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: __________________________

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This form **IS NOT** 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: __________________________

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**Section 9 is only required when the patient is placed in Four Point Restraints.**

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

   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

_____________________________  __________________________  ___________  ___________
    Charge Nurse Signature    Print Name    Date    Time

_____________________________  __________________________  ___________  ___________
    RN Supervisor Signature   Print Name    Date    Time

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