It is recommended that the debriefing be completed within 1 hour of the event, take no longer than 10 minutes. Please return completed form to Mary S. or Kevin M.
4. Was there anything else that could have been tried? If so, why wasn’t it used?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Restraint
5. Did the incident require the order for restraint? Y N
   a) Was the threshold for imminent danger met?
   ____________________________________________________________________________
   b) What would have happened if restraint was not used?
      ____________________________________________________________________________

6. Were medications administered?
   a) Oral? Y N
   b) Intramuscular? Y N
   c) Given over objection? Y N

7. Was the patient harmed during the event?
   a) Explain:
      ____________________________________________________________________________
      ____________________________________________________________________________
      ____________________________________________________________________________

8. Was staff harmed during the event? Y (Explain) N
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

9. Outcome of Code:
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

   Charge Nurse: ____________________________ Date ________________________
   Supervisor/Manager Review: _______________________ Date _____________________

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