

**Analysis of Debriefing Form**

The purpose of this form is to determine the root cause of the crisis behavior in order to help prevent the behavior from reoccurring. This form should be completed by the team within 1 to 2 days after the crisis incident. The team should include the student or student designee, parent or guardian, staff involved with the crisis, on-site supervisor, executive team member, medical staff/nurse, and behavioral support staff. The facilitator of the analysis meeting should be someone not directly involved with the crisis incident.

**Directions:** The facilitator asks the questions below to the team then asks why to the responses that may have contributed to the change in behavior at least 5 times until the root cause of the response is determined. Then ask what changes can be made to prevent that root cause from triggering behavior next time. Use the Root Cause Analysis 5 Why’s Chart to guide the conversation.

**Behavioral Supports (before the behavior change)**

* Was the positive to negative student to staff ratio at least 4:1?
* What error correction procedures were used?
* How did staff remain rationally detached in order to maintain appropriate paraverbals, posture, and proximity (3Ps)?
* Was the student prompted to use the calming area and taught coping strategies at first sign of the behavior change? How?
* How did staff respond to low points in his or her engagement of the activity and modify antecedent interventions?
* Does the staff working with the student during the incident have a positive relationship with the student?

**Instructional Supports (before the behavior change)**

* Were all staff actively supervising by moving, scanning, and interacting positively with the student?
* Was the activity meaningful and relevant to the student?
* Was the student engaged in the activity to their potential?
* Was downtime minimized?
* Did staff fade prompts at the appropriate pace?
* Were instructional materials prepared before the activity began?
* Are the staff trained in trauma-informed practices?
* Are the staff trained in the impact of that students’ diagnosis(es)?

**Environmental Supports (before the behavior change)**

* How does the environment where the behavior change occurred establish and define boundaries?
* Was the student aware of the expectations and the rules?
* Can all areas of the classroom be observed?
* Was the environment calm and welcoming?
* How did the organization of the materials promote student engagement?
* How and when was the class and/or student schedule referred to?
* What transition cue was provided to warn of any change?

**Triggers of Behavior Change (before the behavior change)**

* When did the student’s behavior change?
* Did the individual witness something upsetting?
* Is there a personal conflict going on currently or that one that could have been triggered?
* Was the safety plan effective if trauma was triggered?
* Did the student have to wait an inordinate amount of time for something he or she wanted?
* Did the student indicate they needed help, attention, or assistance?
* Was the student ignored, treated unfairly, or receive a consequence?
* Was the student experiencing symptoms of an illness?
* Was the student taking medications or did he/she not receive medications?
* Was the behavior plan implemented with fidelity?

**Effective Intervention (after the behavior change)**

* What were the first signs of the student being upset and who noticed them?
* How soon after the change in behavior occurred did staff respond?
* What intervention was tried first and by whom?
* Why was that intervention chosen?
* How did the student respond to the intervention?
* What was the student’s emotional state at the time?
* What was the staff’s emotional state at the time?
* If the intervention was unsuccessful was another one attempted?
* What else could have been tried?
* Why weren’t those interventions tried?
* Was the ESI used as a last resort?

**Safety**

* What behavior warranted the need for an ESI?
* Did the behavior meet the condition of being a danger to self or others?
* What would have happened if an ESI was not used?
* Who made the decision to use an ESI?
* Did the ESI procedure follow policy and training precautions?
* If injuries occurred, could they have been prevented? How?
* Were the student and/or staff seen by the nurse after the incident?
* Was there enough staff available to assist?
* Was ESI documentation completed correctly?

**Post-Event Procedures**

* Who made the decision to stop the ESI?
* Was the policy followed to stop the ESI when the student was no longer a danger to self or others?
* Could the ESI have been stopped sooner?
* Was the ESI stopped too soon?
* Were the strategies that staff used to de-escalate the student to return to a calm emotional state effective?
* Was the debriefing conversation effective for the student?
* Were the strategies to re-integrate the student back to the classroom effective?

Adapted from Huckshorn, K.A.; LeBel, J.; Caldwell, B. (Eds.) (2018). Six Core Strategies©: Preventing Violence, Conflict and the Use of Seclusion and Restraint in Inpatient Behavioral Health Settings. An Evidence-based Practice Curriculum Training Manual. Originally developed with the National Association of State Mental Health Program Directors (2002-2009): Alexandria, VA. All rights apply to use of these author edited materials.



**Root Cause Analysis 5 Whys Chart**

If the team feels a response to a question above may have contributed to the change in the student’s behavior, write the response then ask why to that response. Repeat asking why until the root cause of why the behavior changed is determined. Then discuss what changes could be made to prevent the behavior change next time. Repeat this process for each question that has a response that may have contributed to the change in behavior. Circle the focus area that correlates with the root cause to guide the team’s next steps. Transfer the root cause and changes for future procedures to the Prevention Plan to provide a full picture of the root causes and needed changes to future procedures.

Response

Why?

Why?

Why?

Why?

Why?

Root Cause

Changes tProcedures

**Prevention Plan**

Transfer the answers from the 5 Why’s Chart to the flow chart below to illustrate all root causes of the student’s change in behavior and the changes that will be made to future procedures so the root cause is prevented. In the last box, indicate who is responsible for implementing the change and the date implementation will occur. The executive team member will monitor the implementation of the prevention plan and communicate any needed training to the Performance Development Team.

**Behavioral Supports**

**Instructional Supports**

**Environmental Supports**

**Triggers of Behavior Change**

**Effective Intervention**

**Safety**

**Post Event Procedures**

**Cause:**

**Cause:**

**Cause:**

**Cause:**

**Cause:**

**Cause:**

**Cause:**

**Changes:**

**Changes:**

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**Changes:**

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