## Commonwealth of Massachusetts

**Department of Mental Health**

# Patient Debriefing and Comment Form Revised 10/2022

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Facility: Date/time restraint or seclusion ended: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_ Med. Rec.#\_\_\_\_**

**We regret the restraint or seclusion happened. Your thoughts and suggestions are important to prevent it from happening again. If necessary, staff will help you fill out this form. Attach extra pages if necessary.**

1. Was your privacy and dignity respected during this restraint or seclusion?
2. (a) Why do you think the restraint or seclusion happened?

(b) What in particular made you upset?

1. (a) When you got upset, what did you do?

(b) When you got upset, what did staff do?

1. (a) What could you do differently when you get upset to prevent the restraint or seclusion?

(b) What could staff do differently when you get upset to help you?

1. Did you and the staff use your Crisis Prevention Plan? Y\_\_\_\_\_ N\_\_\_\_\_ Do we need to change it? Y\_\_\_\_\_ N \_\_\_\_\_
2. Do you have any physical complaints or injury(s) related to the restraint or seclusion? If YES, describe:

1. How did the restraint or seclusion make you feel?
2. Who might be helpful for you to talk with about this experience? The Human Rights Officer is available to speak with you.
3. While you were either restrained or secluded, is there anything else staff could have done?
4. Is there anything else we can do now to help you recover from this incident?

 **/ /**

**Patient’s Signature Date & Time Staff Signature Date & time**

 **/ /**

**\*Patient’s Signature Date & Time Staff Signature Date & time**

**To Staff:** This debriefing and comment form must be offered to the patient **w**ithin 48 hours of the R/S. It may be re-offered later\* if the

patient chooses not to comment initially. The patient may comment in writing or verbally. If verbally, the staff person will complete the form.

Staff must sign and date form even if patient chooses not to comment.

**=====================================================================================================**

**FOR STAFF USE ONLY: Please check all staff follow-up actions that apply.**

**[ ]  Medical [ ]  Counseling**

**[ ]  Crisis Plan Revision [ ]  Treatment Plan Revision**

**[ ]  Human Rights Officer [ ]  Other**

**[ ]  LAR/Family has been asked to participate in debriefing**