Iowa Department of Human Services

# Restraint/Seclusion
# Next Working Day Team Debriefing

| Patient name | Patient # |
|---|---|
| | |

Check event that applies: ☐ Restraint ☐ Seclusion

Restraint/Seclusion:

| Date | Time |
|---|---|
| | |

| Location |
|---|
| |

Persons participating:

Is this the first incident of R/S this admission? ☐ Yes ☐ No If yes, how often in the past 30 days?

1. What events led up to the incident?

2. How did the situation escalate (verbal, non-verbal, physical)?

3. Review of patient input (when possible, have patient read or describe):

4. Review of recommendations and implementation of changes in treatment plan:

5. Notification and debriefing completed with family or significant others by social worker. Persons notified:

☐ No authorization by adult client for notification of family or significant others

| Social Worker/Staff Signature | Date |
|---|---|
| | |