Implementation and Evaluation of Staff Debriefing After Seclusion and Restraint Events

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Abstract

Problem and Purpose: Episodes of seclusion and restraint have recently increased by 380% from January-April 2021 compared to January-April 2020 in one adult Psychiatric Emergency Department in an academic medical center. Multiple factors contribute to this substantial increase in seclusion and restraint use; some factors are more amenable to practice change than others. The Psychiatric Emergency Department prioritizes patient safety and staff safety and aims to implement trauma-informed care. Evidence supports the importance of debriefing after a patient seclusion or restraint event to improve both patient and staff outcomes; however, staff debriefing is not currently practiced in the department. The purpose of this project is to implement staff debriefing after seclusion and restraint events in a Psychiatric Emergency Department. Methods: A quality improvement project was designed to implement a staff debriefing after patient seclusion and restraint events to assist in keeping staff and patients physically and psychologically safe. The goals of this project are to educate and train 100% of identified unit change champions on the debriefing process, debrief 100% of seclusion and restraint events on the unit during the implementation period and complete eight key debriefing components, and reduce seclusion and restraint events on the unit during the implementation period compared to the same timeframe in 2020 by 95%. Results: 100% of identified change champions were trained. The percentage of debriefings completed was 43%. The number of seclusion and restraint events rose by 126%. Conclusions: Reduction of seclusion and restraint events is multi-faceted and staff debriefing is a portion of the initiative and more time is needed to ensure implementation into unit culture and sustainability. The debriefing tool has been adopted for use throughout the organization's Department of Psychiatry.

Implementation and Evaluation of Staff Debriefing After Seclusion and Restraint Events

Seclusion and restraints are used in behavioral emergencies for patients who are an immediate danger to themselves or to someone else. However, because there is a possibility for staff and patients to sustain both physical and psychological injury during this intervention, national initiatives are in place to promote safety for patient and staff and to reduce and/or eliminate seclusion and restraint use during behavioral emergencies. The American Psychiatric Nurses Association. (2018) "supports a sustained commitment to the reduction and ultimate elimination of seclusion and restraint and advocates for continued research to support evidence-based practice for the prevention and management of behavioral emergencies." One of these evidence-based interventions is staff debriefing immediately after the event. Despite these national initiatives, an adult Psychiatric Emergency Department staff in an academic medical center noted that episodes of seclusion and restraint increased by 380% from January-April 2021 compared to January-April 2020.

Although this unit has prioritized patient and staff safety and implemented components of trauma-informed care to promote low numbers of seclusion and restraint events, seclusion and restraint events increased. Some factors contributing to this increase are more amenable to practice change while some factors, such as patient acuity, cannot be changed. Implementation of staff debriefing after patient seclusion and restraint events was needed because this intervention was not well established on the unit (Appendix A). Anticipated outcomes included a 95% reduction in seclusion and restraint events on the unit compared to the same timeframe in 2020. The purpose of this quality improvement project was to implement staff debriefing after seclusion and restraint events in an adult Psychiatric Emergency Department.

Evidence Review

Because this quality improvement project is occurring in a Psychiatric Emergency Department, a literature search was conducted for staff debriefings completed both in the emergency department setting and in the psychiatric setting. Although an evidence-based staff debriefing tool addressing seclusion and restraint events was not found in the literature, all articles addressed staff debriefing after a patient event. An article by Goulet et al, (2017) was rated as a Level V due to being a systematic review with various study types, including descriptive designs. The other three articles by Gilmartin, et al, (2020), Pallas (2020) and Power, et al, (2020) were rated as a Level VI due to their descriptive design. Except for the systematic review by Goulet et al (2017), all articles used a convenience sampling method. The articles by Goulet et al, (2017) and Power, et al, (2020) earned an overall quality of "B", and the articles by Gilmartin, et al, (2020) and Pallas (2020) earned a "C". Despite there being a lack of high-level evidence, the rating and quality of the articles included in this evidence review is appropriate to support the quality improvement project. See Tables 1 and 2.

Gilmartin, et al, (2020) and Pallas (2020) focused on "hot" debriefings after patient events in the Emergency Department. "Hot" debriefings occur immediately after the patient event, instead of later in the day or week. Gilmartin, et al, (2020) found that "hot" debriefing after patient cardiac arrests within the Emergency Department setting benefitted the staff and were able to positively impact changes to the care of future patients. Although this article focuses on debriefing after cardiac arrests, the use of seclusion and restraints in behavioral health are somewhat comparative, as they are both patient emergencies. Pallas (2020) discussed the benefits of a "hot" debriefing to address both the clinical and emotional aspects of various events in the Emergency Department. Similarities were noted between the article by Pallas (2020) and

Power, et al, (2020), as both articles discussed the importance of supporting staff through the use of "hot" debriefings.

Goulet et al, (2017) and Power, et al, (2020) addressed staff debriefing after seclusion and restraint events in the psychiatric setting, most commonly on the inpatient psychiatric unit. Because staff are able to have emotional peer support and learn in real-time how to better manage immediately dangerous patient behavior, future incidences of seclusion and restraint use can be decreased. A systematic review by Goulet et al (2017) found that staff debriefing is a portion of six key strategies used to decrease the use of seclusion and restraints. In addition to decreasing seclusion and restraint events, staff debriefing can also help staff to process their emotions related to the event. Power, et al, (2020) found that nurses experience a variety of emotions before, during, and after implementation of restrictive practices, such as seclusion and restraint, which can affect care of the patient. Staff noted the need for a "hot" debriefing when debriefings did not occur (Power, et al, 2020). After reviewing the evidence, it is clear that the evidence supports a "hot" debriefing for nursing staff and that these debriefings do benefit both nurses and patients.

Theoretical Frameworks

The Health Promotion Model (HPM) was the chosen middle range theory for this project (Figure 1). The four components of this model include person, environment, health, and nursing (Butts & Rich, 2018). In this implementation, unit nurses are the person; the environment includes the physical space and the presence or lack of psychological safety; health is multidimensional and change champions will act in the nursing role throughout intervention implementation. There are multiple assumptions and propositions of the HPM that applied to this intervention, including patients and staff having the ability to perform "reflective self-

awareness", desiring behavioral regulation, positive emotions toward behaviors increase repeatability of actions, and committing to behaviors that they personally benefit from (Butts & Rich, 2018). Health Promotion Model assumptions and propositions were considered as the project implementation plan was developed and throughout the implementation process.

The Framework for Complex Innovations (FCI) was also utilized for this project (Figure 2). A primary concept of FCI is the organization's implementation climate (Helfrich, et al, 2007). The organization and unit support psychological safety for nursing staff, and leadership recognize the need for staff debriefing. Organizational buy-in was essential for intervention success. The second primary concept from FCI is implementation effectiveness. Multiple variables influence intervention effectiveness, but innovation-value fit and implementation are key to the success of this project (Helfrich, et al, 2007). The intervention aligned with unit and organization priorities, and the implementation plan included input from key stakeholders and change champions. The FCI framework assisted with successful intervention implementation because the organization's climate was receptive to implementation of the intervention and there was significant planning with stakeholders to promote implementation effectiveness.

Methods

The setting for this project was a Psychiatric Emergency Department in an academic medical center. All patient seclusion and restraint events on this unit were included in data collection and analysis. Seclusion and restraint events were identified weekly by auditing a spreadsheet compiled by a data analyst in the organization; the spreadsheet contained all seclusion and restraint events for the week in the Department of Psychiatry. Nursing, healthcare providers, security and any other staff involved in the patient event were encouraged to participate in the debriefing. Participation was voluntary.

Charge nurses and senior clinical nurses served as change champions and were trained to lead the staff debriefing. Debriefings occurred immediately following the patient event in a non-patient care area on the unit. A debriefing form was developed specifically for this intervention with feedback from debriefing experts and unit staff because an evidence-based post-seclusion and restraint debriefing form was not found in the literature (Appendix B).

Data collection followed the HRPO outlined data collection process to protect patient privacy and confidentiality (Appendix C). No patient data was collected. Completed debriefing forms were placed in a locked cabinet on the unit. The DNP project leader audited the debriefing forms and entered data using code into a secure data management spreadsheet stored on a password protected device accessible only by the DNP project leader. These interventions protected data confidentiality.

Change champions received training at the beginning of the intervention via an in-person training by DNP project leader; a PowerPoint and debriefing form were also distributed during the training. The clinical site representative was updated on the project's status via weekly communication. Structure, aherprocess, and outcome goal achievement was analyzed weekly throughout implementation. Shift change and individual discussions with change champions were incorporated to enhance compliance. The debriefing protocol was visible on the unit, and the DNP project leader provided in-person support. These implementation aids and strategies assisted with achieving the structure, process and outcome goals (Appendix D).

Due to implementation challenges, the DNP project leader utilized varying strategies to increase intervention compliance. Debriefing forms were placed more strategically throughout the unit to provide staff easy access to the document after Week 2. Visual cues were placed throughout the unit to remind staff to debrief due to low compliance during Weeks 7 and 8. Staff

were also updated through verbal and written communications, and compliance graphs and data were posted in staff areas throughout the unit.

Results

Changes in practice included evaluation of the structure, process, and outcome goals. The structure goal of educating all change champions was 100% completed. Thirteen change champions were educated by the end of Week 1; education for the remaining two champions did extend into Week 3 due to staff scheduling and unit acuity. Despite this, there was always one change champion on each shift by the end of Week 1. The process goal of debriefing compliance as shown through auditing of the required sections of the debriefing form was met most weeks. For each week containing a seclusion and/or restraint event, compliance with documenting the required sections on the debriefing form was 100%, except for Week 6, which was 86% compliance. The compliance percentage of seclusion and restraint events debriefed each week varied with an overall average of 43% compliance. Due to variable compliance and lack of seclusion and restraint events during Weeks 1, 3, 9 and 11, no trends, runs or shifts were identified on the run charts (Appendix E and Appendix F). Tracking data past the implementation period may provide additional information allowing for a more thorough analysis of the process goal. The outcome goal of reducing seclusion and restraint events in PES by 95% compared to the same time period in 2020 was not met during the fifteen-week implementation period. Seclusion and restraint events rose by 126% (Appendix G).

Despite staff being open to implementing staff debriefings, compliance with the intervention varied. Compliance was noted to be higher when the DNP project leader was present on the unit or had specifically reminded staff on that shift to complete debriefings. In

addition, compliance with the intervention was more challenging when the unit was short staffed. Injuries to staff during the seclusion and restraint events were rare.

During the debriefing of each event, the interdisciplinary team identified what went well and why and what could have been improved and how. After reviewing the completed staff debriefing forms, the DNP project leader identified two primary themes. First, there was a noted need to improve communication between the healthcare providers and the nursing staff. Second communication between the security officers and nursing staff was noted to be a strength in the majority of debriefings.

An unexpected benefit was the enhanced teamwork amongst the interdisciplinary team. Depending on the shift and staffing, different security officers respond to behavioral emergencies, but completing the debriefing after seclusion and restraint events allowed nursing staff to learn more of the officers' names, which helped to enhance camaraderie and teamwork. Although there was an increase in seclusion and restraint events, nursing staff reported that they felt the debriefings enhanced their ability to provide quality patient care and helped to prevent additional seclusion and restraint events.

A noted barrier was a lack of participation in the debriefings from the mental health associates on the unit. Nursing staff and security officers were the largest group of participants. Healthcare providers occasionally participated, and mental health associates rarely participated in the debriefings.

Discussion

Although the primary goal of the project, to reduce seclusion and restraint events by 95%, was not met, multiple staff members throughout the interdisciplinary team stated that the debriefings were valuable. Debriefings reportedly assisted staff to not only process their own

emotions about the event but to also identify strengths and weaknesses to apply to future seclusion and restraint events. More time is needed for complete integration of staff debriefing into the unit's culture.

In addition, documentation of the debriefings was thoroughly completed. The debriefing tool utilized in this project was developed by the DNP project leader with input from various debriefing experts. Due to the high percentage of the complete debriefing documentation and feedback from staff about the high usability and practicality of the form, it is clear that the debriefing tool was effective and appropriate for this project.

Because reduction of seclusion and restraint use is a multi-faceted intervention, limited information in the literature was found specifically addressing implementation of an immediate or "hot" staff debriefing after seclusion and restraint events with patients in the Psychiatric Emergency Department. Due to this, it is difficult to compare this quality improvement project to existing literature. As previously discussed, seclusion and restraint events rose during the implementation period compared to the same timeframe in the prior year.

Observed and anticipated outcomes differed most notably with the percentage of debriefings completed and the number of seclusion and restraint events. Potential reasons for the low debriefing compliance were staffing shortages and needing more time for the intervention to be completely integrated into the unit's culture. However, staff did report that the debriefing was beneficial when completed. A potential reason for the increase in seclusion and restraint events during the implementation period was patient acuity. There is currently no mechanism on this unit to track patient acuity, but staff expressed a perceived increase in patient acuity in 2021 compared to 2020.

The most prominent threat to this quality improvement project is that many factors, such as patient acuity, are unable to be controlled. The baseline comparison group was patient seclusion and restraint events occurring during the same implementation period but in a previous year, 2020. Multiple patient and staffing factors influence seclusion and restraint events causing uncontrollable variables in each group.

Two primary limitations were noted for this quality improvement project. First, there were no patient seclusion and restraint events during Weeks 1, 3, 9, 11 and 13 of the implementation period. While the lack of seclusion and restraint events assisted in achieving the project's overall goal, it limited the ability to collect fifteen weeks of debriefing compliance data. The second limitation noted was that Week 14 had a 0% debriefing compliance percentage. Due to these limitations, additional time is needed to collect data around debriefing compliance to have a more complete understanding of the unit's compliance.

Conclusion

Reduction of seclusion and restraint events is multi-faceted, and staff debriefing is a portion of the initiative. This project is one of the few quality improvement projects looking at one specific intervention's effect on seclusion and restraint events. Despite the overall goal not being met, staff identified communication between security and nursing staff as a strength during seclusion and restraint events, which can increase patient safety.

Strengths of this project include development of a debriefing tool that was able to guide change champions during debriefing the interdisciplinary team and collect necessary data. The debriefing tool is succinct, practical and liked by staff. In addition, the debriefing tool helped to engage all members of the interdisciplinary team who attended the debriefing. The tool also helped to identify what went well and what could have been improved during each debriefing.

Because more time is needed to fully implement staff debriefings into the unit's culture, unit champions continue to promote implementation of intervention to ensure sustainability of staff debriefing. In addition, the Department of Psychiatry at this organization has formally implemented use of this debriefing tool for all staff debriefings after each patient seclusion and restraint event occurring in the department.

Implications for practice and future quality improvement projects include implementation of the debriefing tool into other psychiatric settings throughout the organization's healthcare system where seclusion and restraint events occur. Continuing to track data in this organization's Psychiatric Emergency Department to measure debriefing compliance and effectiveness is also needed. In conclusion, this quality improvement project utilized an effective debriefing tool to guide the interdisciplinary team during debriefing after patient seclusion and restraint events, but more time is needed to better understand the impact of staff debriefing on patient seclusion and restraint events.

References

American Psychiatric Nurses Association. (2018). APNA Position Statement on the Use of Seclusion and Restraint. https://www.apna.org/m/pages.cfm?pageID=3728.

Butts, J.B. & Rich, K.L. (2018) Philosophies and Theories for Advanced Nursing Practice. Sudbury, MA: Jones and Bartlett.

Gilmartin, S., Martin, L., Kenny, S., Callanan, I., & Salter, N. (2020). Promoting hot debriefing in an emergency department. BMJ Open Quality, 9(3). https://doi.org/10.1136/ bmjoq-2020-000913

Goulet, M.-H., Larue, C., & Dumais, A. (2017). Evaluation of seclusion and restraint reduction programs in mental health: A systematic review. *Aggression and Violent Behavior*, 34, 139–146. https://doi.org/10.1016/j.avb.2017.01.019

Helfrich, C.D., Weiner, B.J., McKinney, M.M. & Minasian. L. (2007). Determinants of implementation effectiveness adapting a framework for complex innovations. Medical Care Research and Review, 64(3), 279-303 doi: 10.1177/1077558707299887

Pallas, J. (2020). The Acute Incident Response Program: A Framework Guiding Multidisciplinary Responses to Acutely Traumatic or Stress-Inducing Incidents in the ED Setting. Journal of Emergency Nursing, 46(5). https://doi.org/10.1016/j.jen.2020.05.016

Power, T., Baker, A., & Jackson, D. (2020). 'Only ever as a last resort': Mental health nurses' experiences of restrictive practices. *International Journal of Mental Health Nursing*, 29(4), 674–684. https://doi.org/10.1111/inm.12701

Tables

Table 1
Evidence Review Table

Citation: Goulet, M.-H., Larue, C., & Dumais, A. (2017). Evaluation of seclusion and restraint reduction programs in mental health: A systematic review. *Aggression and Violent Behavior*, 34, 139–146. https://doi.org/10.1016/j.avb.2017.01.019					Level V- Due to having a mix of various study types, including descriptive designs.
Purpose/ Hypothesis	Design	Sample	Intervention	Outcomes	Results

As stated in Goulet, et al (2017), the purpose is "to examine the effectiveness of SR reduction programs in mental health settings."	Systematic review	**Search Strategy:** Six databases were searched by a student who was supervised by the authors and the student's professor. The databases searched were CINAHL, Web of Science, PubMed, Medline, Embase, and the Cochrane Library. The first author then reviewed the found article for literature search completeness. A list of search terms was included in the article. The revised Cochrane Risk of Bias Tool was independently used by three authors to review article quality. Authors solved disagreements via consensus. Inclusion and exclusion criteria were documented. **Eligible Studies:** All articles, regardless of study type, were eligible as long as they met the inclusion criteria. Articles must be in English or French, and include the mental health adult patient population, patients placed in seclusion or restraint, articles	**Control:** Varied by study. Not all studies had a control group **Intervention:** Interventions varied based on the study. Some studies used various established programs to reduce seclusion and restraint and some articles used a collection of strategies. **Intervention fidelity (describe the protocol):** N/A for systematic review	**DV:** Reduction of seclusion and restraint events via two or more interventions **Measurement tool (reliability), time, procedure:** Varied significantly based on the type of seclusion and restraint reduction program being implemented.	**Level of Measurement:** Meta-analysis was substituted for discussion of description of studies, programs implemented and results due to the marked variances of each study. **Outcome Data** Retrieval: Researchers pooled article data Analysis: 26-week measures of abstinence provided were used by researchers and were deemed to be the most rigorous in the literature. Two reviewers rated the study quality independently using a standardized protocol; a third review author was utilized to resolve any disagreements between the initial two reviewers. All reasons for inclusion and exclusion were documented. **Conclusions:** Regardless of the seclusion and restraint reduction program used, six main themes emerged: 1) leadership, 2) training, 3) post-seclusion and/or

		published between 2010-2015, more than one intervention being implemented **Excluded:** Articles with only one intervention; no evaluation of intervention; intellectually disabled patients,, pedopsychiatry and gerontopsychiatry patient populations **Included:** Twenty - three articles total met the previously listed inclusion criteria. **PRISMA:** Details and PRISMA diagram included in article **Power Analysis:** N/A for systematic review			restraint review, 4) patient involvement, 5) prevention tools, and 6) the therapeutic environment. **SR Bias Risk:** According to Goulet, et al (2017), "Given the heterogeneity of identified outcomes, it was impossible to assess risk of bias across studies (measures of consistency, heterogeneity, and funnel plot with Egger's test). We were therefore unable to discuss missing studies or outcomes."
Citation: Power, T., Baker, A., & Jackson, D. (2020). 'Only ever as a last resort': Mental health nurses' experiences of restrictive practices. *International Journal of Mental Health Nursing*, 29(4), 674–684. https://doi.org/10.1111/inm.12701					Level VI
Purpose/ Hypothesis	Design	Sample	Intervention	Outcomes	Results

As stated in Power, et al (2020), the purpose is to "elucidate information from front-line mental health nurses regarding the use of restrictive practices" (i.e seclusion and restraints).	Descriptive design	**Sampling Technique**: Convenience sampling **# Eligible**: All mental health nurses in Australia **# Accepted**: 64 complete questionnaires were received. The total number of incomplete questionnaires received was not given. **# Control:** N/A **# Intervention:** 64 complete questionnaires were received. The total number of incomplete questionnaires received was not given. **Power analysis:** Not discussed/given. **Group Homogeneity:** Per Powers, et al (2020), "Most respondents were registered nurses with postgraduate qualifications in mental health (50%), followed by credentialed mental health nurses (25%), registered nurses (17%), and enrolled nurses (2%). Of the respondents, 23% identified as male and 77% female. Respondents held a range of postgraduate qualifications including	**Control:** N/A **Intervention:** Electronic survey **Intervention fidelity** (describe the protocol): The survey was conducted electronically via SurveyGizmo, and responses were anonymous. The survey was posted on Twitter and Facebook in addition to being emailed to the Australian College of Mental Health Nurses. Ethical approval was granted by the Human Ethics Research Committee.	**DV:** Qualitative responses obtained through electronic survey **Measurement tool (reliability), time, procedure:** Electronic survey developed by the researchers collected demographic information, clinical experience, qualifications and experience with restrictive practice. The researchers were primarily concerned with participant responses to the open-ended question of, "Without breaching confidentiality, can you tell us about a time you were involved in secluding or restraining a consumer, including what led to the event and how it made you feel?" A timeframe was not mentioned for data collection. Theme analysis was initially conducted by the first author using Braun and Clarke's (2012) method. The team then discussed and refined the results. The COREQ statement	**Statistical Procedures(s) and Results:** No statistical analysis completed. **Qualitative results:** Nurses experience a variety of emotions before, during, and after implementation of restrictive practices which can affect care of the patient. Five themes emerged in response to restrictive practices: response to fear, to maintain safety for all, a legacy of time and place, the last resort, and a powerful source of occupational distress. Occupational distress includes staff reporting feeling like the event should have been better managed and even feeling "disgusted" by patient care during the event. The need to support staff during restrictive practices was discussed. Staff reported a lack of debriefing availability and the

		doctoral qualifications (14%), masters by coursework (28%), and graduate diploma (23%). Respondents were drawn from all Australian states and territories; however, the majority of survey respondents currently/previously worked in New South Wales (30%) and Victoria (33%). Most respondents were still currently practicing (94%); 84.4% had been in practice for at least 9 years and most (94%) did not identify as belonging to a minority or marginalized group. Respondents had a range of direct experience with restrictive practices; including initiating seclusion and restraint (58%), assisting with restrictive interventions including actual restraining or monitoring secluded persons (26.6%); witnessed but not involved (5%); and mixed experience (10.9%). Seventy-seven percent of respondents		serves as a guide in reporting qualitative data.	importance of having this available for staff.

		indicated that they were currently very familiar with their organizations' policy/guidelines regarding seclusion and restraint, while 23% stated they were not."			

Citation: Gilmartin, S., Martin, L., Kenny, S., Callanan, I., & Salter, N. (2020). Promoting hot debriefing in an emergency department. *BMJ Open Quality*, *9*(3). https://doi.org/10.1136/bmjoq-2020-000913					Level VI
Purpose/ Hypothesis	Design	Sample	Intervention	Outcomes	Results
As stated in Gilmartin et al (2020), the purpose "of this quality improvement project was to introduce hot debriefing to our ED following all cardiac arrests."	Quality improvement project- descriptive design	Sampling Technique: Convenience sampling # Eligible: Exact number not stated but all ED cardiac arrests were eligible # Accepted: Exact number not stated but all ED cardiac arrests were accepted # Control: Exact number not stated but baseline data from	Control: Comparative baseline of debriefings completed after cardiac arrested in the ED was 0% Intervention: Implementation of a "hot" debriefing process after all patient cardiac arrests Intervention fidelity (describe the protocol): A quality improvement team was formed to	DV: "hot" debriefing process Measurement tool (reliability), time, procedure: Six-month implementation time in which a tool developed and trialed by unit staff was implemented. The tool was initially trialed in simulation and then revised until the team felt it was appropriate for implementation. There was no mention of testing the tool for	Statistical Procedures(s): N/A Results: Sixteen hot debriefings (42%) were completed throughout the implementation period. Issues surrounding technical skills (airway management, etc) and non-technical skills (poor scribing and communication) were

		October 2018 to March 2019 was used as a control # Intervention: 38 cardiac arrests occurred during the implementation period from April-September 2019 Power analysis: Not mentioned Group Homogeneity: All patients presented to the ED and had a cardiac arrest. Patient information is not detailed. All staff participating in the debriefing worked at the same ED and were involved in the patient's cardiac arrest. Detailed staff information is not provided.	develop the debriefing tool; change champions were added to assist with implementation of intervention. The debriefing tool was revised based on simulation debriefing experiences prior to being implemented. Information sessions were conducted with team members to help them become familiar with the purpose of debriefing. Three PDSA cycles were conducted throughout the implementation period.	reliability. Although the tool was used specifically for cardiac arrests, the article mentioned that team members coils use it for other purposes, if team members felt like debriefing was needed. Only cardiac arrest debriefings were tracked. Debriefing forms were reviewed monthly, and the number of debriefing forms completed was compared to the department's cardiac arrest registry to determine debriefing compliance. Suggestions for changes or improvements made in debriefings were followed up on.	identified and addressed. A staff survey revealed that "100% of participants felt debriefing improved or changed their clinical practice, 90% of respondents felt the process helped their mental well-being, and 95% felt the time taken to complete the hot debriefing process was 'Just right'"

Citation: Pallas, J. (2020). The Acute Incident Response Program: A Framework Guiding Multidisciplinary Responses to Acutely Traumatic or Stress-Inducing Incidents in the ED Setting. Journal of Emergency Nursing, 46(5). https://doi.org/10.1016/j.jen.2020.05.016	Level VI

Purpose/ Hypothesis	Design	Sample	Intervention	Outcomes	Results
As stated in citation, in Pallas (2020), "to develop and implement a novel debriefing program as an early intervention for acutely stress-inducing events in the emergency department."	Descriptive design	Sampling Technique: Convenience # Eligible: All clinical staff working in the John Hunter Hospital's Emergency Department (ED) # Accepted: All volunteers were accepted # Control: N/A # Intervention: More than 100 interdisciplinary staff members have been trained to lead a debriefing Power analysis: Not mentioned Group Homogeneity: All staff leading the debriefings were provided the same training and worked in the same ED. Some differences are expected because the staff champions were from various parts of the interdisciplinary team. No breakdown of champion information was provided.	Control: No control group Intervention: Implementation of the Hot AIR debriefing process which also addressed staff emotions during the debriefing process Intervention fidelity (describe the protocol): All volunteer champions received training to complete the seven step debriefing process. The training was provided informally and often within the clinical environment during the champion's shift. Training was done individually and within a group. Training lasted 15-20 minutes and the champion was given a HotAIR badge sticker, reference manual, and reference card. The sticker helped to promote the program and allow staff to easily identify HotAIR champions.	DV: Hot AIR debriefing process Measurement tool (reliability), time, procedure: This tool was developed by the researchers and based on the critical incident stress management concepts, psychological first aid, and peer support. Reliability and validity of the debriefing tool was not discussed. A timeframe of when the training occurred was not mentioned, but the intervention lasted over a three-month period. Encounters between the clinical staff and HotAIR responders were not documented to protect the debriefing participants' privacy and confidentiality.	Statistical Procedures(s): N/A Results: Champions provided positive feedback via open response about the debriefing process. This process had also been implemented in other areas at the same hospital due to the ED's positive results. The author stressed the adaptability of the model to other clinical areas. The author did recognize the need for more rigorous studies to be completed with the HotAIR debriefing.

			Debriefings were conducted anytime “any acutely traumatic or stress-inducing event experienced by a health care worker during the course of their work.” ED staff voluntarily attended debriefings and debriefings happened near or in the clinical area as soon as possible after the incident but before the end of the clinical shift. If champions felt additional support was needed for the group or individual, they were able to escalate the concerns. Although managers and other leadership were trained to lead a debriefing, only frontline staff lead the debriefings.		

Table 2

Evidence Synthesis Table

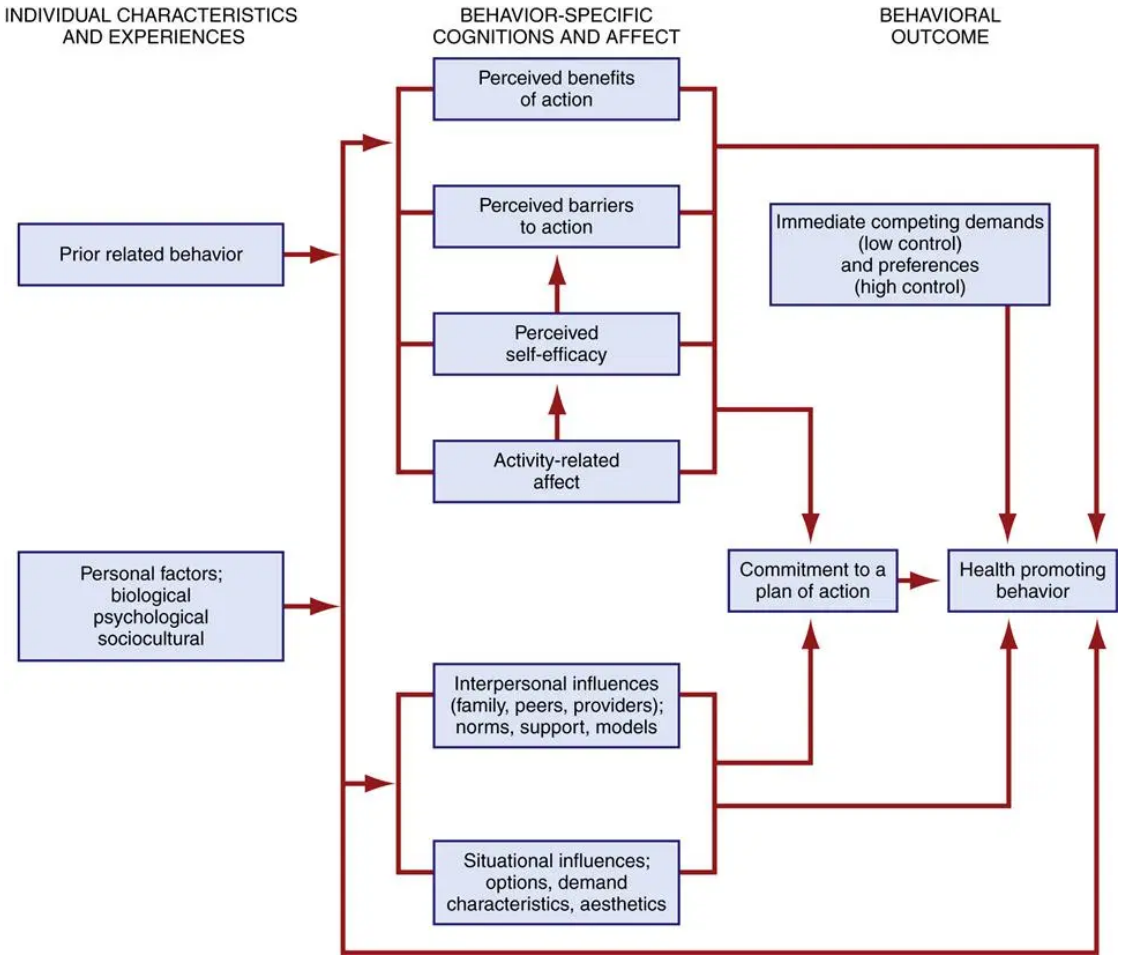
Evidence Based Practice Question (PICO): Are Psychiatric Emergency Services staff debriefing after seclusion and restraint events helpful in reducing patient seclusion and restraint events?			
Level of Evidence	**# of Studies**	**Summary of Findings**	**Overall Quality**
V	**1**	Goulet et al, (2017) found six main themes regardless of the seclusion and restraint reduction program or interventions used: 1) leadership, 2) training, 3) post-seclusion and/or restraint review, 4) patient involvement, 5) prevention tools, and 6) the therapeutic environment. The post-seclusion and/or restraint review includes the importance of staff event review which includes debriefing.	B- Bias could not be determined per the authors. A variety of study types were used which made it impossible for the authors to complete a meta-analysis on the data. This caused the authors to only be able to identify themes for seclusion and restraint reduction. Search strategies were well-defined. Limitations were discussed.
VI	**3**	Gilmartin, et al, (2020) found that staff debriefing after cardiac arrests within the Emergency Department setting benefitted the staff and were able to positively impact changes to the care of future patients in cardiac arrest. Addressing the emotional needs of staff after a traumatic event is essential. Pallas (2020) discusses the HotAIR debriefing tool which provides a template to address both the clinical and emotional aspects of various events in the ED. This tool can and has been adapted to fit the needs of other hospital areas. The "hot" debriefings are essential to supporting staff needs discussed by Powers, et al, (2020). Powers, et al, (2020) found that nurses experience a variety of emotions before, during, and after implementation of restrictive practices which can affect care of the patient .Occupational distress includes staff reporting feeling like the event should have been better managed and even feeling "disgusted" by patient care during the event. The need to support staff during restrictive practices was discussed. Staff reported a lack of	C- Gilmartin, et al (2020) discussed some literature and provided sufficient background. Control group present. Additional program training details could have been included. No reliability or validity discussed with the tool. No power analysis discussed. C- Pallas (2020) did an extensive discussion of the literature with significant background. However, there was no control group and the study was poorly designed with a lack of debriefings tracked and only feedback given about the tool by the volunteer champions. The volunteer feedback was listed in the article as comments without any additional champion feedback. Program training details were also vague. No reliability or validity discussed with the tool. No power analysis discussed. B-Powers, et al, (2020) discussed literature supporting the problem. There was no control group, but the study aim was well-defined and executed. Established tools were utilized to support researchers' analysis and presentation of themes. No power analysis was discussed, and the sample size was small.

		debriefing availability and the importance of having this available for staff.	

Figures

Figure 1

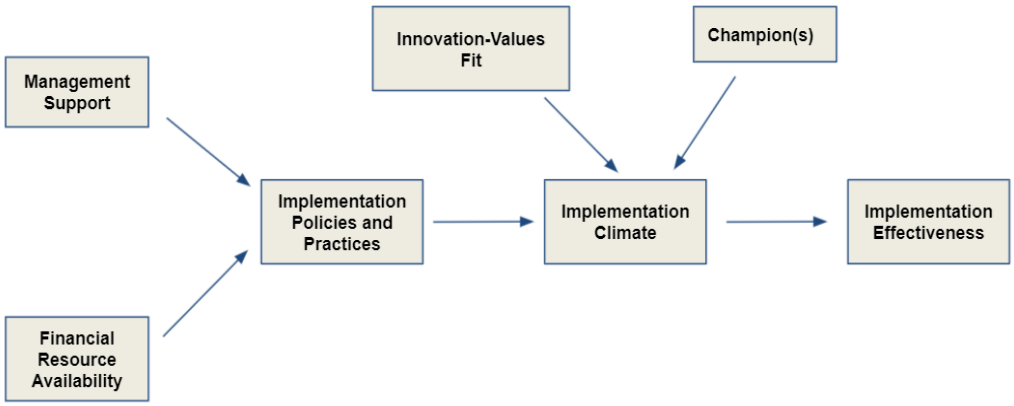
Health Promotion Model



(Nola Pender Health Promotion Model, 2020)

Figure 2

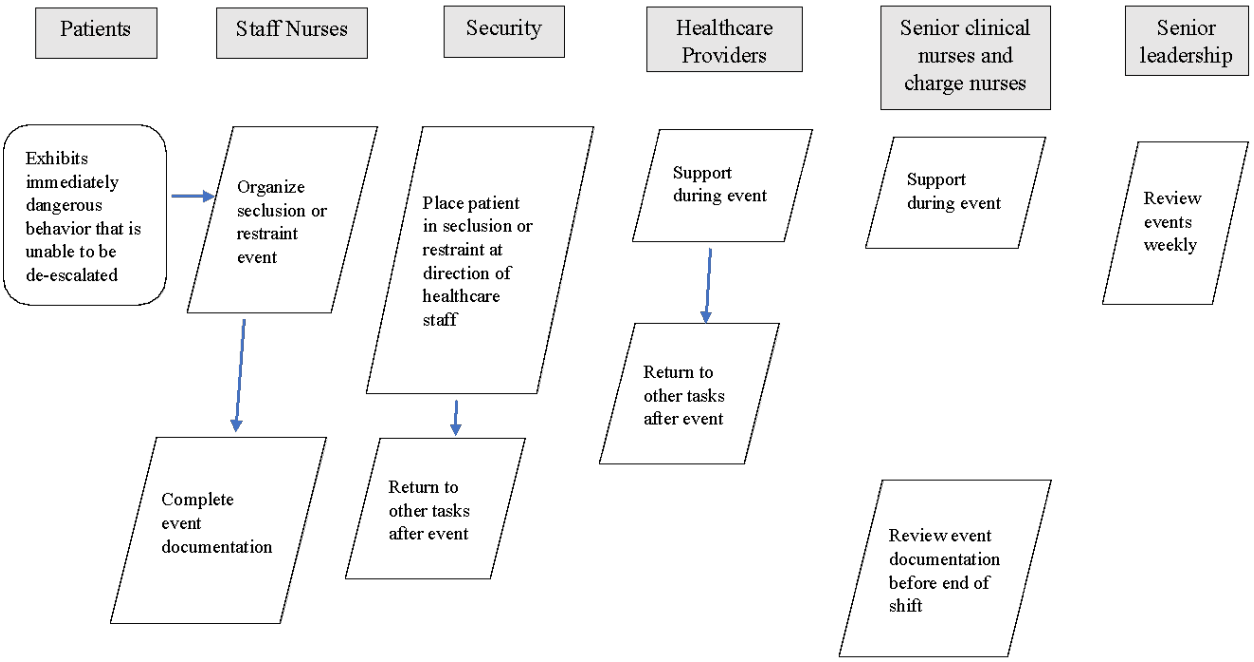
Framework for Complex Innovations



Adapted from Helfrich, et al, (2007)

Appendices

Appendix A



Appendix B

Staff Debriefing Tool

Write your name and put a check mark next to your role. In the last column, write "yes" if you were assaulted or injured during the event or "no" if you were not assaulted or injured.

Name	**Nurse/MHA**	**Healthcare Provider**	**Security/ Solutions**	***Assaults or Injuries? If yes, follow institutional protocol.**

Staff Debriefing Tool

***Type of Event(s):** Physical Hold Seclusion Mechanical Restraint
Date of Debriefing: _____
Name and Role of Debriefer: _____

Reactions
***How is everyone feeling?** _____
_____

Information

***Review of event**

Briefly summarize event.

What was going on with the patient immediately prior to the event (, etc)? _____
_____

What was going on in the unit immediately prior to the event (contributing factors, environment of unit, etc)? _____
_____

Analysis

***What went well and why?** _____
_____

***What can be improved and how?** _____
_____

***What needs to be escalated to leadership? (ie. Broken or non-functioning equipment, staff injury, staffing, etc)** _____
_____

Summary
***What are your takeaways from this debriefing?** _____
_____

Adapted from these resources and documents:

American Heart Association. (n.d.). PEDIATRIC/NEONATAL CODE BLUE and RAPID RESPONSE 5 minute TEAM DEBRIEFING GUIDE. https://www.heart.org/idc/groups/heart-public/@wcm/@hcm/@gwtg/documents/downloadable/ucm_486571.pdf.

American Heart Association. (2016, January 6). Postevent Debriefing Hot. https://www.heart.org/idc/groups/heart-public/@wcm/@hcm/@gwtg/documents/downloadable/ucm_486571.pdf.

Kessler, D. O., Cheng, A., & Mullan, P. C. (2015). Debriefing in the Emergency Department After Clinical Events: A Practical Guide. *Annals of Emergency Medicine*, *65*(6), 690–698. https://doi.org/10.1016/j.annemergmed.2014.10.019

Appendix C

Champion Training Form

Champion Name	Training (Y/N)	Date of Training	Additional Notes

Debriefing Audit Form

2		Total Number of Secluion and Restraint Events on the Unit	Total Number of Staff Debriefings Completed	Percentage of Staff Debriefings Completed
3	Week 1			
4	Week 2			
5	Week 3			
6	Week 4			
7	Week 5			
8	Week 6			
9	Week 7			
10	Week 8			
11	Week 9			
12	Week 10			
13	Week 11			
14	Week 12			
15	Weeek 13			
16	Week 14			
17	Week 15			

Debriefing Compliance Form

	Type of Event 1=Yes 2=No	Injuries 1=Yes 2=No	Feelings 1=Yes 2=No	Review of Event 1=Yes 2=No	What went well 1=Yes 2=No	What can be improved 1=Yes 2=No	Issues to escalate 1=Yes 2=No	Questions/concerns 1=Yes 2=No
Week 1								
Event #1								
Event #2								
Event #3								
Event #4								
Event #5								
Week 2								
Event #1								
Event #2								

Event #3								
Event #4								
Event #5								
Week 3								
Event #1								
Event #2								
Event #3								
Event #4								
Event #5								
Week 4								
Event #1								
Event #2								
Event #3								

Event #4								
Event #5								
Week 5								
Event #1								
Event #2								
Event #3								
Event #4								
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Week 6								
Event #1								
Event #2								
Event #3								
Event #4								

Event #5								
Week 7								
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Event #2								
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Event #4								
Event #5								
Week 8								
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Event #2								
Event #3								
Event #4								
Event #5								

Week 9								
Event #1								
Event #2								
Event #3								
Event #4								
Event #5								
Week 10								
Event #1								
Event #2								
Event #3								
Event #4								
Event #5								
Week 11								

Event #1								
Event #2								
Event #3								
Event #4								
Event #5								
Week 12								
Event #1								
Event #2								
Event #3								
Event #4								
Event #5								
Week 13								
Event #1								

Event #2								
Event #3								
Event #4								
Event #5								
Week 14								
Event #1								
Event #2								
Event #3								
Event #4								
Event #5								
Week 15								
Event #1								
Event #2								

Event #3								
Event #4								
Event #5								

Appendix D

Staff Debriefing Protocol

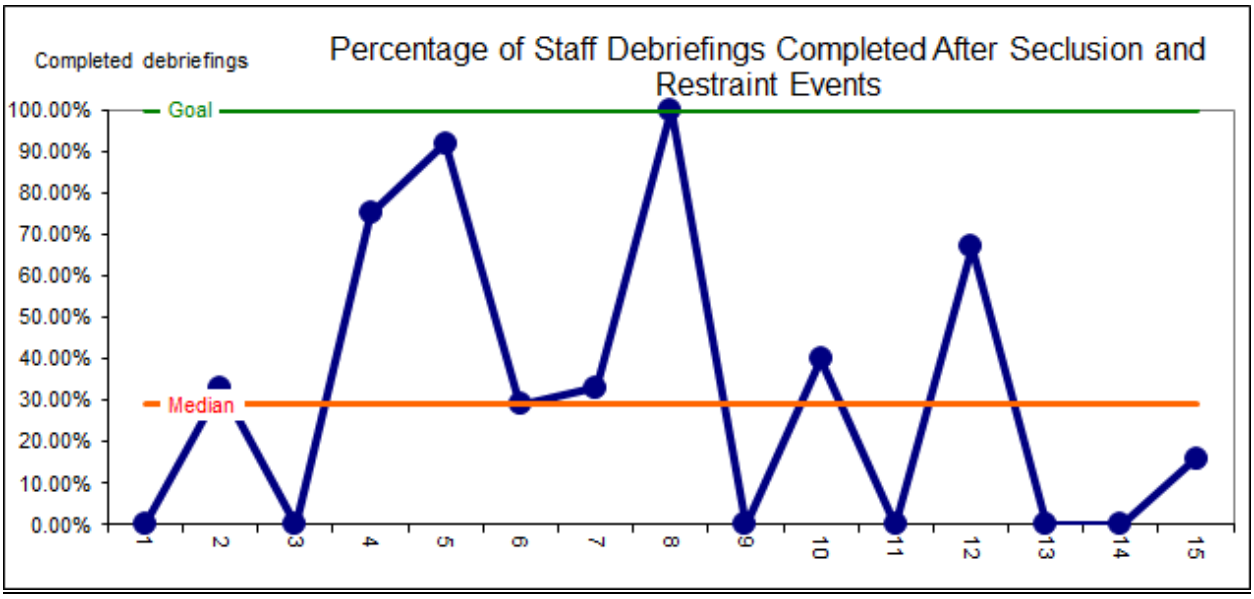
Psychiatric Emergency Services Post-Seclusion and Restraint Event Staff Debriefing Protocol

1. Psychiatric Emergency Services (PES) staff will complete a debriefing immediately following each seclusion and restraint event, and the debriefing will be led by a trained nurse debriefing champion.
2. Healthcare providers, nursing staff, security officers, Solutions officers and any other staff member involved in the event are invited, but not required, to participate in the debriefing.
3. The trained nurse debriefing champion will document the debriefing and ensure that all participants signed in on the debriefing form sign in section.
4. After completing the debriefing, the trained nurse debriefing champions will:
    a. Escalate any identified issues/concerns to appropriate management
    b. Securely store the debriefing form in a predetermined location
5. A designated person will review the completed debriefing forms and provide needed feedback and follow-up to debriefing champions and staff.

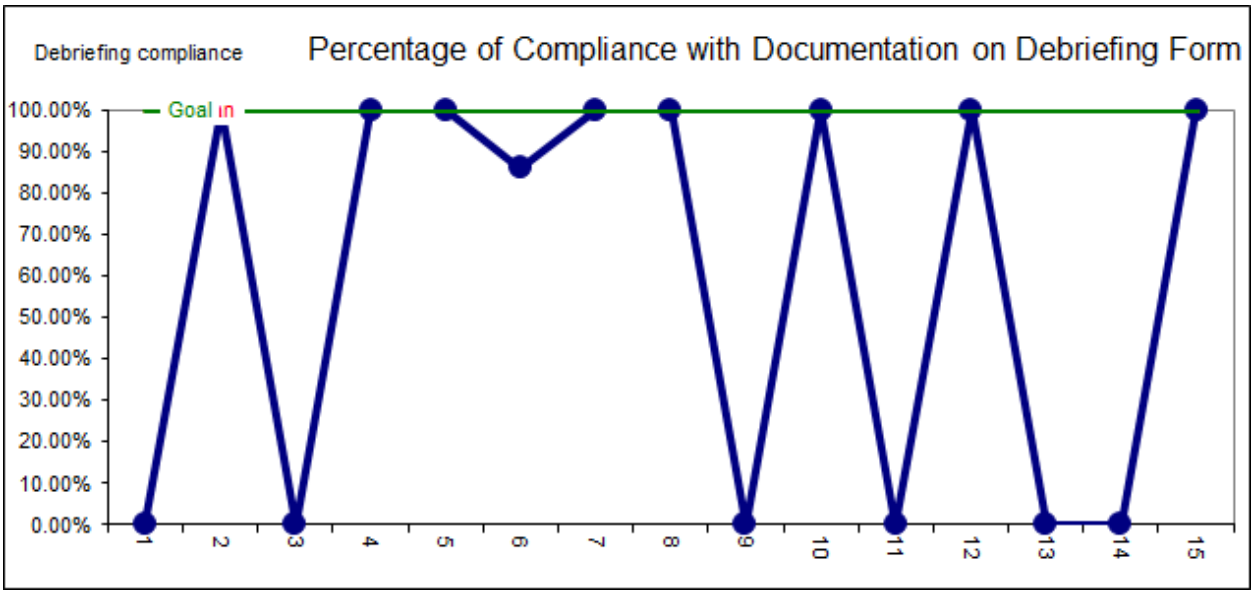
Education Training PowerPoint

Debriefing Visual Cue

Appendix E


Completed debriefings
Percentage of Staff Debriefings Completed After Seclusion and Restraint Events
Goal
Median
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15

Appendix F


Debriefing compliance
Percentage of Compliance with Documentation on Debriefing Form
Goal in
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
1
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12
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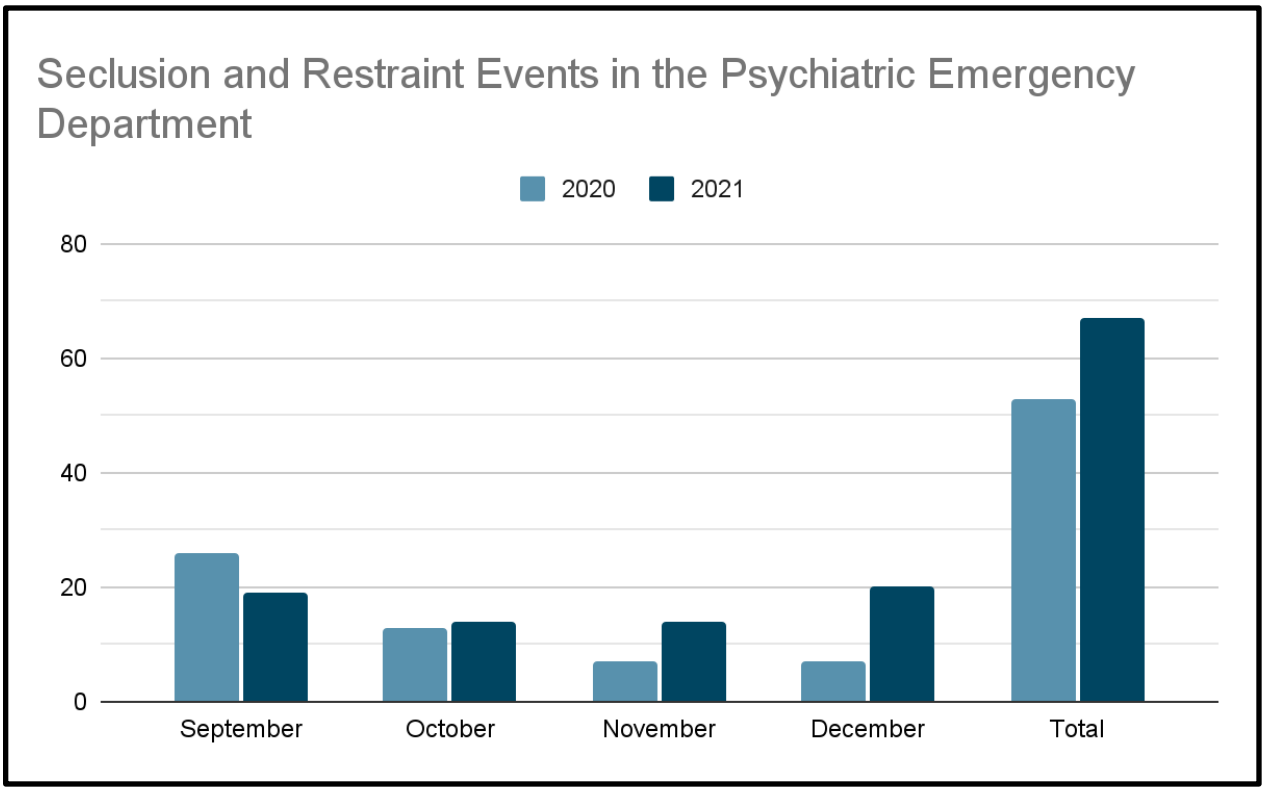
15

Appendix G


Seclusion and Restraint Events in the Psychiatric Emergency Department
2020
2021
80
60
40
20
0
September
October
November
December
Total