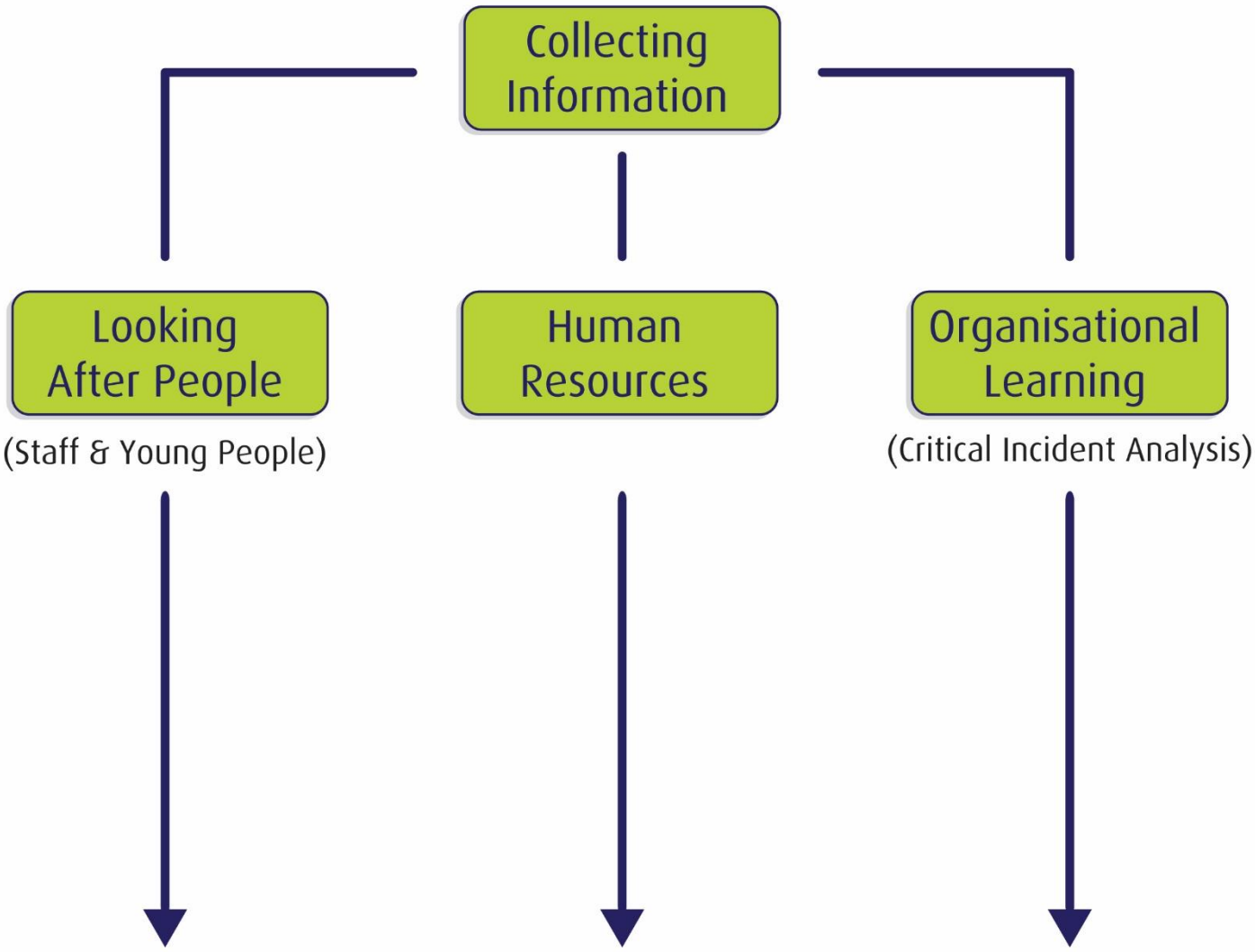
living and learning together

BRADSTOW SCHOOL

within a Culture of Gentleness



Post Incident Review Process

Post Incident Review Process and Debriefing – Collecting Information

Overview

Debriefing is an integral part of any organisation's processes that should be embedded into organisational learning and development. The process enables improvements in the way the organisation operates and to the continuous development of its processes, approaches and procedures. It is not about apportioning blame, but essentially it is a process by which lessons can be identified, discussed, analysed and incorporated into organisational thinking and learning thereby improving outcomes for the young people and their caregivers.

Debriefing allows individuals, departments and the wider organisation to examine their strengths and areas for improvement

One of the benefits of debriefing is the opportunity for individuals to reflect on their own practice. This reflective process improves our organisational thinking which, in turn, leads to a more effective and supportive environment for the young people.

Debriefing processes have two elements that run in parallel:

- They can affect change in practice and procedures enhancing outcomes for our young people through providing an expedient training and feedback opportunity.
- They can provide emotional support to staff and young people, if the experience of a restrictive practice or incident of challenging behaviour was traumatic (Jones and Kroese 2006 cited in Sturmey 2015).

1. Looking after Young People and Staff - Immediate Post-Incident Support

This part of the debrief process occurs immediately after an incident ensuring the wellbeing of young people and staff, and to capture key issues and immediate Health and Safety concerns.

The following approaches support this process:

- Supervision
- Continuing Professional Development
- Wellbeing policy
- Mental Health First Aiders
- Positive Behaviour Support policy
- Counselling
- A regular review of Behaviour Support Plans to ensure they are accessible to staff and young people
- A communication profile / passport for each young person i.e. PECS, symbol support etc.
- Restrictive Practice Reduction Strategy

- Safeguarding Policy

i. Young People

Person centred approaches are needed for each young person according to their individual communication system. Those undertaking a debrief need to have access to a range of communication resources (please refer to the Functional Communication Team) and an awareness of the young person's support needs.

For young people who are more cognitively able, incident debriefs provide an opportunity to learn about themselves, their behaviour and their own self-management or regulation through reflection and learning strategies for the future.

The approach we take should be proactive and seek to repair relationships.

Enhancing communication for and with our young people is a key role of our educational/residential setting. Providing the means to reflect on an incident can pose a number of challenges in practice for those individuals with a severe learning disability and limited communication skills, however, each young person must be given the opportunity to debrief following an incident and this is to be recorded within their records.

If a young person exhibits a change of behaviour indicating anxiety or distress following an incident they should be supported to access additional specialist help.

ii. Staff

<u>Context</u>

Staff stress may be linked to the behaviours displayed by the young person or be influenced more by the working environment itself. (Thomas and Rose 2007). The nature and type of incident will affect the emotional response of staff (Hastings 2005). This will in turn impact on that person's ability to implement the PBS plan effectively.

Hastings (2005) talks about the impact of challenging behaviour as taking resources (of energy) from the people supporting the individual. This creates a negative feedback loop that can be so destructive for the child's self-esteem and stress levels (Lecavalier 2006). The more stress staff are under then less effective they are at implementing strategies the child relies on. Hastings (2010) shares the causal relationship between staff and child behaviours. He describes it as "Staff behaviour affects behaviour problems, and behaviour problems affect staff behaviour."

This aspect of the debriefing process is aimed at providing support for the staff members involved in an incident.

De-briefing is designed to provide teams who have been involved in an incident to review

the episode and express their feelings. Similarly, such a process provides information about usual/typical reactions to serious or traumatic incidents and directions for seeking further assistance should any individual experience difficulties following an incident.

Psychological debriefing would usually be accessed at the request of team members involved in an incident but is available for all incidents.

Debriefing is not a disciplinary process, it is a reflective learning process designed to increase individual and service improvement. If poor practice is brought to light through this process it will be referred through the appropriate policy and actions taken accordingly. Likewise if staff have experienced psychological trauma they will be offered support and / or referral on as necessary.

Debriefing should become a routine element of everyday practice and should occur at the end of every shift or School day. However, it is accepted that the pressures of operational caregiving may make this impractical at times, in which case a debriefing should be held as soon as possible following the incident. For example, conducting a debriefing on the next day or the next available shift.

Such debriefs are usually held by the team supervisor e.g. Home or Deputy Manager, shift leader or teacher before the end of the shift or the school day.

The pressure on operational staff can lead to debriefing being overlooked. This should not be allowed to happen as effective debriefing will ultimately minimise stress and possible trauma, highlight issues or H&S concerns, and identify learning for operational staff.

To offer members of staff the correct immediate support to deal with the trauma associated with serious incidents, and receive the appropriate follow up, the team supervisor should consider the following:

- Removing the staff member from the situation
- Ensuring first aid has been administered if required
- Assessing staff member's emotional presentation to establish if further support is required before leaving site
- Request follow up (wellbeing call) from Care Management
- Further wellbeing assessment on return

Effective debriefs may have organisational benefits including improved staff retention and reduction of sickness/injury and increases in the positive interactions experienced by the young people ultimately leading to improved quality of life and wellbeing.

2. **Human Resources**
3. **Organisational Learning (Critical Incident Analysis)**

This is the opportunity to review and critically analyse the incident after a short period of time when all the facts are available (including those from the immediate debrief). It will always follow any “Notifiable” incident and incidents that the SMT and broader team agree are significant

Interrupting the incident cycle helps to ensure incidents reduce and improves young people’s and staff wellbeing. Ensuring staff and young people take an active part in this process ensures that any recommendations and actions are valued and likely to be carried through.

The Critical Incident Analysis will be seeking to answer the following questions:

Who was involved?

What happened?

Where did it happen?

Why did it happen?

What did we learn?

(Cook et al., 2002; Hardenstine, 2001)

This process is specific to behavioural incidents and does not set out to duplicate the main incident reporting and recording process. It sets out to augment this process and provide further specific information where this is necessary. This is concerned with the assimilation of further/new information that can be gathered about any young person who has displayed behaviours that led to an incident (and usually therefore an Incident Report). The information that can be gained from the Incident Report would be examined in the light of the functional analysis/formulation that has been carried out for the individual young person.

The fundamental question facing the team is “does this incident tell us anything new about the individual or the way in which we support the individual and their behaviours?”

N.B. the review of Incident Forms could become a standing agenda item for each home meeting, thus being recorded and supports maintained outside of the critical incident analysis process.

A consideration facing the staff team is whether any change should be made to a behaviour programme at this particular moment in time. There is considerable research evidence that newly introduced programmes should be allowed to operate for some time before adjustments are made. Individuals who have found a particular behaviour to have a functional outcome will inevitably struggle with a programme that sets out changes to that outcome and early adaptations may undermine the ability of the individual to learn the contingencies that the new programme is trying to create. The rationale for alterations to behaviour programmes should therefore be documented.

The Critical Incident Analysis (proforma attached as Appendix 2) is a formal, recorded and facilitated process, leading to a report outlining recommendations and any actions necessary to reduce the chances of reoccurrence. The resulting action plan will enable the recommendations to be progressed with SSG oversight where necessary.

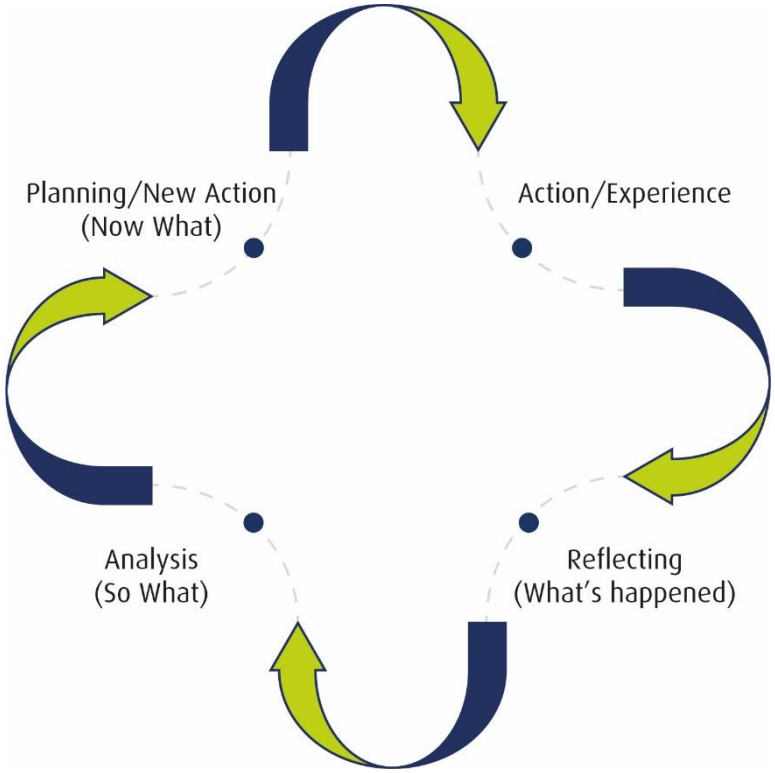
The primary purpose of debriefing is to identify areas from which lessons can be learnt, identifying good practice and areas for improvement. The outcomes from all debriefs will be recorded in a written format.

This is a process whereby the individual members of staff reflect on their behaviour and actions within an incident, and examines alternative strategies for the next time such an incident might occur. It is a learning and development tool, and should be seen as a positive process, and not part of any investigation or disciplinary process.

Once the report and action plan is completed it should be circulated to those who attended the meeting and within the wider team where necessary. The SMT will then make and strategic changes necessary.

The Critical Incident Analysis process:

It is widely accepted that the most effective way of learning as an adult is by following the stages of the experiential learning cycle shown in the diagram below.



The **action stage** is the activity that has been undertaken for which the process will revolve around. (Incident)

The **reflecting stage** is the opportunity to examine the incident, reflect on the response and recall the details.

The **analysis stage** is the opportunity to evaluate the actual events and identify what went well and what could be improved.

The planning/new action stage is the process of delivering those improvements to ensure there is no repetition in the future.

The challenge of the above process is the implementation of the cycle to ensure organisational learning. This may take a number of different mediums to achieve through direct learning or delivery of specific training to the staff teams or individuals.

Appendices

1 – Debrief Considerations and basic principles

2 - Critical Incident Analysis Meeting

3 - Critical Incident Analysis Proforma

Appendix 1. – Critical Incident Analysis considerations and basic principles

Considerations

The following considerations form the basic principles underlying the debriefing process. This will apply equally across the range of types of debriefing.

- The process should be tailored to the group involved and specific situation
- The goal of Critical Incident Analysis should be to facilitate personal, group and organisational learning and improvement. Essentially, this requires the individual and/or group to recall and reflect on information and experience so that meaning can be drawn and learning facilitated. Recall can be encouraged in numerous ways using writing, drawing, thinking and talking within the context of the meeting
- Meeting facilitators should aim to create an atmosphere where individuals feel able to be open and honest without fear of reprisal. Debriefs should not be used to apportion blame or to criticise individual behaviour. It should be recognised that everyone has the potential to make mistakes and with hindsight is always possible to see alternative methods of achieving results. A successful process will allow those present to critically analyse their own actions and constructively contribute to a discussion about all other elements of the event.
- The facilitator should adopt a neutral stance in relation to the event or operation in order that the end product comes from the group being debriefed.
- The facilitator should familiarise themselves with an overview of the incident, those attending and any issues that have already been identified. They should use this information to plan a broad structure for the debriefing.
- Meetings should be conducted in a manner that will encourage an open and honest debate which is supportive, constructive and conducive to learning.
- It is best to go through events in a manner that is easily understood by all participants. Generally information will be collated in a chronological order, so participants can follow the sequence of events. This is usually broken down into three stages. Pre Event, During the Event and Post Event.
- The discussion needs to be controlled, directed and to the point.
- The process should be exploratory and should aim to find the reasons and thought process behind actions.
- The sequence of events should be discussed with the staff concerned for each task performed. Questions should be asked to make sense of events.
- Praise and encouragement should be given whenever individuals have performed with skill and competence.
- Health and Safety issues should be highlighted and action required for improvement identified and assigned to an individual.
- Where individual competence has not been demonstrated to acceptable standards it is important that their development needs are identified and addressed either

personally or through Supervision. It is important that such discussion is made outside of the process so as not to cause embarrassment or invite personal criticism.

- The aim is to examine team performance and not that of individuals. Great care must be taken to ensure that the process does not attribute blame to any individual or cause any participant to feel uncomfortable.
- Questions should be managed throughout to ensure an equal level of understanding and that all participants have an opportunity to contribute.
- Sufficient time should be allowed for the meeting to ensure it is not rushed and meets its objectives.
- All visual aids should be considered and utilised as necessary.
- The facilitator should aim to conclude the meeting with a summary of the learning identified throughout the process.
- The outcomes must be suitably recorded on the Critical Incident Analysis Proforma and where the learning would benefit other members of the staff disseminated into organisational learning as appropriate.

Appendix 2

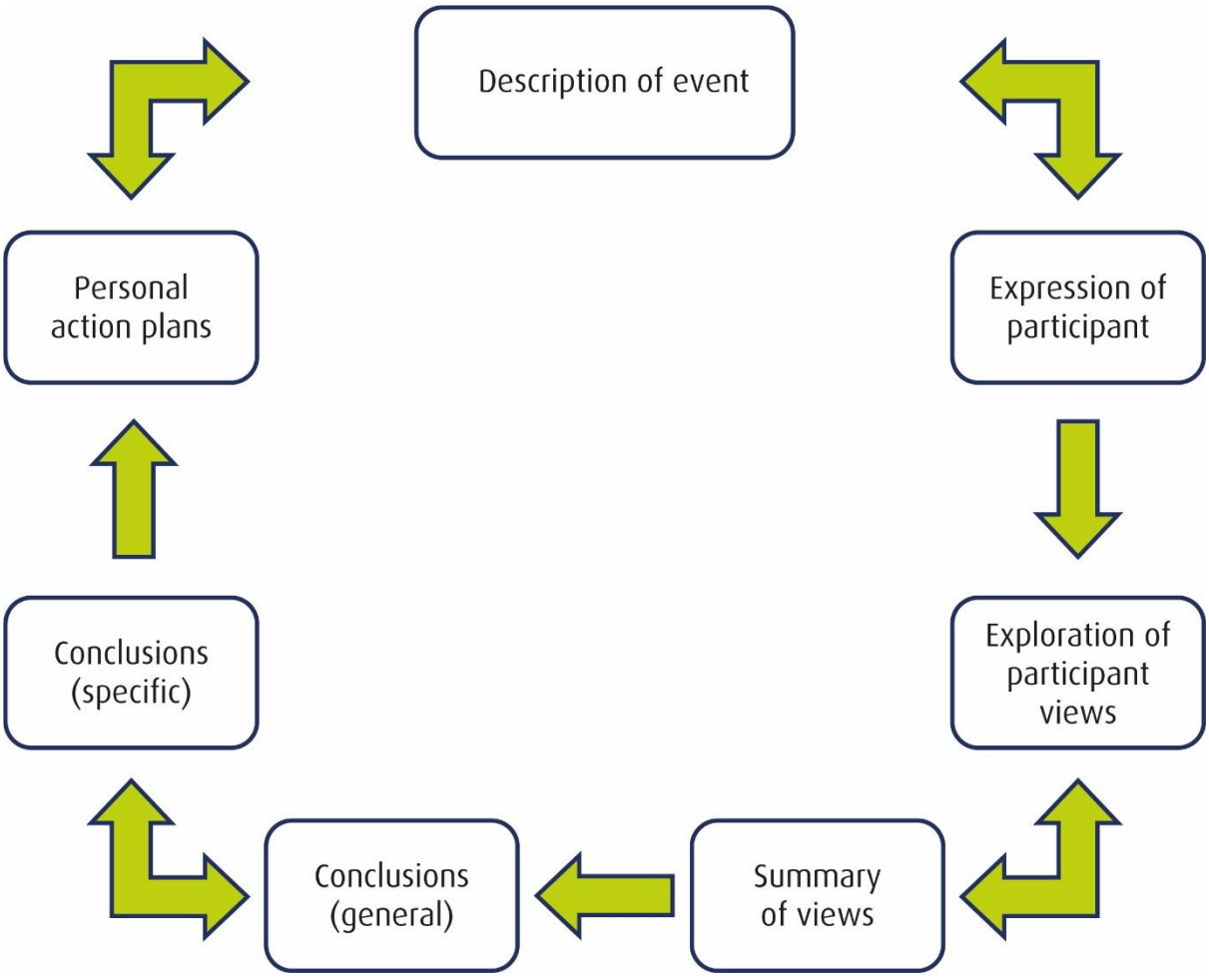
The Critical Incident Analysis Meeting

Events should be worked through in a chronological manner which all participants can follow using the three stages of Pre Event, During Event and Post Event (Section 1.). It may be helpful to have a prepared timeline or flow chart to assist this can be used to prompt the memory of the participants and encourage a greater range of viewpoints. (See following model).

There are different ways of collecting the information;

- By asking participants to share their thoughts on post it notes which can then be collated together for group discussion
- Using a flip chart or whiteboard to record
- Breaking into groups to discuss aspects of the incident being analysed

The following model may be used for the basis of the Critical Incident Analysis Meeting



Description of Event – This stage should be used to examine the chronology of the event.

Expression of Participant Opinions – Having established the Chronology of the event participants should be given the opportunity to reflect on their experiences for a couple of minutes.
Exploration of Participant Views - This stage should be used to allow the participants to discuss those elements of the incident that were a success and/or required improvement.
Summary of Views – After all participants have had the opportunity to explore both the positive and negative elements of the incident it is important to take time to summarise the views and identify any common themes.
Conclusions (General) – This stage should be used to draw any general conclusions from the incident. These will usually be in the form of recommendations.. This may involve breaking into a group phase.
Conclusions (Specific) – This stage should be used to draw conclusions about individual actions or events during the incident that went well or required improvement.
Personal Action Plans – Time should be allowed for participants to reflect on their own experiences and feedback to allow them to develop action plans for similar incidents in the future.

These should follow the **SMART** principles;

- **SPECIFIC**
- **MEASURABLE**
- **ACHIEVABLE**
- **REASONED**
- **TIME BASED**

The Closing

After the participants have been given sufficient time to complete their action plans it is important to allow any remaining questions to be asked before bringing the meeting to a close.

Appendix 3. – The Critical Incident Analysis Proforma

Instructions:

1. Try to investigate as soon as possible to understand why and how certain decisions were made.
2. Speak to as many people possible who were involved in the behavioural incident. Encourage respondents to use blameless feedback and observations to support improvement.
3. Discussion can be brief, and is focused on gathering factual information, not hearsay.
4. Identify areas for further investigation / Support / Individual learning.

Type of behavioural incident:

☐ Risk to staff:

☐ Risk to student:

☐ Risk to other:

Location:

☐ In School:

☐ In Residential Unit:

☐ In Community:

☐ In Transport:

1. What happened? (Brief details) – Attach a copy of the incident form

2. System Factors

A. Employee Factors

- ☐ Was the member of staff fatigued, ill or agitated?
- ☐ Was there a language barrier?
- ☐ Were there personal or social issues?
- ☐ Was the member of staff new/agency/not a regular member of staff to the individual/team?
- ☐ Other Please State:
- ☐ Not applicable

Comments

B. Task Factors

- ☐ Was there a procedure / risk assessment available to guide the action that the staff took?
- ☐ Was the procedure / risk assessment current, approved and applicable to the action / intervention performed?
- ☐ Were the steps clear, accurate and easy to follow?
- ☐ Other Please State:
- ☐ Not applicable

Comments

C. Training and Education Factors

- ☐ Was the member of staff knowledgeable, skilled & competent in the action / intervention performed?
- ☐ Did the employee have the appropriate training?
- ☐ Did the employee follow the procedure as written?
- ☐ Did the employee seek supervision or help?
- ☐ Other Please State:

Comments

D. Environmental factors

- ☐ Was there adequate PPE available and was the member of staff using/wearing it?
- ☐ Was there adequate operational (administrative and managerial) support?
- ☐ Was the physical environment conducive to the action / intervention performed?
- ☐ Was staffing sufficient to provide uninterrupted task performance?
- ☐ Were there distractions present? (Other students, staff, phone interruption, etc.)
- ☐ Did workload impact the provision of good care?
- ☐ Other Please State:

Comments

E. Service Factors

- ☐ Were adequate financial resources available?
- ☐ Were the staff who were called to assist adequately prepared? (staff providing assistance was unfamiliar with task)
- ☐ Does the administration work with the departments regarding what and how to support their needs?
- ☐ Other Please State:

Comments

F. Factors Specific to the Individual Young Person

- ☐ Was there any health or medical issues?
- ☐ Was the individual tired / hungry?
- ☐ Did the individual understand the activity / task?
- ☐ Was there effective communication systems in place?
- ☐ Did the individual have a viable alternative?
- ☐ Is the individual's behaviour increasing in intensity / frequency or decreasing?
- ☐ Other Please State:

Comments

3. Why did it happen? Where did the system breakdown to allow this event to occur? (Consider system factors categories attached.)

A. Employee Factors

B. Task Factors

C. Training Factors

D. Environmental Factors

E. Service Factors

F. Factors Specific to the Individual Young Person

4. What will we do to reduce the probability of it happening again?

5. How will we know if these changes have worked?

6. How will we communicate the lessons learned from this investigation and any resulting changes in processes?

7. SMT Recommendations

- ☐ Individual supervision; Who by? When by?
- ☐ Individual training; What? When by?
- ☐ Reflective learning; Checked back in supervision? When by?
- ☐ Advised external counselling;
- ☐ ID Meeting
- ☐ Review of PBS
- ☐ Other; Please specify:

Comments

8. Who will be responsible

Action:	
By Who:	
Follow Up Date:	

Action:	
By Who:	
Follow Up Date:	

Action:	
By Who:	
Follow Up Date:	

Action:	
By Who:	
Follow Up Date:	

SMT Review

Name	Title	Signature	Date

This form is specifically for behavioural incidents and is just one part of a comprehensive incident response process and should be read in conjunction with accident / incident reports, risk assessments, positive behaviour support plans, etc.