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Impact of Post Seclusion and Restraint Debriefing on an Inpatient Child and Adolescent Psychiatric Unit: A Quality Improvement Project

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Impact of Post Seclusion and Restraint Debriefing on an Inpatient Child and Adolescent Psychiatric Unit: A Quality Improvement Project

A DNP Project Presented to the Faculty of
the Nicole Wertheim College of Nursing and Health Sciences

Florida International University

In partial fulfillment of the requirements
for the Degree of Doctor of Nursing Practice

By

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Abstract

Problem: Seclusion and restraint (SR) are techniques utilized frequently on inpatient psychiatric units to manage situations in which patients are an imminent threat themselves or to others. According to Joint Commission guidelines, SR is defined as the use of chemical, mechanical or physical methods, intended as a last resort, to control aggressive and dangerous behavior (Crisis Prevention Institute, 2010). Despite its intended use as a last option, SR is still commonly used on inpatient child and adolescent psychiatric units. Due to this incidence and the many negative consequences of SR, such as injury, death, or traumatization, its reduction on inpatient psychiatric units is an important clinical problem.

Background: The rate of SR on a child and adolescent psychiatric unit in a small psychiatric hospital in the Southeastern United States was much higher than was considered acceptable by their organization's standards. Also, a review of the SR paperwork documenting these incidents over a two-month period found that the post incident debriefings were not being completed properly.

Method: A two-part debriefing system was implemented on a 44 bed child and adolescent inpatient psychiatric unit. This was accomplished through the use of an educational intervention on how to properly conduct and document a debriefing as well as the implementation of a second debriefing within 48 hours of the incident. Staff's perception, gained knowledge, confidence, and willingness to change practice were assessed through the use of Likert scales before and after intervention. Chart reviews were also conducted before and after intervention to determine if there was an improvement in documentation.

Conclusion: Significant improvements were seen in staff perception of debriefing, confidence to perform a debriefing, as well as its importance post SR. Improvement was also

noted in regard to documentation completeness and accuracy. Staff did not feel the intervention was effective in increasing their knowledge of debriefing practices overall, despite the intervention showing changes in practice.

Keywords: *child and adolescent seclusion AND restraint, debriefing, debriefing techniques in seclusion AND restraint*

Introduction

Seclusion and restraint (SR) are techniques utilized frequently on inpatient psychiatric units to manage situations in which patients are an imminent threat themselves or to others. According to Joint Commission guidelines, SR is defined as the use of chemical, mechanical or physical methods, or the use of seclusion, intended as a last resort to control aggressive and dangerous behavior (Crisis Prevention Institute [CPI], 2010). SR is intended for use only in crisis situations, not as a means of punishment, coercion, convenience, or discipline (CPI, 2010). Despite its intended use as a last resort, SR is still commonly used on inpatient child and adolescent psychiatric units. According to a systematic review by Nielsen et al. (2020), 22-47% of children and adolescents are being restrained while on inpatient psychiatric units. Another systematic review by Hert et al. (2011) showed that 26% of children and adolescents were placed in seclusion and 29% of patients experienced some sort of restraint either physical, chemical or mechanical. A quality improvement study by Black et al. (2020) reported 26-29% of children and adolescents experienced SR while on inpatient units. These numbers seem to be in agreement. Due to this incidence and many negative consequences, the incidence of SR on inpatient psychiatric units is an important clinical problem.

Problem Statement

The rate of SR on a child and adolescent psychiatric unit in a small psychiatric hospital in the southeastern United States was much higher than was considered acceptable by their organization's standards. According to Walker and Pinkelman (2018), SR has been shown in many instances to cause physical and psychological trauma and in some cases even fatalities. For this quality improvement project, when referring to SR at the facility, it will include physical and chemical restraints only, as mechanical restraints were not allowed by policy.

In order to better understand the SR process at the facility, a review of the SR paperwork documenting these incidents over a two-month period was conducted. During this analysis, it was found that the post incident debriefings were not being completed properly. According to policy, the debriefing is expected to be completed within twenty-four hours post intervention by a registered nurse, however, 87% of debriefings were incomplete. Of the incomplete documentation, 72% included notations like “patient refused to participate” or “patient was aggressive,” while 18% were not completed at all. The documentation also showed that the majority of these debriefings, 74%, were not first time incidents. Meaning the same patients were repeatedly experiencing SR interventions. According to Scanlan (2010), debriefings have been shown as a means to decrease SR overall by serving as a means to prevent the incident from reoccurring in the future. The literature review expands upon how improvement and expansion of the current debriefing system provides an opportunity to decrease SR overall.

Consequences of the Problem

Current literature indicates that the high incidence of SR is a problem. According to Matte-Landry and Collin-Vezina, (2020), seclusion, physical, and chemical restraints have been shown to cause psychological harm, physical injury, and in some cases even death. SR can be especially traumatizing for children with a past history of trauma (Matte-Landry & Collin Vezina, 2020). Restrictive measures can be associated with negative physical and psychological outcomes as well.

A qualitative study by Hammer et al. (2018) found SR to have significant negative, psychological impacts for persons with a history of abuse. The trauma informed care perspective indicates that they may become re-traumatized due to mental associations between the restraint and the trauma incident (Hammer et al., 2018). Mohr et al. (2003) had similar findings in their

literature review. Laughane et al. (2012), conducted a qualitative study examining patients with psychosis and found SR undermined the the patients' trust and triggered feelings of powerlessness. A quality improvement project by Nunno et al. (2006) found that between 1993 and 2003 there were 45 fatalities on inpatient child and adolescent facilities related to SR. An analysis of autopsy reports between 1997 and 2010 conducted by Berzlanovich and Keil (2013) found evidence of 26 deaths related to SR. The main causes were overwhelmingly asphyxiation, strangulation, and chest compression; all were attributed to improper technique. According to The Substance Abuse and Mental Health Administration [SAMHSA] (2021), there are between 50 and 150 deaths related to SR annually. A systematic review by Kerstling et al. (2019) of case controlled, experimental, and case reports found an injury rate of between 4% and 14.9% for persons in physical restraints.

Significance of the Problem

Data shows that 22-47% of children and adolescents are restrained or secluded while on inpatient psychiatric units (Hert et al., 2011; Pogge et al., 2013; Nielsen et al., 2020; Black et al., 2020). This is significant as SR can place children and adolescents at higher risk of injury, particularly if the restraint goes over fifteen minutes (Nielson et al., 2020). Nielson et al. (2020) also found SR to have no therapeutic effect and in some instances to even fracture the therapeutic bond. The researchers also indicated that SR may be psychologically harmful for not only children and adolescents but staff members as well. Through their systematic review, they uncovered incidents of traumatization, re-traumatization, loss of self-esteem, and damage to the therapeutic bond between staff and patient (Nielson et al., 20200.

Background of the Problem

Due to its high incidence and many negative consequences, reduction of SR on inpatient psychiatric units is an important clinical problem. This importance was recognized by the SAMHSA which joined with the National Association of State Mental Health Program Directors (NASMHPD) to find the best way to accomplish a reduction in its incidence. To accomplish this goal, SAMHSA examined existing programs that were successful in reducing the use of SR. From this data they developed a training curriculum that included The Six Core strategies to decrease the use of SR in the inpatient setting (Lebel et al., 2010). The strategies included organizational change, use of data to inform practice, prevention tools, parental roles, workforce development, and debriefing techniques (CPI, 2021). The strategy of debriefing techniques was utilized directly in this project.

SR is also an important clinical problem for nurses. A qualitative study by Muir-Cochrane et al. (2015) found that nurses saw no alternative to SR when patients become agitated or aggressive. The nurses interviewed agreed that their first method of de-escalation was to utilize SR. Many overwhelmingly felt this was due to the lack of policy in regard to de-escalation (Cochrane et al., 2015). They also agreed that substitutions to SR were not encouraged as part of their training. The lack of an alternative solution implies that there were no other possible choices besides SR available (Muir-Cochrane et al., 2015). In essence, SR was a first resort, not a last resort. The actual definition of SR, according to Joint Commission guidelines, defines SR as crisis intervention to control aggressive and dangerous behavior when all other methods fail (CPI, 2010). It is clear from this definition that in many instances SR is not being utilized appropriately.

Another qualitative study by Muir-Cochrane et al. (2018) examined staff attitudes in regard to the potential elimination of SR as a means to treat aggressive and dangerous behavior. The study showed that nurses feared the elimination of such practices would leave them without means to address aggression and violence on the unit (Muir-Cochrane et al., 2018). The nurses overwhelmingly responded that to eliminate SR would place themselves and other patients at high risk for physical injury (Muir-Cochrane et al., 2015).

Providers can be quick to utilize SR as a first resort as well. According to a mixed methods qualitative study with a qualitative component by Kontio et al. (2010), providers and nurses saw SR as a normal part of inpatient hospitalization. Many admitted that they utilized SR before considering other options to control patients perceived as dangerous or out of control (Kontio et al., 2010). A significant portion of those surveyed considered the use of SR to be unethical, however, it was still utilized as they deemed no other alternative (Kontio et al., 2010). Participants also agreed that they had little or no training on alternatives to SR and would be open to education on less restrictive options (Kontio et al., 2010).

Literature Review

For this review of the literature, the Florida International University A-Z databases were explored within the last ten years. The term *child and adolescent seclusion OR restraint* was initially searched but yielded 77, 906 articles. It was truncated to *child and adolescent seclusion AND restraint and* 427 relevant articles were found. A search for *debriefing techniques in seclusion AND restraint* yielded four articles. Relevant articles were also located through the reference sections in the systematic reviews. This resulted in 431 articles. The abstracts of these articles were reviewed. The search was narrowed based on the strengths and relevance of the studies and this resulted in 67 articles.

According to Needham and Sands (2020), debriefing can be defined as an intervention that occurs after a restraint incident with the purpose of supporting the patient, evaluating their well-being, and assessing for follow up care. It gives the child time to vent, discuss what happened, and validate their feelings and experiences (Needham & Sands, 2020). Mullan and Cheng (2014) describe debriefing as reflective learning opportunities for both staff and patients. It is a form of practice based learning that serves to identify strengths and weaknesses of both staff and patient (Mullan & Cheng, 2014). Debriefing techniques as a means to reduce SR have been explored in the literature primarily as part of bundled intervention strategies or as qualitative studies.

A quality improvement study by Eblin (2019) took place on a fourteen bed unit over three months, level of evidence: six. It involved implementing a SR decision making algorithm as a part of a bundled intervention strategy. They found that staff debriefing immediately after the intervention, as well as within 72 hours of the intervention, combined with behavioral modification plans and a decision-making algorithm, significantly reduced SR on an adolescent inpatient psychiatric unit by 55% overall (Eblin, 2019).

An editorial examining best practices for reducing SR by Lebel et al. (2010) examined expanded debriefing techniques, level of evidence: seven. They found that the implementation of NASMHPD Six Core Strategies, including expanded one-part debriefing techniques, workforce development and SR prevention tools significantly reduced SR incidents overall. They also examined the efficacy of two-part debriefing techniques, one immediately post intervention and one by the treatment team within 24 hours, and found them to be effective in a review of the literature (Lebel et al., 2010).

According to the Six Core Strategies, debriefing techniques are exercised with the intention of preventing problematic behavior in the future (SAMHSA, 2010). A quality improvement project by Azeem et al. (2017) took place on a 26 bed child and adolescent inpatient psychiatric unit over three years, n= 238, level of evidence: six. They examined the impact of expanded debriefing techniques as part of a bundled intervention consisting of the Six Core Strategies (SAMHSA, 2010). They utilized a two-part debriefing technique, one immediately post intervention and one within 72 hours (Azeem et al. 2017). The debriefings were done in a non-punitive manner in order to examine what could be done in the future to prevent problematic behavior. They also explored how the situation could have been better handled (Azeem et al., 2017). The intervention successfully decreased the use of SR from 17.2% to 6.7% overall.

A systematic review including qualitative and mixed method studies conducted by Hammervold et al. (2019) included 12 studies, level of evidence: five. This review included only five empirical studies directly related to post event debriefing to decrease SR, one of which involved children and adolescents. The studies overall showed a 67% decline in SR through the use of expanded debriefing techniques. However, in the great majority of these studies the debriefing techniques were part of bundled interventions (Hammervold et al., 2019).

A qualitative study by Bonner and Wellman (2010) took place on an adult psychiatric unit and included 30 participants over two years, level of evidence: six. Patient and staff perspectives on debriefing techniques post SR intervention were examined. These debriefings included discussions on what caused the incident and how the situation could have been improved. Ninety-seven percent of staff and 94% of patients considered post incident review to be helpful (Bonner & Wellman, 2010). The ability to vent and discuss what happened during the

event was considered extremely beneficial by 93% of patients and staff (Bonner & Wellman, 2010).

Needham and Sands (2010) conducted an exploratory research study with 275 patients over one year, level of evidence: six. The researchers conducted a retrospective file audit taking five variables into consideration: counseling, ventilation, support, physical intervention and psychoeducation. They limited the audit to the first seclusion incident in order to establish ‘criterion related validity’ (Needham & Sands, 2010). Through these audits they were able to establish that post seclusion debriefing was seen positively by patients, giving them a chance to vent their frustrations and share their feelings about the events. The patients also saw the debriefings as a means to take back some of the control they felt they lost during the intervention (Needham & Sands, 2010).

Goulet et al. (2018) conducted a case control qualitative study with a quantitative component. The study implemented an expanded post SR debriefing technique and included 195 patients on a 16 bed unit over six months, level of evidence: six. Staff and patient attitudes regarding the intervention were examined through training interviews analyzed by a content analysis method (Goulet et al., 2018). SR rates before and after were also measured. SR was found to be reduced in the six-months post intervention by 10.6% (Goulet et al., 2018). Staff and patients also found the debriefing to be helpful in strengthening and re-establishing the therapeutic alliance (Goulet et al., 2018).

A qualitative analysis that utilized retrospective chart audits by Ling et al. (2015) examined experiences of patients before, during, and after restraint. The audits were conducted over a period of four years and included 90 patients, level of evidence: six. Patients reported a loss of trust in staff and also experienced feelings of powerlessness and anger post incident (Ling

et al., 2015). Many patients also described a sense of interpersonal tension towards the staff members, particularly those that restrained them (Ling et al., 2005). Patients, however, did favor the ability to debrief post restraint and found it to be beneficial in easing this tension and re-establishing trust with staff, a key part of the therapeutic relationship (Ling et al, 2015).

An expert editorial and literature review by Greene et al. (2006) described a collaborative problem solving (CPS) approach for reducing SR, level of evidence: seven. The primary focus of CPS involves giving patients the tools, meaning the ability to problem solve, in order to avoid problematic behaviors in the future (Greene et al., 2006). CPS involves staff working closely with patients to teach them cognitive awareness and skill building. The goal of CPS is to educate patients on how to recognize the point at which their emotions are becoming unmanageable and to prevent emotional escalation using coping strategies (Greene et al., 2006). This encouragement of inner cognitive awareness and coping techniques are similar to those suggested in post incident debriefing techniques.

A systematic review including descriptive and qualitative research conducted by Goulet et al. (2017) included 31 studies, level of evidence: five. The researchers found that debriefing post SR was considered beneficial by staff. They cited a high level of violence on inpatient units and found that staff generally had a need to process these events for their own psychological well-being (Goulet et al., 2017). They also felt the need to re-establish trust and repair any damage done to the therapeutic bond with the patient (Goulet et al., 2017).

A scoping review of 31 studies conducted by Mangaoil et al. (2020) found debriefing post SR to be beneficial by staff, level of evidence: five. Although the intention of post incident debriefing was primarily to reduce recurrence and to assist the patients in processing the incidents, the study indicated that debriefings were helpful in allowing staff process their

feelings. Staff found debriefing to be particularly helpful when processing incidents that were perceived as violent, distressing, disturbing or even traumatic (Mangaoil et al., 2020). To illustrate this level of violence, Needham et al. (2005, as cited in Mangaoil et al., 2020), indicated that 70% of nurses working on an inpatient psychiatric units had been assaulted at least once by a patient during their career. They also found debriefing to be beneficial as a means to identify staff members who may require further event processing, psychological support, or medical attention (Mangaoil et al., 2020).

A qualitative study with a quantitative component by Whitecross and Lee (2013) involved a semi-structured interview and counseling intervention after SR incidents. Thirty-one subjects over a period of one year were included, level of evidence: six. They utilized the Impact of Events (IES-R) trauma scale, a widely used tool to measure trauma symptoms (Whitecross & Lee, 2013). Semi-structured interviews were also implemented as a form of debriefing. The findings pre-intervention denoted increased IES-R trauma scores, implying that some form of trauma was experienced and a diagnosis of acute stress disorder (ASD) or post-traumatic stress disorder (PTSD) were possible (Whitecross & Lee, 2013). The post SR debriefings surprisingly were not found helpful in decreasing the subjects' PTSD or ASD symptomatology. Researchers described this lack of effectiveness as most likely due to the delayed nature of the debriefings as the sessions were conducted three to seven days post incident (Whitecross & Lee, 2013). It is likely that this this lag time decreased the effectiveness of the sessions in addressing the trauma symptomatology.

A phenomenological study conducted by Ezeobele et al. (2013) examined the seclusion experiences of 20 patients. This qualitative study took place over a period of three days in an inpatient adult psychiatric unit, level of evidence: 6. Face-to face, semi structured interviews

were conducted on the third day following seclusion. The findings indicated that the patients were left feeling as if they were alone and everyone was against them (Ezeobele et al., 2013). They also harbored resentment toward staff and saw the SR incidents as staff attempts to exert power and control (Ezeobele et al., 2013). It is clear from these results that a debriefing after seclusion incidents could serve as a means to re-establish the therapeutic connection between patient and staff and also to explore ways to avoid these events in the future.

A quality improvement project by Andrassy (2016) examined the use of a 'feelings thermometer' as a means to reduce SR on a 140 bed child and adolescent residential unit, level of evidence: 5. The 'feelings thermometer' was used as a means for patients to express themselves from 'cool' to 'on fire' (Andrassy, 2016). The project included an educational intervention that went over when and how to use the 'feelings thermometer' as well as how to perform de-escalation for patients who were becoming upset (Andrassy, 2016). The implementation of this project showed a significant decrease in SR from 129 incidents to 91 incidents over a six-week period (Andrassy, 2016). Based on these findings, it appears early intervention can be utilized as a means to prevent SR (Andrassy, 2016).

No randomized controlled trials on the use of debriefing techniques have been conducted. This is most likely the case as to withhold debriefing techniques from the control group would be unethical. Despite this lack of randomized controlled trials, qualitative studies and bundled intervention studies have shown positive results and attitudes regarding the practice. The quantitative study by Goulet et al. (2018) on the impact of debriefing techniques alone showed significant results, however this was done with adults.

Goals and Objectives

This quality improvement project implemented a two-part debriefing system on a 44 bed child and adolescent inpatient psychiatric unit. This was accomplished through the use of an educational intervention that covered how to properly conduct and document a debriefing. This project also implemented a second debriefing during treatment team within 48 hours of the incident. Through the use of Likert scales before and after intervention, staff's perception, gained knowledge, confidence, and willingness to change practice were assessed. Chart reviews were also conducted before and after the intervention to determine if there was an improvement in documentation.

PICO

Population: Registered Nurses, Physicians, Nurse Practitioners, Therapists, Mental Health Technicians working on a 44 bed child and adolescent inpatient psychiatric unit.

Intervention: Education on debriefing (its purpose, indication, and how to complete properly) as well as an expansion of the current debriefing system. Also, chart audits of SR incident paperwork conducted before and after the intervention.

Comparison: The current debriefing system/current practice.

Outcome: Staff has increased knowledge on debriefing. Staff feel more competent and confident when completing a debriefing. Staff show an improvement in documentation.

Definition of Terms

Seclusion and Restraint: The use of chemical, mechanical, and/or physical and methods or seclusion intended as a last resort to control aggressive and dangerous behavior (CPI, 2010).

Debriefing: A meeting post SR incident that occurs between a staff member and the patient about an incident that led to SR and how it can be prevented in the future.

Debriefing Documentation: This refers to the paperwork done after any SR intervention throughout the hospital. It includes justification for restraint, a description of what happened, type of restraint used, its duration, and how the patient tolerated the restraint. The post incident debriefing is part of this packet as well.

Self-Efficacy: Defined by Bandura (1993) as a person's belief in their own capabilities and confidence in the ability to exercise control over themselves and events that impact their lives.

Theoretical Framework

The theoretical framework of this project is based on is Bandura's Self-Efficacy Theory. Self-Efficacy Theory is centered upon the premise that perceived self-efficacy plays an important role in the ability to self-manage (Bandura et al., 2003). It applies to all persons across the lifespan but particularly to children and adolescents as it is a very challenging time of development. During adolescence, demanding physical, physiological, social and developmental changes occur simultaneously (Bandura et al., 2003). It is especially true that during this time a person's perception that they are self-efficacious can exert influence over four key processes: affective, cognitive, motivational, and academic (Bandura, 1993). For this research project, the affective process is most relevant.

The affective process refers to a person's belief to manage stressful and uncomfortable situations (Bandura, 1993). Feelings of intense sadness and anger can be very difficult to endure, and in some cases the patient may feel hopeless, as if these negative feelings will never abate. According to Bandura, perceived self-efficacy in the ability to maintain control over these feelings and stressors can lead to improved feelings of well-being and increased belief in the capacity to be successful (1993). Persons with weak self-efficacy tend to dwell on their coping deficiencies, inabilities, and past failures during these difficult situations (Bandura, 1993). They are likely to perceive danger when it is not there, leading to feelings of loss of control. This loss of control is likely to produce depression, anxiety, and behavioral dysfunctions (Bandura, 1993). In comparison, persons with stronger beliefs in their abilities will perceive the situation as more manageable and therefore react in a more positive and appropriate manner (Bandura, 1993).

Many of the children and adolescents on the facility's inpatient unit suffer from mood and anxiety disorders. Many come from broken homes, foster care situations, or have physical or sexual abuse histories. Feelings of low self-worth and low self-efficacy are common. Therefore, it is important to empower these children through the debriefing process by allowing them a chance to review what happened and see how they can better handle the situation in the future. Debriefing provides support and encouragement to the child in order to boost their self-confidence and belief in their ability to cope and manage stress (Greene et al., 2006).

Methodology and Project Design

Intervention

The proposed intervention involved educating staff on the importance of the immediate post SR debriefing and encouraged the debriefings to be completed in a timely and

comprehensive manner. Documentation education was also provided and chart checks before and after intervention were be conducted to assess for change. As part of the intervention, a second debriefing was encouraged as well. This debriefing was expected to be done during treatment team the day following the SR incident.

According to Lebel et al (2010) debriefing is a two-part process. In the case of this project, the first part occurred immediately after SR intervention. This was a brief meeting intended to establish initial rapport and aid in the de-escalation process. The second debriefing took place within 48 hours and was a more formal affair, focusing on event analysis, future event avoidance, and coping skills (Lebel et al., 2010). The second debriefing was expected to be held during the daily treatment team meeting with the provider, therapist, and registered nurse in attendance. If available, mental health technicians that were directly involved in the incident were invited to attend as well. Mental health technicians tend to have the most direct patient contact and frequently are first hand witnesses to the incidents requiring restrictive interventions. For each SR incident, the patient was expected to attend treatment team in order to discuss what happened, how it can be avoided, and what could have been done differently.

The staff education focused on how this meeting was to be non-punitive in nature and according to Bandura's Self Efficacy Theory, 'build up' the child (1993). This increased self-confidence and perceived self-efficacy instill self-reliance and improve emotional regulation (Bandura, 1993). Staff were educated on how and when to complete this second debriefing. Tips on how to best communicate during this intervention were also included. According to CPI (2013), the debriefing should occur as soon as possible after the incident. It is very important, however, to ensure everyone is calm and rational. If tempers are flaring it is not possible to rationally discuss coping skills and triggers (CPI, 2013). Staff were also instructed to look for

patterns and trends in patient behavior (CPI, 2013). Were events taking place at certain times? Were specific staff members normally present? Was it before meals? After an intense phone call to family? Finally, focus on what did go well, rather than only the negatives (CPI, 2013). This allows the patient to look back at the situation with a more positive light and learn from it. This is also a great opportunity to discuss coping skills, trigger identification, and preferred de-escalation techniques.

A large portion of this intervention included education on documentation of the SR incident. This included a discussion on how to 'hand off' the task to the next shift if the incident occurred around shift change. Strategies on how to approach patients after SR were also incorporated. Chart checks were conducted before and after the intervention in order to assess for complete and proper documentation. These checks took place in medical records and involved reviewing the SR records during specific time periods pre and post intervention.

Education

Staff members who participated in this project were educated through a brief voice-over video session lasting approximately 12 minutes. The session included education on the definitions of debriefing, SR, and why debriefing post SR was important. The presentation began with an overview of SR, including its definition and consequences as well as current practices and policies at the facility. It also included an education grounded in Banduara's self-efficacy theory on how to complete a debriefing properly (Bandura, 1993). Staff members were encouraged to discuss coping skills, trigger identification, de-escalation techniques as well as safety plans with the patients. Implementation of a second debriefing during treatment team was also covered. Finally, documentation was reviewed to ensure the debriefings were properly noted in the medical record.

Project Design

This quality improvement project included a pre and posttest survey to collect quantitative data and evaluate the effectiveness of the educational intervention. Data was collected regarding staff perceived benefit, feelings of competence, and willingness to change practice. Surveys were provided before and after the educational session. Demographic information was also collected at the time of survey that included: role on the unit (registered nurse, nurse practitioner, physician, therapist, or mental health technician), participant gender, time worked at the facility, and age. There was also an opportunity for study subjects to contribute any questions or comments. Identities were protected as no personal identifiers were collected. Participants were assigned a number to provide for anonymous data collection. The data was analyzed using descriptive statistics in order to detect changes, improvements, or failures to change or improve. The type of survey used was a Likert scale.

Measurement Instruments

Likert scales provide statements presented to a participant who selects the most relevant answer. The choices are proposed upon a continuum and include: strongly disagree, disagree, neutral, agree, or strongly agree. According to Wakita et al. (2015), Likert scales are a commonly used measurement tool in the field of psychological research. Likert scales are able to measure the opinion or attitude of the person being assessed if the psychological distance between the categories is equal (Wakita et al., 2015). This is usually accomplished through the use of a 'neutral' category like 'neither agree or disagree' which was included in this project. The data is mixed in regard to which type of Likert scale presents the highest test re-test reliability between five and seven scales (Wakita et al., 2015). For this project, a five category scale was used.

Setting

The setting for the project was a 44 bed inpatient child and adolescent psychiatric unit located in the Southeastern United States. The unit was a crisis stabilization program for children from 4-17 years old with a broad array of psychiatric conditions including but not limited to behavioral issues, mood disorders, psychosis, attachment and substance abuse disorders. In regard to the setting of the educational session, it was sent to participants using the email address of their choice, allowing them to complete the session and surveys at their convenience, either at home or in the workplace.

Sample

The sample was non-randomized and included staff members working on the child and adolescent unit. The types of staff included were nurses, physicians, nurse practitioners, nurse managers, therapists, and mental health technicians. The goal was to reach 30 participants in order to generate enough statistical power to detect statistically significant change in attitude and perceived safety on the unit. Inclusion criteria for being a part of this quality improvement project included working on the child and adolescent as either a registered nurse, nurse practitioner, physician, therapist or mental health technician and being willing to participate. Staff members who did not fall into the roles listed above such as housekeepers and recreational therapists were not asked to participate.

Protection of Human Subjects

Institutional Review Boards (IRB) function under the Federal Office of Human Research Protection and have a federal mandate to protect humans utilized as research subjects to ensure they are treated ethically and fairly (Smith & Frey, 2016). It is required that an assessment of

human risk be undertaken for any study on human subjects in order to decrease any risk of harm (Smith & Frey, 2016).

This project was submitted to the Florida International University IRB and grated approval. For this project, no patient or staff names or identifying data were utilized. The data was stored on a secure, password locked computer. The data was anonymized to prevent accidental breach of confidentiality.

According Fisher et al. (2013), it is imperative that research subjects are treated with respect, beneficence and justice, particularly when children and adolescents are involved as they are considered a vulnerable population. This vulnerability is due to the limited mental and emotional capacities of children which restricts their ability to consent (Fisher et al., 2013). According to Vaswani (2018), it is important not to ignore children as potential research subjects as this vulnerability makes them an important group to study. Like adults, they have the right to be researched and should have a voice. Vaswani described them as “experts in their own world” who should have the ability to exert influence over their lives (2018, p. 500).

The concept of minimal risk is extremely important as well, meaning the amount of risk involved in the study will be no greater than the amount of risk normally encountered (Fisher, 2013). For this research project, this concept of minimal risk was maintained as debriefing was shown by the literature to be beneficial for all parties involved.

Results

Fifty surveys were sent out to qualified staff members working on the child and adolescent unit using Qualtrics, a survey and data collection program (see Appendix A, Appendix B, Appendix C). Following this initial invitation, email reminders were sent out from Qualtrics three times over a period of two weeks in order to boost participation. Overall, 29 completed survey were returned. The data was exported from Qualtrics and analyzed. The p-value was calculated using simple logistic regression where 'strongly agree' was the outcome of interest and the predictor variable was whether the question was asked before or after the presentation. Analysis was also done with 'agree' as the outcome of interested however no statistically significant results were found. For this project, a p value of less than .05 was considered to be statistically significant. Based on this significance level, six of the 12 Likert statements showed statistically significant improvement, meaning the null hypothesis was rejected and the results were likely not to be due to chance or experimental error (Parsons et al., 2019).

In order to test the significance of these findings, logistic regression models were utilized to predict the probability that a respondent would mark 'strongly agree' to each of the statements based on whether they were responding before or after the survey. The following table shows the proportion of respondents who said they strongly agreed before and after the presentation, as well as the p-value associated with the model.

Table 1

Which Questions for Respondents Who Strongly Agreed Increased Significantly?

Question text	Percent who strongly agreed before	Percent who strongly agreed after	P-value	Significant increase?
I understand the term ’debriefing’ and what it means in the context of a seclusion and restraint intervention.	0.808	0.893	0.385	No
I understand the purpose of debriefing after a seclusion and restraint intervention.	0.917	0.893	0.772	No
I feel confident when completing a debriefing with a patient after an incident.	0.586	0.741	0.226	No
I feel competent to complete the debriefing documentation properly and completely.	0.414	0.778	0.007	Yes, at .01 level
I feel confident in intervening and offering assistance and encouragement to patients who are beginning to exhibit problematic behavior.	0.621	0.846	0.068	No
I see the importance in always completing the debriefing portion of the SR packet completely and thoroughly.	0.630	0.964	0.011	Yes, at .05 level
If I am not able to debrief with the patient after a seclusion and restraint incident, I give report to the next shift so they can complete it.	0.310	0.893	0.000	Yes, at .001 level
I feel that expanding the current debriefing system would make the unit more safe.	0.483	0.786	0.021	Yes, at .05 level
I feel that patients will benefit from a new debriefing system.	0.414	0.714	0.025	Yes, at .05 level
I feel that staff will benefit from a new debriefing system.	0.483	0.714	0.078	No
I feel a new debriefing system would help me to establish a better therapeutic relationship with my patients.	0.357	0.679	0.018	Yes, at .05 level
I feel that learning about debriefing will lead me to change my practice in the future. I feel that I will change my practice in the future as a result of this debriefing project.	0.483	0.679	0.137	No

Demographics

Demographic information was collected including name, age, time worked, and role on unit (Figure 1). These demographics were found to have no significant associations to the Likert statement responses. Overall, 84% of the respondents were female, 15% male and 1% chose not to answer. Registered nurses made up the greatest percentage of participants at 52%. Twenty-four percent were therapists, 14% mental health technicians, and providers made up 10% overall. Time worked on unit was evenly distributed between three to twelve months, one to three years, and three to twelve years. Three providers took part in the project, two were physicians and one was a nurse practitioner.

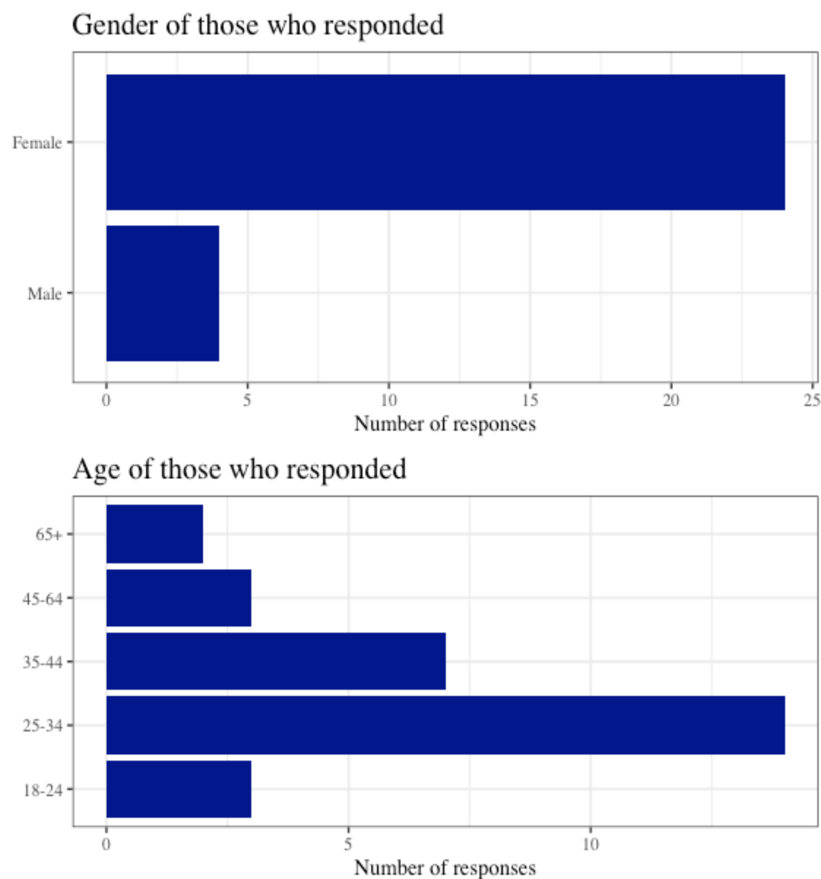

Figure 1

Respondent Demographics

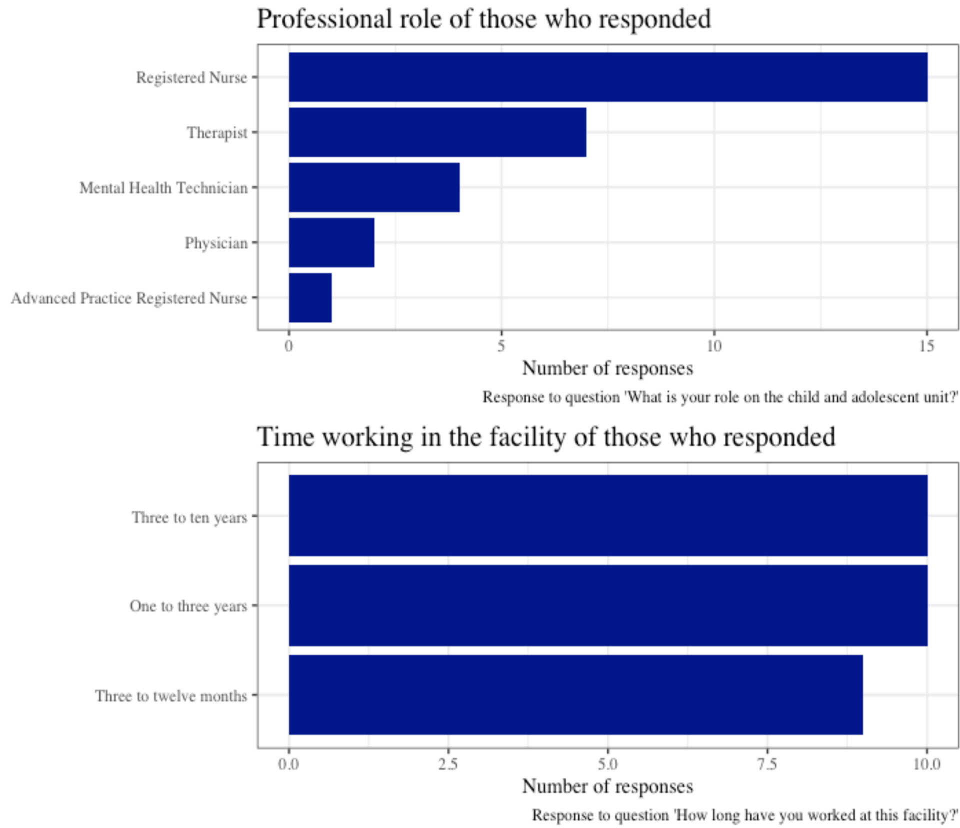

Figure 1

Respondent Demographics (continued)

Discussion

Documentation

Documentation, its importance, and how to complete the debriefing paperwork properly was a substantial part of the presentation. Based on the Likert data collected, there was a significant increase in staff understanding the importance of completing debriefing documentation completely ($p < .05$), feeling confident to complete it properly ($p < .01$), and

being willing to pass this responsibility on to the next shift if they were unable to complete it themselves ($p < .001$).

Prior to this intervention, a review of 200 charts was conducted and 30 seclusion and restraint packets were reviewed. Based on this initial assessment, 84% were done incorrectly or incompletely, 63% did not speak directly to the patient, and 16 % were completely blank. For this project, improperly completed documentation refers to documentation that denotes that the nurse did not speak directly to the patient. For example, the nurse is expected to ask the question "what could you have done to avoid this incident from happening in the future?" as part of the debriefing. An improper answer would be "patient refuses to answer" or "patient is psychotic." The responses should be reflective of what the patient feels and says. Direct quotes are best as they show the patient's mindset.

In order to assess documentation improvement, a second chart review was conducted post intervention. This included 150 charts. From these charts, 22 debriefing packets were analyzed and the debriefing portion of the packet was found to be documented 100% fully and thoroughly, a stark increase from prior to the intervention in which only 16% were completed properly. Answers were more reflective of patient response and quotations were frequently utilized. Based on this improvement, it appears this educational intervention was successful in improving documentation. According to Siegert et al. (2021), documentation can be viewed as an indication of learning and provides insight into and is a direct reflection of current nursing practice and education. Meaning, an improvement in documentation for this project implies that learning and change of practice did take place.

Confidence

Prior to the educational intervention, based on the Likert scale findings, staff indicated they felt confident in completing a debriefing with a patient ($p = 0.226$) as well as intervening and offering assistance to a patient ($p = .068$). In essence, they felt confident prior to intervention and therefore did not show significant improvement. It is possible improvement was masked based on the nature of the scale, meaning it was impossible to show improvement if the initial answer was “strongly agree.” However, the statistically significant increase for the statement “I feel competent to complete the debriefing documentation properly and completely” ($p < .01$) indicates that staff was not feeling this confidence when it came to their documentation. The improvement in documentation post intervention implies increased feelings of confidence and competence not only in regard to documentation but in debriefing overall.

Knowledge

Based on the lack of significant improvement for the statements “I understand the term ‘debriefing’ and what it means in the context of a seclusion and restraint intervention” ($p = .385$) and “I understand the purpose of debriefing after a seclusion and restraint incident,” ($p = .772$), staff felt they had a strong grasp of what debriefing was, its purpose, and benefits. However, the statistically significant improvements in statements that imply an improved understanding of debriefing contradict this. Sixty-nine percent of staff strongly agreed that patients would benefit from a new debriefing system ($p < .05$) and 75.9% of staff strongly agreed that expanding the current debriefing system would make the unit more safe ($p < .05$) (see Figure 2). These results somewhat align with the quality improvement study by Bonner & Wellman (2020) that was able to show that 97% of staff and 94% of patients found post seclusion and restraint to be useful as a means to vent frustrations and re-establish the therapeutic bond. The staff who participated in

this project felt they had a strong understanding of debriefing initially. However, it seems clear that they underestimated its value in its ability to prevent reoccurrence of SR (Eblin, 2019) and strengthen the therapeutic bond (Goulet, 2017).

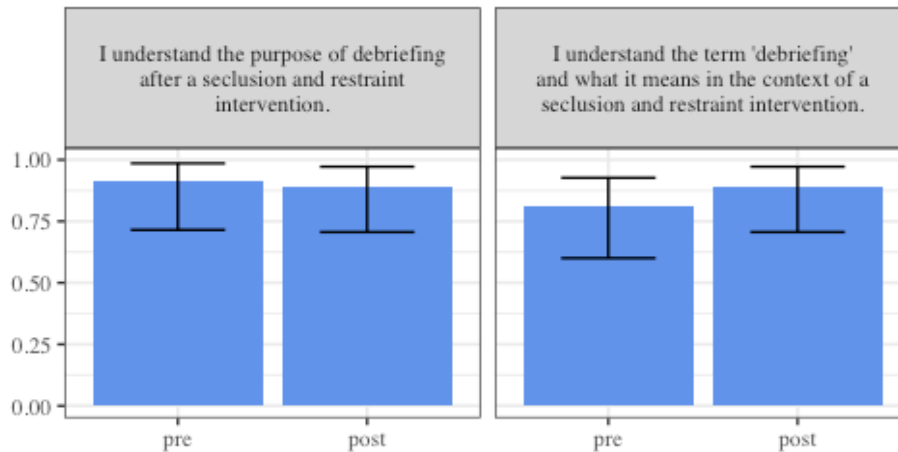

Figure 2:

Debriefing Knowledge: Likert Interpretation.

Perception

Significant improvements were seen for the statements “I feel expanding the current debriefing system will make the unit more safe” ($p < .05$) and “I feel the patients will benefit from a new debriefing system” ($p < .05$). Staff however did not feel that staff members would benefit from a new debriefing system ($p = .078$) (see Figure 3). This differs from the findings from a scoping review completed by Mangaoil et al. (2020) that found post SR debriefing to be beneficial as a means for staff to vent their own personal frustrations after a SR incident. Goulet et al. (2017) also found staff to perceive debriefing as beneficial, especially after SR incidents that were considered violent or disturbing.

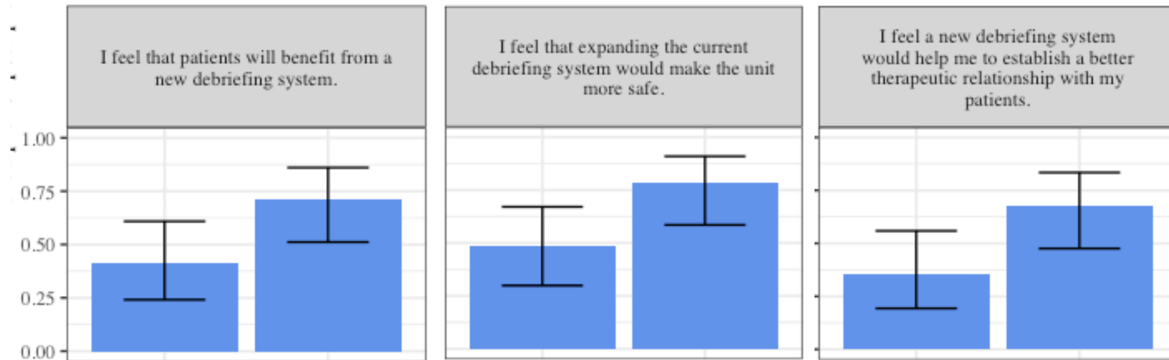

Figure 3

Debriefing Benefit; Likert Interpretations

Therapeutic Bond

Sixty-one percent of staff felt that a new debriefing system would help them to establish a better relationship with their patients (P < .05). Greene et al. (2006) described a collaborative problem solving (CPS) approach, meaning staff members must work closely with patients to help equip them with the tools they need to solve problems and manage stress. The key to CPS is the collaboration between adult and child, working together to solve and avoid problems (Greene et a., 2006). At its core, staff work closely with children not only to teach them problem solving skills but to help improve their mental flexibility and frustration tolerance (Greene et al., 2006). This CPS approach aligns well with the theoretical framework on which this project is based: Bandura's Self Efficacy Theory. This restored relationship is the first step to improved self-esteem, added trust, and decreased vulnerability (Bandura et al., 2003). Improving the staff-patient relationship is the first step in accomplishing this goal.

Change in Practice

Christian (2021) found that research and gained knowledge lead to implementation of best practice and lasting practice change. This change is due to increased capability as well as attitude regarding practice (Christian, 2021). This project was able to successfully show that staff knowledge on the topic of debriefing was improved and that staff felt more confident in completing a debriefing post intervention. It is important to remember, however, that change does not occur unless there is an actual intent to change, and ‘intention’ can be considered a predictor of changed behavior (Wellings et al., 2017).

The result to the final question of this project “I feel that learning about debriefing will lead me to change my practice in the future” did not show a statistically significant improvement. However, 48.5% before the intervention and 67.9% of respondents after the intervention strongly agreed that learning about debriefing would lead them to change practice. This aligned with the educational intervention, improvement in documentation, and administrative support going forward are likely to be an indication of lasting change in the future in regard to debriefing practices.

Second Debriefing

Part of the educational intervention included a second debriefing. This was a meeting that took place during treatment team to discuss the SR incident and how to avoid it in the future. The educational session provided tips on how to complete and document this debriefing effectively. Based on the provider scores post intervention, 100% of providers (n = 3) strongly agreed that they would change practice in regard to future debriefings. The three providers also strongly agreed that expanding the debriefing system would be of benefit to the patients and

serve to make the unit more safe. It is important to point out that the provider sample size (n = 3) is extremely small and that these results are not statistically significant.

Limitations

Limitations to this study include lack of control group and small sample size (n = 29) which limits its generalizability. Fifty surveys were sent out and attempts were made to remind prospective participants to participate. Email reminders were sent out directly via Qualtrics on three separate occasions during a two-week period after initial dissemination. These reminders led to an increase in completed surveys. The remaining 21 surveys were either incomplete (3) or had no response (18).

Time constraints were also a factor as the chart reviews were only conducted for approximately one month after intervention. This was a brief time period immediately post implementation and was therefore not sufficient to monitor for lasting change. A longer period of monitoring charts or randomized chart checks over time would likely have been more accurate in assessing for improvement in documentation. According to Lindo et al. (2016), nursing documentation is a direct indicator of the quality of care provided. Therefore, an improvement in documentation could be seen as a direct indication of patient care.

Also, the intervention session was done online due to COVID-19 restrictions, making it unclear if all participants were engaged in the session. Perhaps in person sessions would have been more thought-provoking for staff and more likely to cause lasting change in practice. However, this may not have been the case as according to a systematic review by Weightman et al. (2017), online, in person, and blended learning formats were found to be equally effective in teaching new skills. This systematic review included 33 studies; 83% of which showed no

significant difference in learning or improvement of skills (Weightman et al., 2017). The remaining studies were found to have mixed outcomes (Weightman et al., 2017).

Looking back, having a 'not applicable' answer possibility in the Likert scale would likely have been beneficial, especially for mental health technicians who do not normally document on SR incidents/debriefings. This also would have indicated if any staff members felt documentation was not their responsibility which would have been an opportunity for teaching in the future. According to the Losby and Wetmore (2012), it is important to have a 'not applicable' option as the absence of one can promote a "forced choice." This can lead to participant frustration and cause the data to be less indicative of the actual attitude and perception being measured (Losby & Wetmore, 2012).

A factor that could have limited the internal validity of this project was the Hawthorne Effect, meaning the subjects knew they were part of a quality improvement project on debriefing that involved their workplace. Based on the Hawthorne Effect's premise, staff would be more likely to choose answers that showed improvement, gained knowledge, or change. According to Wickström and Bendix (2000), the Hawthorne Effect is likely to influence a person's behavior in that they are attempting to please the study creator or simply help them meet their study objective (Wickström & Bendix, 2000). Despite this study not being completed in person, these factors were still likely to exist and should be considered.

In regard to cultural competence, according to Ogden (2012), Likert scales are likely to have limitations in regard to the cultural background of the study subjects. An issue that may arise is that members of a culture tend to base their response as a group member of their own culture, and their choice is not necessarily made as a part of the group that is being examined (Ogden, 2012). This can skew their selections and impact the results overall.

Implications for Nursing Practice

This project showed a statistically significant improvement in confidence in regard to staff thoroughly completing and documenting a two-part debriefing post SR intervention. This appears to be the only quality improvement project to use debriefing as a sole intervention in the context of a child and adolescent unit. A case controlled qualitative study with a quantitative component was conducted by Goulet et al. (2018). Their study examined the impact of debriefing as a sole intervention in an adult inpatient unit. They found that the implementation of expanded debriefing reduced the rate of SR by 10.6%. Staff and patients also considered the debriefing to be helpful in strengthening and re-establishing the therapeutic alliance (Goulet et al., 2018).

This lack of child and adolescent debriefing studies, and success of a similar adult study, open the door for quantitative projects to be undertaken to explore if debriefing interventions are able to decrease SR overall. Future studies could also compare one and two-part debriefing combinations to see which are more effective in decreasing SR incidents, strengthening the therapeutic bond, and increasing staff perceptions of safety.

Implications for Practice at the Facility

The findings from this quality improvement project were shared in a meeting with the chief nursing officer, clinical manager, and child and adolescent nurse manager at the facility. They unanimously agreed that to continue the debriefing education would be beneficial. They also planned to continue the chart audits as a means to monitor documentation compliance. According to Wellings et al. (2017), these types of actions by nursing and clinical leadership are required for permanent transformation to occur. Strong administrative support was also shown to be predictive of lasting change (Wellings et al., 2017). On the contrary, barriers to change

include busy schedule, lack of administrative support or involvement, and current hospital procedures and policies (Wellings, 2017). Barriers like this exist in any hospital environment. The nursing and clinical teams were educated on these obstacles and planned to provide support and examine current policy in order to promote change as a means to improve outcomes overall.

According to the US Department of Health and Human Services, Health Resources and Services Administration [HRSA] (2011), the advancement of any quality improvement project into practice requires a quality improvement plan. This plan is created through a systemic process that involves leadership and incorporates measurable outcomes (HRSA, 2011). The meeting with leadership determined that the SR training will be incorporated into new hire orientation. They also intended to do a debriefing training for all staff members trained in non-violent crisis intervention as they were expected to be involved in SR situations. The measure to determine if the debriefings are being done properly in the future will be to examine documentation through chart checks. This writer recommended setting a measureable goal for completeness and accuracy of 85% to leadership. This was taken under advisement however a specific goal during the meeting was not set. Instead, the goal will be set in the future based on the chart review findings. A policy that outlines how completeness and accuracy should be measured will also be required. Quality improvement is a continuous process of adaptive change that requires data collection as a means to provide feedback and guide this process (HRSA, 2011).

Theoretical Framework

The theoretical basis for this project, Bandura's Self Efficacy theory, describes how self-regulation is based on one's belief in their ability (Bandura et al, 2003). This idea of self-efficacy plays a strong role in worldview, perseverance, resiliency in the face of adversity,

vulnerability to stress, as well as depression and anxiety, all of which are extremely relevant for this child and adolescent population in psychiatric crisis (Bandura et al., 2003). This project was able to show that staff members felt the expanded debriefing system would allow them to form a stronger psychological bond with their patients ($p < .05$). According to Hunter (2012), therapeutic relationships are a key part of successful treatment and are known to be strong factors in promoting a positive psychotherapeutic outcome.

Conclusion

In conclusion, this quality improvement project was successful in showing improvement in the statements “I see the importance in completing the debriefing portion of the SR packet completely and thoroughly” ($p < .05$) as well as “If I am not able to debrief, I will give report to the next shift so they can complete it” ($p < .001$). There was also a 100% improvement in documentation completeness and accuracy based on chart checks one-month post intervention. A vast improvement from 16% completeness.

The project also was successful in improving staff perception of debriefings, its perceived importance, and its ability to strengthen the therapeutic bond. This was shown through the statement responses to “I feel a new debriefing system would help me to establish a better therapeutic relationship with my patients” ($p < .05$) and “I feel that patients will benefit from a new debriefing system” ($p < .05$). The project did not show a significant increase in debriefing knowledge overall as staff felt they already had a firm grasp on the definition and purpose of debriefing. However, the results did show significant increase in staff perception and willingness to change practice. This is based on the statements “I feel that expanding the current debriefing system would make the unit more safe” ($p < .05$) and “I feel that the patients will benefit from a new debriefing system” ($p < .05$). This indicates that there was some knowledge

gap in regard to debriefing, its purpose and benefits, specifically in the context of a child and adolescent inpatient psychiatric unit.

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Appendices

Appendix A

Demographics Survey

WHAT IS YOUR ROLE ON THE CHILD AND ADOLESCENT UNIT?

[ ] REGISTERED NURSE
[ ] THERAPIST
[ ] MENTAL HEALTH TECHNICIAN
[ ] PHYSICIAN
[ ] NURSE PRACTITIONER

WHAT IS YOUR GENDER?

[ ] MALE
[ ] FEMALE

WHAT IS YOUR AGE RANGE?

[ ] 18 – 25
[ ] 25 - 35
[ ] 35 – 45
[ ] 45 – 55
[ ] 55 - 65
[ ] 65 +

HOW LONG HAVE YOU WORKED AT THIS FACILITY?

[ ] LESS THAN THREE MONTHS
[ ] THREE TO SIX MONTHS
[ ] SIX TO TWELVE MONTHS
[ ] ONE TO TWO YEARS
[ ] TWO TO FIVE YEARS
[ ] FIVE OR MORE YEARS

ARE THERE ANY COMMENTS OR FEEDBACK YOU WOULD LIKE TO PROVIDE?

Appendix B: Pre-Test

Statements	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I understand the term 'debriefing' and what it means in the context of a seclusion or restraint (SR) intervention.					
I understand the purpose of debriefing after a SR intervention.					
I feel confident when completing a debriefing with a patient after an incident.					
I feel competent to complete the debriefing paperwork properly.					
I always complete the debriefing portion of the SR packet completely and thoroughly.					
If I am not able to debrief with the patient after a SR incident, I give report to the next shift so they can complete it.					
I feel that expanding the current debriefing system would make the unit more safe.					
I feel that the patients would benefit from a new/expanded debriefing system.					
I feel as if staff will benefit from a new debriefing system.					
I feel a new debriefing system would help me to establish a better therapeutic relationship with the patients.					
I feel confident in intervening and offering assistance and encouragement to patients who are beginning to exhibit problematic behavior.					
I feel that learning about debriefing will lead me to change my practice in the future.					

Appendix C: Post-Test

Statements	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I understand the term ‘debriefing’ and what it means in the context of a seclusion or restraint (SR) intervention.					
I understand the purpose of debriefing after a seclusion and restraint (SR) intervention.					
I feel confident when completing a debriefing with a patient after an incident.					
I feel competent to complete the debriefing paperwork properly.					
I always see the importance of completing the debriefing portion of the SR packet completely and thoroughly.					
If I am not able to debrief with the patient after a SR incident, I plan to report to the next shift so they can complete it.					
I feel that expanding the current debriefing system would make the unit feel more safe.					
I feel that the patients will benefit from the new debriefing system.					
I feel as if the staff will benefit from the new debriefing system.					
I feel the debriefing system will help me to establish a better therapeutic relationship with the patients.					
I feel more confident in intervening and offering assistance and encouragement to patients who are beginning to exhibit problematic behavior.					
I feel that I will change my practice in the future as a result of this debriefing project.					

Appendix D: IRB Letter

MEMORANDUM

Dr. Monica Scaccianoce
Beth Gabriel
Elizabeth Juhasz, Ph.D., IRB Coordinator
June 29, 2021
Office of Research Integrity Research Compliance, MARC 414

"Improving Staff Knowledge, Perceptions and Readiness to Change in Regard to Debriefing: A Quality Improvement Study."

The Florida International University Office of Research Integrity has reviewed your research study for the use of human subjects and deemed it Exempt via the **Exempt Review** process.

IRB Protocol Exemption #: IRB-21-0272 **IRB Exemption Date:** 06/29/21 **TOPAZ Reference #:** 110589

As a requirement of IRB Exemption you are required to:

. 1) Submit an IRB Exempt Amendment Form for all proposed additions or changes in the procedures involving human subjects. All additions and changes must be reviewed and approved prior to implementation.

. 2) Promptly submit an IRB Exempt Event Report Form for every serious or unusual or unanticipated adverse event, problems with the rights or welfare of the human subjects, and/or deviations from the approved protocol.

3) Submit an IRB Exempt Project Completion Report Form when the study is finished or discontinued.

Special Conditions: N/A For further information, you may visit the IRB website at http://research.fiu.edu/irb.

EJ

Appendix E: Letter of Support

May 20, 2021

Monica Scaccianoce, DNP, MSN, APRN, PMH-BC

Clinical Assistant Professor
Nicole Wertheim College of Nursing and Health Sciences
Florida International University

Dear Dr. Scaccianoce,

Thank you for inviting Fort Lauderdale Behavioral Health Center (FLBHC) to participate in the DNP project of Beth Gabriel. This letter is to approve Beth Gabriel conducting a quality improvement project as part of the requirements for The Doctor of Nursing Practice program at Florida International University (FIU). This letter is to grant her permission to conduct the project "Improving Staff Knowledge, Perceptions and Readiness to Change in Regard to Debriefing Practices: A Quality Improvement Study" at our facility.
We understand this project will be implemented at our site and will involve a pre-test, an educational PowerPoint voice over session, as well as a post-test to assess learning impact. This intervention will take place online due to current COVID restrictions.

The goal of this project is to provide better care and improve patient outcomes by increasing knowledge on debriefing practices. Participation in this project will be voluntary. Prior to project implementation we understand that the FIU institutional review board must evaluate and approve the project. Any data collected by the surveys in this project will be protected and kept confidential. All participants' information will be de-identified. Data collected from this project will be stored on a password protected computer. Pre-generated hospital data will not be utilized in this project such as seclusion and restraint rates, incidents, prevalence, demographics, incident type etc. per FLBHC request.

It is expected that this project by Beth Gabriel will not interfere with normal hospital function as it is expected to be completed in a professional manner and following our hospital standards. I support this project and the education of FLBHC staff on debriefing practices.

Sincerely,

Manny Llano, CEO