

PROTECTING PEOPLE WITH SPECIAL NEEDS FROM THE DANGERS OF RESTRAINTS: Post Restraint Debriefing with Staff

All crisis management programs contain a post-restraint debriefing for people in care which includes an analysis of their triggers, their feelings about the restraint, and a physical assessment to check for injury after the restraint. In similar fashion, staff debriefing can provide an opportunity for staff who are involved in or witness a restraint to process what happened. Debriefings have been proven to mitigate adverse or traumatizing effects of a restraint for staff and people in care.^{i,ii} Establishing a formal staff debriefing process provides important information about:

- The staff member's triggers
- Their feelings about the restraint
- Their physical well-being following the restraint
- What happened before, during, and after the restraint

Begin each staff debriefing by acknowledging the stress involved in conducting a restraint. Affirm that the agency understands the importance of working to avoid and eliminate restraints.

Potential Staff Debriefing Questions:

Questions regarding the person receiving services:

1. Why was the restraint used?
2. Did the person in care display any signs that they were upset or agitated before the restraint occurred?
3. Did the person in care want something before the restraint occurred?
 - a. Were they able to get what they wanted? If not, why not?
 - b. Do you think this contributed to the restraint being used? If yes, how so?
4. How familiar was the person receiving services with their behavior support plan? Did they have an opportunity to have input into the development of the plan?
5. (If applicable) Was the behavior support plan fully followed?
 - a. If so, what parts of the plan didn't work?
 - b. Should the plan be revised?
6. Was anyone injured in any way? If so, what actions were taken to address the injury?

Questions regarding staff:

7. What was your state of mind before initiating the restraint?
8. How would you describe the relationship you had with the person receiving services?
9. Were there other staff available who may have had a better relationship and could have de-escalated the situation? Was this staff member a part of the de-escalation process? If not, what prevented this staff member from intervening?
10. What action led you to believe a restraint was required?
11. What would have happened if a restraint had not been conducted?
12. Were you familiar with the behavior plan of the person receiving services?
 - a. Did staff use the strategies outlined in the behavior plan. If yes, were the strategies helpful?
 - b. Do you have any recommendations on ways to revise the behavior plan of the person receiving services to make it more effective?
 - c. What other techniques could have been used but were not? Why not?
13. Describe the language and tone of voice you were using.
14. Describe the body language you were using.
15. What have you learned because of the incident?

Questions regarding environmental/agency culture:

16. What was occurring before the incident?
17. What actions were taken to improve the safety of the environment before and during the incident?
18. Were there witnesses, including other staff and people in care, to the incident? How did staff manage this?
19. If there were witnesses, did any of them appear to be upset? If so, what was done to address this?
20. Was there opportunity for staff to be flexible with the rules? If no, why not?

Providers should analyze the following to reduce the use of restraints going forward:

- Effectiveness of any interventions attempted prior to restraint
- Best practices used or misused during the incident
- Areas in need of improvement
- Trends in use of restraints

After the debriefing and analysis of the above factors, providers can use the information gained to improve future outcomes in reducing the use of restraints.

ⁱ Six Core Strategies for Reducing Seclusion and Restraint Use. (2006, November 20). Retrieved January 04, 2018, from <https://www.nasmhpd.org/sites/default/files/Consolidated%20Six%20Core%20Strategies%20Document.pdf>

ⁱⁱ Sutton, D., Webster, S., & Wilson, M. (2014). Debriefing following seclusion and restraint a summary of relevant literature. Retrieved January 4, 2018 from <https://www.tepou.co.nz/uploads/files/resource-assets/debriefing-following-seclusion-and-restraint-281014.pdf>

