Encourage adult, child, family involvement (independent session or formal meeting)

*(Ibid)*

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## Formal Debriefing

- Set ground rules:
  - Confidential, respectful communication (emotional safety)
  - Close meeting after beginning (stability, group process)
- Explain process:
  - Outline steps

*(Cook et al, 2002; Goetz, 2000)*

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## Debriefing Strategies

- Facts: What do we know that happened?
- Feelings: How do you feel about the events that happened?
- Planning: What can/should we do next?
  - Operational Issues
  - Training Issues

*(Goetz, 2000)*

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## Goals of Formal Debrief

- Identification of triggers
- Identification of Antecedent behaviors
- Exploration of Alternatives used and responses

*(Crisis Prevention Institute, 1995)*

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## Discussion Points

- De-escalation preferences and responses
- What behavior was being controlled for?
- Was anyone in imminent danger?
- Could consumer been allowed to “win”?

*(Crisis Prevention Institute, 1995; Fishkind, 2002)*

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## Discussion Points

- Medication history and response
- Event time chart
- Documentation (timely, sufficient)
- Notifications made and response

*(Crisis Prevention Institute, 1995; Fishkind, 2002)*

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## Staff Debriefing Issues

### Staff

- May be afraid of repercussions/punishment
- May feel ashamed or angry
- May have personal trauma history that affects ability to analyze event objectively
- Interventions need to avoid blame, threats or defensive reactions

*(Hardenstine, 2001)*

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## Questions for Staff

- What were the first signs?
- What de-escalation techniques were used?
- What worked and what did not?
- What would you do differently next time?

*(Ibid)*

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## Questions for Staff

- How would S/R be avoided in this situation in the future?
- What emotional impact does putting someone in restraints have on you?
- What was your emotional state at the time of the escalation?

*(Ibid)*

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## On Apology

- Debriefing is more than “setting the record straight”. It is about sharing responsibility for what happened, when appropriate (often is).
- If we expect people in care to learn from events, so we need to role model learning.
- When staff make mistakes or miss cues they need to disclose this mistakes.
- For some few courageous hospitals, the use of apology frequently begins the start of a seclusion, restraint, or involuntary med use debriefing activity.
- To date, no one has been litigated... *(Lazare, 2007)*

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## Consumer Debriefing Issues

- Use a staff person (or service user) not directly involved in the S/R event.
- Customize approach (setting, attention span, memory, etc.)
- Formal debriefing may need to be delayed up to 48 hours
- Avoid blaming, shaming or lectures

*(Hardenstine, 2001)*

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## Consumer Questions

- “How did we fail to understand what you needed?”
- “What upset you most?”
- “What did we do that was helpful?”
- “What did we do that got in the way?”
- “What can we do better next time?”

*(Massachusetts DMH, 2001)*

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## Treatment Plan Revisions

- How do comments, such as the ones below, get translated into treatment revisions?
  - “If just wanted to make a phone call”
  - “I wanted to listen to music and they were telling me to go to my room ...”
  - “Staff were yelling and I got angry/scared...”

*(Ibid)*

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## Operational Revisions Include Modifications to (for example):

- Supervision Policy
  - e.g., “onsite supervisor takes the lead”
- Staff Training Activities
  - e.g., “S/R reduction project addressed in new employee orientation”

*(Huckshorn, 2001)*

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## Operational Revisions

- Policies/procedures
  - e.g., “staff can allow child to leave group and go swing outside during community meeting if, in their opinion, this will avoid an event.”
  - e.g., “ER staff will allow family or friends to stay with client through stay
- Unit milieu/environment
  - e.g., “creating comfort rooms”
  - e.g., “ERs hire consumers on call to come in and sit with people; create environments that are not intimidating

(Huckshorn, 2001)

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## Operational Revisions

- Staffing Patterns
  - e.g., “per diem staff will have assigned units”
  - e.g., “staff with special skills will be assigned to people who are intoxicated or extremely upset”
- Staff Competencies/Skills
  - e.g., “de-escalation training/documentation added”
  - e.g., “staff who work in emergency settings will demonstrate competencies to calm consumers”

(Huckshorn, 2001)

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## Operational Revisions

- Communication procedures
  - e.g., “on call executive will be notified for all events”
  - e.g., “non-ER supervisors will be invited to review event, that shift
- Physician/treatment team/treatment planning
  - e.g., “positive trauma assessment *responses* will be included in the treatment plan problem list”

(Huckshorn, 2001)

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## Event Observers

- Don't forget the “Event Observers”
- Observing a seclusion or restraint event (violence) is just as traumatic to observers as to direct participants
- Need to be debriefed also
- Consumer/advocates and assigned staff can help here

(Huckshorn, 2001; Bluebird & Huckshorn, 2000)

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## Summary: Debriefing

- Do an immediate post event analysis, as well as a formal debriefing the next working day
  - Keep facts and feelings separate
  - Respect emotions
  - Address physical and emotional needs of client and staff

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## Summary

- Must include executive management involvement (not delegated)
- Information gathered must be used to identify, evaluate, and modify:
  - Facility policies and procedures
  - Unit or ER environments and rules
  - Staff interactions
  - Individual treatment plans
  - Training needs, and more

(Goetz, 2000)

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## Summary

- Assure feedback loops are closed to executive management, risk management, QM, advocates, middle management, general staff
- Use consumer/family advocates to assist in debriefing procedures and follow-up with all involved parties

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## Contact Information

Beth Caldwell  
Caldwell Management Associates  
413-644-9319  
[bethcaldwell@mailcity.com](mailto:bethcaldwell@mailcity.com)

Kevin Huckshorn / Sarah Callahan  
National Technical Assistance Center (NTAC)  
NASMHPD  
703-739-9333, ext 140 & 141  
[kevin.huckshorn@nasmhpd.org](mailto:kevin.huckshorn@nasmhpd.org) or  
[sarah.callahan@nasmhpd.org](mailto:sarah.callahan@nasmhpd.org)

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