## **Trauma Informed Post Incident Review: Staff**

The use of restrictive practice including restraint and seclusion can be traumatic for health care service users and providers. Following an adverse incident staff may use this tool to support their debriefing process. Debriefing should be undertaken as soon as possible post incident (**24-48hours TBC**). Debriefing sessions are voluntary, confidential & non-judgemental.

Service users and witnesses to the incident should also be offered an opportunity to debrief, using a trauma informed service user debriefing approach.

Respectful communication should be used to better understand:

1. The facts of the event

2. Feelings

3. Planning (to improve patient outcomes and support staff)

## Who should attend?

1. Staff member(s) who were present during the event

2. Senior staff member (facilitator)

3. Patients key worker (if possible/appropriate)

## Who should organise it:

A senior staff member who has been designated (at start of the shift in handover)

A debrief is conducted following all adverse incidents:

* Share responsibility for what happened; learn from event in a non-judgemental way.
* Ensure support for the emotional, psychological, and physical well-being of the young person and staff.
* Provide an educational process where staff member and the young person are assisted with their reactions to the event using a no-blame approach.
* Offer additional resources to health care provider such as support from the Employee Assistance Program and Occupational Health.
* Ensure debriefs are a separate process from formal reviews and are not forums for critique or analysis.
* Ensure staff debriefs are conducted as soon as possible after the event.
* Assess the factors leading to the use of a restraint and steps to reduce the potential future need for a restraint.
* Revise the patient’s care plan as necessary.

Post Incident Debrief Tool:Staff

Facilitator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff present: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the service user have a history of childhood adversity?

Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the incident: (what did you observe in relation to the incident)

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Did the incident include verbal aggression? Yes No . If Yes, was it direct towards:

Staff Other patient Others\_\_\_\_\_\_\_\_\_\_\_\_

Did the incident include physical aggression? Yes No

If yes, towards who?

Staff member Self (self-harm) Another patient Property Other \_\_\_\_\_\_\_\_\_\_\_\_\_

Were verbal de-escalation tools used? Yes No

If Yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What other intervention was used to aid de-escalation (Client-led de-escalation tool):

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Was the young person physically restrained? No Yes Duration\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the young person placed in a room alone (seclusion) or in a high observation area?

Yes No If yes describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were other restrictive practices used? Yes No

If yes, please describe:

Pharmacological (PRN) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Environmental (Door locked) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the outcome of staff interventions, what worked well and what was not so effective?

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Was the young person offered an opportunity to debrief? (By who and when)

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What may have triggered the incident?

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What can we learn from this incident about the young person, if a similar incident was to reoccur?

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Is there anything that you would do differently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the young person’s care plan and/or risk management plan need to be modified in any way?

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Were any other services users who may have witnessed or have been impacted by the incident, offered an opportunity to debrief (By who and when)

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Identify the further staff support in place (1:1 Clinical supervision/Reflective practice group/, by who and when) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Adapted from Needham & Sands, 2010)