

*Reducing Risk and Preventing Violence, Trauma,
and the Use of Seclusion and Restraint*

Debriefing Activities

*Six Core Strategies ©
A Tertiary Prevention Tool*

Module created by Goetz & Huckshorn, 2003.
Updated by Huckshorn in 2006, 2008, 2011,
2013, 2016

Objectives

- 1) Identify the three suggested debriefing activities that follow each S/R event in Behavioral Health Settings: a) immediate post-event, b) formal event debriefing, and c) consumer debriefing.
- 2) Understand the key elements and processes involved in these debriefing activities. Most important is to understand and document “the story” from the patient and staff perspective
- 3) Describe how to utilize “lessons learned” during debriefing to make changes in organizational rules, policies and practices that work to more effectively prevent the use of seclusion and restraint in your organization.

Definition of Debriefing

- ▶ A stepwise tool designed to:
 - ▶ rigorously analyze a critical event,
 - ▶ examine what exactly occurred in real time from both the patient and staff's perspective,
 - ▶ make sure that all staff involved feel safe to discuss what happened, in detail,
 - ▶ collect “real time data” on what occurred, and
 - ▶ to facilitate an improved outcome next time (manage events better or avoid event next time). *(Huckshorn, 2013; Scholtes et al, 1998)*

Debriefing Questions

- ▶ Debriefing should answer these questions:
 - **What happened?** This is the most important...
 - *Why did it happen?*
 - ***Can you document “the story” of what happened?***
 - *What did we learn?*
 - *What do we change?*

(Huckshorn, 2013; Cook et al, 2002; Hardenstine, 2001)

Debriefing Goals

1). First goal is to repair any harm done by the use of S/R, on an individual and all the people that were watching, including other clients and staff.

- Use apology before you start to talk; “I am sorry this happened, very sorry...”
- Encourage all staff to discuss the event and what could have been done differently.
- As a manager, if you think that staff are not comfortable talking in a group then meet with those staff, individually and follow-up

Debriefing Goals

2) To prevent the future use of seclusion and/or restraint by documenting “the story of what happened”.

- 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 including staff’s understanding the need to negotiate
- Identify staff’s understanding of their ability to manage these situations to avoid hands on (staff empowerment to make decisions in the moment.)

(Massachusetts DMH, 2001; Huckshorn, 2013; Cook et al, 2002; Hardenstine, 2001; Goetz, 2000)

Debriefing Goals

- 3) To address hospital policy problems and make appropriate changes.
 - Determine what organizational rules and regs are contributing to patient: staff or patient: patient conflicts on units, and how staff are responding to these conflicts.
 - Recommend changes to the organization's philosophy, policies and procedures, environments of care, rules, treatment approaches, staff education and training

(Massachusetts DMH, 2001; Huckshorn, 2013; Cook et al, 2002; Hardenstine, 2001; Goetz, 2000)

Know the *Process* you wish to change; in this case
S/R use!

- ▶ 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

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

Step 1: Had a treatment environment been created where conflict was minimized

(or not)? How are new admissions greeted? Who is doing the admission assessment? Are new admissions offered drinks, food, a blanket, a shower? Were they oriented to the unit and their room, their staff?

Step 2: Could the trigger for conflict (disease, personal, environmental) have been prevented (or not)? *Did you identify risk factors on admission such as worries about family members, bills, pets? Did the person present with disorganized thinking and what did you do? Did the person seem paranoid and where did you place them re a bedroom? How did you reassure them?*

Step 3: Did staff notice and respond early to events (or not)? *Do staff stay in the milieu or gather in nursing station or in corners. Do staff know their key roles in the milieu? How? Does someone monitor this work?*

The S/R Process

Step 4: Did staff choose an effective intervention (or not)? *In other words, did the intervention match the person's behavior and what was done "ahead of time" to avoid the use of S/R?*

Step 5: If the intervention was unsuccessful was another chosen (or not)? *Was there time? What was done?*

Step 6: Did staff order S/R only in response to imminent danger (or not)? *Do most staff understand the definition of imminent danger?*

Step 7: Was S/R applied safely (or not)? *Per hospital or facility policy.*

The S/R Process

Step 8: Was the individual monitored safely (or not)? *Per hospital or facility policy.*

Step 9: Was individual released ASAP (or not)? *In general, most people are ready to come out of either seclusion or restraint in less than 30 minutes.*

Step 10: Did post-event activities occur (or not)? *Related to debriefing?*

Step 11: Did learning occur and was it integrated into the treatment plan and practice (or not)? *Per now, CMS and JC expect treatment plan revisions following all S/R events.*

Types of Debriefing

- ▶ Immediate “**post acute event**” debriefing
 - ▶ Include consumer interview, if possible, and
- ▶ **Formal debriefing** the next working day
 - ▶ Include consumer’s debriefing, if possible
- ▶ **Consumer Debriefing** (if delayed from above)

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

Consumer Debriefing On Apology

- ▶ Debriefing is more than “setting the record straight.” It is about sharing responsibility for what happened.
- ▶ If we expect people, in care, to learn from events we need to role model learning.
- ▶ When staff make mistakes or miss cues they need to disclose these.
- ▶ Use of apology is a way to open up the conversation after R/S and start to rebuild trust
- ▶ For example, “I am very sorry this happened to you. Can we talk about it?”
(Lazare, 2007)
- ▶ Most important is the involvement of hospital/facility leaders who are available to **hear of these issues and act...**

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)

Consumer/ Peer Debriefer

MA DMH, Worcester State Hospital, *Job Description*

- ▶ Conducts individual client debriefings after incidents of restraint and/or seclusion in order to identify individual, unit and hospital-wide strategies to reduce/eliminate restraint and seclusion.
- ▶ Participates in the development of treatment planning which encourages alternate interventions
- ▶ Acts as an advocate for the client in treatment planning
- ▶ Identifies human rights issues as they arise during debriefings and collaborates with Human Rights Officer(s) as necessary.

Post-Acute Event Debriefing

- ▶ Who should be present?
 - At a minimum:
 - ▶ Key individuals involved, including staff who authorized the restraint
 - ▶ Supervisor (on-site or called in)
 - ▶ An individual from outside the involved staff can often help with objective facts and feelings (if available)

(Huckshorn, 2001; Goetz, 2000)

Post-Acute Event Debriefing

- ▶ Focus on hierarchy of needs first: (physical & emotional of clients). Make sure everyone is ok.
 - Survival
 - Safety
 - Staff issues also
- ▶ GOAL: Return to pre-crisis milieu.
- ▶ Communicate event with administration, unit staff (thru shift report), family, if allowed.
- ▶ To be successful, post-acute event debriefings need to be followed up on by hospital/facility leadership.

(Huckshorn, 2001; Goetz, 2000)

Formal Debriefing

- ▶ Within 24-48 hours of event.
- ▶ Led by senior manager, not involved in event, trained in process.
- ▶ Purpose? Goals? Find out and document “the story”...
- ▶ The full story of what happened, for any event, needs to be teased out from all involved parties. One side cannot tell “the full story.”
- ▶ And the main issue here is that a majority of patients do not just “escalate.” There is most always a trigger and staff need to find out what that was.

(Huckshorn, 2001; Goetz, 2000)

Real Example: Sam

- ▶ Sam, a 27 yr. old male was admitted to a inpatient unit because he was carrying a BB gun, downtown, and said he was a “rapper.” On further assessment Sam was known to have Schizoaffective DO. And he also uses pot when he can (like his age- related peers).
- ▶ Sam was arrested and sent to jail and then to the inpatient MH facility.
- ▶ On day two no one could tell Sam how long he would be here and they would not let him use his IPod.
- ▶ He tried to leave his group activity and was moved into a corner and told no. Has cornered and pushed over a table and got restrained even though the table down threatened no staff.
- ▶ What should have happened?

Real Example: Sam

What should have happened?

- ▶ We knew from Sam's admission history that he had been abused by his dad and his foster dad (physically).
- ▶ We knew from his mom that he did NOT do well with authoritative males.
- ▶ We knew from Sam, and his mom, that music was one of his main calming strategies.
- ▶ We knew from the MD and Nursing assessment that he was hypomanic and had not had good sleep for 8 weeks and had been off his meds; meaning that he could not "sit still" in a group and could not really pay attention.
- ▶ We DID NOT KNOW that staff had not been trained adequately to avoid these kinds of conflicts and, instead, thought they were to just enforce the rules... (Huckshorn, 2012)

The chart note said: "Patient got aggressive and violent and was restrained..." If this was your facility would you have followed up?

Real Example: Julie

- ▶ Julie, 56, was brought to ED by police after acting “strange” at a local grocery store. She seemed disoriented and angry. She reported that the store staff had “taken her credit card and did not tell her why...”
- ▶ She repeated this story a lot of times (3 documented times) but was ignored by ED staff.
- ▶ This hospital ED had an unwritten “safety practice” where all “psych patients” were restrained to gurneys in ED if they were confused. No one came in to talk to Julie for another 45 min. By then she was really agitated and her mouth was slightly drooping.
- ▶ Eventually work up showed that Julie had a small stroke or TIA. She sued that hospital for \$1 million in damages.
- ▶ What should have happened?

Real Example: Julie

- ▶ Emergency room staff are often not trained in behavioral health disorders. As a result they can often discount, or ignore, the statements made by people brought in to their care if *they look like people with BH health disorders*.
- ▶ The real lesson here is the unfortunate reality that many health care professionals have learned to ignore what “patients with BH disorders” tell them or try and tell them.
- ▶ This is a critical issue for us, moving forward. People with BH disorders may not be very clear in their communications at times. It is up to us, the supposed professionals, to spend the time and energy to drill down on these communications and try and get more information. Immediately & Objectively.
Staff that have learned, unconsciously, “not to listen to crazy people”, need to be re-trained.
This is a pervasive issue across the country. How would you have handled this information?
(Huckshorn, 2014)

Real Example: Gregory

- ▶ Gregory, 36 yrs. old, 160 lbs, was admitted with depression and a substance use disorder. He grew up in South Carolina. He had been intermittently homeless, after he lost his job 3 years ago, and got angry and violent in the home on a number of occasions. His wife filed for divorce a few weeks ago and he became suicidal, and was admitted.
- ▶ On his 4th day of inpatient care, he walked over to a smaller, younger man who was sitting in a chair in the dayroom. Gregory, without any words, then punched this other patient three times in the face and walked away.
- ▶ The unit staff then became very divided on whether Gregory should be restrained or secluded and ended up bullying the RN to put Gregory into seclusion.
- ▶ What should have happened?

Real Example: Gregory

- ▶ All the hospital staff did with Gregory, from his admission and on, was to monitor him for withdrawal signs and suicidal ideation. Other than his admission assessment, no one really interacted with him on any individualized level. No one asked about his “personal story” and staff were not trained to do that.
- ▶ This hospital did not have any Peer staff to do this work either.
- ▶ Gregory, retrospectively, reported that he had tried to tell 3 different staff members that this other male staff was “coming on to him.” Two staff ignored this and 3rd one said “you are way bigger than him so do not worry.”
- ▶ Staff failed to investigate this issue and that Gregory was very homophobic. As such he took measures into his own hands.
- ▶ After Gregory did what he thought he should do to protect himself, he went back to his room. He was no longer a danger and should not have been placed in seclusion post this event.
- ▶ **What would you have done? If this issue had been managed timely this individual would not have been punished...**

Real Example: Donnie

- ▶ Donnie, 23 yrs. old, was admitted to an inpatient service; his first admission. Admit assessments note that he is agitated, psychotic, and responding to internal stimuli.
- ▶ All hospital assessments were completed. These assessments all find the same symptoms.
- ▶ Donnie gets admitted to a room and staff mostly leave him alone except to get him to meals and to medications. Staff prompt him to groups but he refuses to go.
- ▶ Eight days go by and Donnie comes out of his room and attacks staff.
- ▶ Medical record states “Donnie came out of his room and attacked staff for no reason. He was placed in restraint for one hour.”
- ▶ What should have happened?

Real Example: Donnie

- ▶ Donnie has had a very chaotic life. He was abandoned by his parents, who were drug addicts, and who were not there for him as a child. He was removed from his home at 8 years of age and placed in foster care. He then experienced over 5 foster home placements, running away from some. All of the above are considered to be serious traumatic life experiences. Donnie was, and is, of mixed race in the south and was bullied.
- ▶ All of this information was provided on admission or a few days after. None of this information made it into the treatment plan for Donnie.
- ▶ No hospital staff understood the serious trauma history of this young man. No hospital clinician understood that Donnie needed careful engagement and support on day one.
- ▶ No staff were individually assigned to Donnie to try and engage him or even make him feel safe, on admission or following.
- ▶ Donnie was treated as “just another young adult who had, unfortunately, gotten sick.” He got no special treatment, services or supports even though he WAS SPECIAL. Donnie’s issues were clear but ignored and not understood. *(Huckshorn, 2016)*

Treatment Plan Revisions

- ▶ How do comments, such as the ones below, get translated into treatment plan revisions?
 - “If only they let me 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 and scared...”
 - “No one paid any attention to my concerns...”
 - “No one listened to me and my concerns...”
 - “I could not find a staff person to talk to me...”
 - “I had to get out of there, my dog had no one to feed him. No one paid attention to me.”

(MA, 2012; NASMHPD, 2012; Huckshorn, 2016)

Treatment Plan Revisions

- ▶ For behavioral health facilities the treatment plan needs to be revised based on lessons learned from the S/R event that just happened. The patient should be included and family members, if involved.
- ▶ For some clients safety/calming plans can be developed, with them, and provided to the client to have on their person.
- ▶ On admission and post any S/R event the individual needs to be met with a staff member skilled in “customer services.” That staff person needs to try everything possible to build trust with that patient that could work with the patient including food, one to one conversation, just sitting close by, offering snacks or drinks, asking what the person needs, being empowered to ignore the rules if it is safe to do so.
- ▶ Inpatient and residential staff have a lot of control on what happens in their facilities.
- ▶ See Prompt Sheet for Treatment Plan Revisions.

Executive Level Review: Operational Revisions secondary to Debriefing

▶ Policies/procedural changes

- “staff can allow child to leave group and swing in recreation area if this will avoid an event.”
- “patients that want to use the phone for personal reasons, can use at any time unless, over time, this is demonstrated to be a pattern.”
- Staff will be assigned to each new admission and expected to engage. Staff will be measured on their effectiveness to engage with assigned individuals.

▶ Staffing procedure changes

- “per diem staff will have assigned units; not just float around from day to day.”
- “because unit becomes more acute at change of shift – re-schedule an FTE to provide cross shift coverage from noon to 8pm.”

▶ Change in Bilingual/bicultural support

- “ready access to bilingual/bicultural interpreter” who can talk to consumer and provide staff with cultural understanding for more than 1-2 hours a day.

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
 - Get enough information that “tells the full story about what happened to lead up to this event.”
 - Report and document “the story of what happened”. If you have no story you have not done the work necessary.

Summary: Debriefing

- ▶ Do Consumer Debriefing to:
 - Minimize trauma – addressing physical and emotional needs
 - Offer an apology – rebuild the relationship
 - Learn what could be done next time
- ▶ Debriefing information needs to be *used* as learning opportunities to make clinical and administrative change

Summary: Debriefing

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

(NASMHPD, 2010)

Summary: Debriefing

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

“Excellence is the result of caring more than others think is wise, asking more than others think is safe, dreaming more than others think is practical, and expecting more than others think is possible.”

Author unknown

Provided by the Tennessee delegation 2/7/03