A
fter incidents in inpatient mental health settings, it is good practice to provide either a team debrief or post-incident support – or both. However, an evaluation conducted on five wards in a mental health trust explored perceptions and experiences among a group of 44 staff, patients and carers. The findings informed reflective groups for staff and joint awareness training sessions for staff and patients. The joint sessions increased staff confidence in taking part in debrief and/or post-incident support. They also appeared to promote understanding and empathy, so the idea of joint sessions could be translated into ‘joint debriefing’ where appropriate, thereby supporting the current move towards coproduction of care.

Debrief and post-incident support is an integral part of the Department of Health’s Positive and Proactive Care (DH, 2014) guidance, as well as the ‘Safewards’ approach (www.safewards.net), which aims to reduce aggression, violence and the need for physical interventions in psychiatric wards.

Much of the recent evidence on post-incident support focuses on help for staff (NHS Improvement, 2017; Holmes et al, 2012), both to support their learning (Dismukes et al, 2006) and improve their understanding of patients’ perspective (Ilkiw-Lavalle and Grenyer, 2003).

There still appears to be little in literature, policy or guidance, on the benefits of involving carers in debrief or post-incident support processes. The National Institute for Health and Care Excellence quality standard on how to prevent and manage violent behaviour among people with mental health problems (NICE, 2017) only mentions carers once, and only in relation to what patients can expect (it says that “the person with a mental health problem [...] should be offered the

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In this article...
- How to define incidents in mental health that warrant debriefing and/or support
- Barriers and facilitators to the use of debrief and post-incident support in mental health
- Benefits of joint staff/patient awareness training for improving the post-incident response

Debrief and post-incident support: views of staff, patients and carers

Key points
- Debrief and post-incident support are known to benefit staff and patients in mental health care
- Debrief is often limited to serious incidents, but what counts as a ‘serious’ incident is subjective
- A quiet space and a facilitator with whom all have a good relationship are conducive to debrief and post-incident support
- Barriers to debrief and post-incident support include embarrassment, cultural attitudes and low staffing levels or a lack of staff time
- Joint staff and patient training can be helpful in breaking down barriers and creating mutual understanding and empathy

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Abstract
Debrief and post-incident support after incidents in mental health inpatient settings are known to have benefits for staff and patients. An evaluation conducted on five wards in a mental health trust explored perceptions and experiences among a group of 44 staff, patients and carers. The findings informed reflective groups for staff and joint awareness training sessions for staff and patients. The joint sessions increased staff confidence in taking part in debrief and/or post-incident support. They also appeared to promote understanding and empathy, so the idea of joint sessions could be translated into ‘joint debriefing’ where appropriate, thereby supporting the current move towards coproduction of care.

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opportunity to contribute to the immediate debrief and discuss the incident with a member of staff, an advocate or a carer”.

**Evaluation**

Northumberland, Tyne and Wear Foundation Trust provides mental health, learning disability and neurological care for people across the North East, as well as some specialist services at national level. The ‘Talk 1st’ and ‘Positive and Safe’ approaches (www.safewards.net) have been used at the trust since 2016 to look at what can generate and what can help prevent conflict and violence in its inpatient services.

In 2017, I conducted an evaluation of the perceptions and experiences of debrief and post-incident support among 44 staff members, patients and carers. I explored, in particular, participants’ understanding of when and how often these tools were used, what prompted their use (facilitators) and what prevented it (barriers). At every stage of the evaluation, I liaised with the trust’s patient safety department to ensure the work was in line with our ‘Talk 1st’ strategy.

My aim was to identify any needs for support, training and service improvement, as well as create opportunities for sharing best practice. I looked for themes in the data gathered and used them to:

- Inform needs-based staff, reflective groups and joint staff/patients awareness training sessions;
- Give direct feedback to the wards wherever appropriate;
- Evaluate the effectiveness of current local policy.

The trust’s policy on debrief and post-incident support (Northumberland, Tyne and Wear Trust, 2017a) was under review at the time of the evaluation and the results were shared, but reassured that no confidential information would be disclosed.

**Methods**

**Data collection**

Different questionnaires were put together for staff, patients and carers. They explored:

- What participants understood by ‘debrief’ and ‘post-incident support’ and what their experience of these tools had been;
- How often debrief and post-incident support took place, how effectively they were used and whether provision was consistent;
- Participants’ preferences on how debrief and post-incident support are carried out, including when, where and by whom;
- What could be improved and how.

The questionnaires were used to conduct structured face-to-face interviews and focus groups, most of which took place in the settings where staff worked, patients stayed and carers visited. Data was gathered face-to-face with all participants, except one carer who completed the questionnaire on paper.

At clinically busy times, it was more difficult to speak to staff on the wards. To avoid disrupting service delivery, some of the data from staff was gathered via small focus groups, which had the added benefit of serving as reflection and support groups.

The data collected was analysed by drawing themes from the interviews and questionnaires and these themes were discussed with the patient safety department.

**Settings**

Data collection took place between June and September 2017 in five wards: three medium secure mental health services, one low secure mental health service, and one learning disability acute admission service. These wards had been chosen because they were already working together on strategies to reduce incidents using the ‘Talk 1st’ and ‘Positive and Safe’ approaches. The rationale was that it would be easier to disseminate information and implement training and support in these wards thanks to the existing links between them.

**Information, consent and confidentiality**

Before the evaluation, an application of intention had been submitted to, and approved by, the trust’s research department. Team leaders, managers and responsible clinicians had been approached ahead of the project, informed of it and given a chance to raise any concerns they may have had – for example, about a patient’s capacity to give consent.

I spent time on each ward explaining the purpose of the evaluation to staff and patients, and answering their questions, including during ward community meetings. An information sheet was provided to, and consent was gained from, each participant before the evaluation. Each participant was able to answer a questionnaire and agreed to find time to do it.

Interviews lasted from 20 minutes to an hour, depending on time pressures and participants’ tolerance of the interview process. Participants were made aware that findings from the evaluation would be shared, but reassured that no confidential information would be disclosed.

**Recruitment and population**

Participation was on a voluntary basis. Who I recruited ultimately depended on the selected wards, on the availability of potential participants during the periods when I was based on the wards, and on people’s willingness to participate. I visited each ward several times to promote participation.

Although not a requirement, all participants had some experience to draw upon from being directly involved in an incident in their current or a previous setting or having witnessed an incident.

It was deemed inappropriate to ‘cold call’ carers or send them a questionnaire in the post without having discussed the evaluation with them beforehand, as they may have found this intrusive and, in the case of a postal questionnaire, would not have been able to ask questions. Instead, I approached carers in person when they visited the wards. Ward team members who knew carers helped recruit them.

In total, 44 people took part: 28 members of staff, 3 patients and three carers. Members of staff all had clinical roles – for example, as nursing or medical staff, psychologists, occupational therapists, activity and sports workers, or education staff.

“What type of incident should trigger debrief and/or post-incident support?”

**Limited sample**

There were limitations due to the recruitment methods. Inclusion in the evaluation was based on availability and willingness of participants, so this would have limited the size and representativity of the sample.

Staff who took part were all working in an inpatient clinical setting (although arguably they are the ones with the most experience of incidents and post-incident support). Participating patients would not have included patients on section 17 leave (time away from the ward for patients detained under the Mental Health Act) at the time of the evaluation, nor patients who were very unwell. Carers could only be approached when they visited the wards and only three agreed to take part.

Non-clinical staff (for example, domestic, catering or admin staff) were not approached, despite the fact that they may also have valuable experience of debrief and post-incident support. This was an oversight that was only raised after the evaluation had been completed.
Clinical Practice

Research

Findings

Definition
Traditionally, in psychiatric inpatient settings, debriefing is used after incidents involving restraint, rapid tranquillisation or seclusion, but there are other types of incidents that may warrant debriefing; for example, absconson. Many participants raised important questions such as: what constitutes an incident? What type of incident should trigger debrief and/or post-incident support? They made a valid point regarding the subjectivity of what is considered an incident, a serious incident, and an incident requiring debrief and/or post-incident support.

Quality
Patients gave mixed feedback about the support they received after an incident. Some reported feeling well supported while others reported feeling challenged, rather than supported, by staff. The three carers also gave mixed feedback on the consistency and quality of post-incident information and support they received. Staff generally reported it was helpful when time was permitting.

Frequency
Several patients expressed the wish to be approached more often after an incident to discuss what had happened. They thought that one reason why this was not happening was that staff did not know how to broach the subject.

Some staff reported only being offered a team debrief when an incident was deemed ‘serious’. Of the 28 staff members who took part in the evaluation, 14 reported rarely or never being offered a team debrief, while eight said that team debrief was regularly offered after incidents. Most staff felt that there had been progress on that matter but that there was room for improvement. Staff commented that they appreciated dedicated reflective groups and ‘positive and safe’ meetings as well as incident-specific debriefing.

Facilitators
Patients and staff spoke of the importance of having a quiet space, away from where the incident had taken place, to conduct or receive debriefing or support. They also stressed the importance of the debrief or support being facilitated by someone they had a good relationship with. The facilitator’s role or background was not necessarily important to patients, but some staff thought that the facilitator should be a senior member of staff.

Barriers
Staff and patients reported similar barriers to debrief and/or post-incident support taking place. One of them was embarrassed at being seen to need support after an incident. Some staff spoke of a work culture where debrief was ‘just not the done thing’ and where incidents were considered inevitable due to ‘the nature of the job’. Staff also mentioned that debrief was not always prioritised by coordinating staff.

Another barrier often cited by both staff and patients was low staffing levels. Staff spoke of having paperwork to complete as well as having to deal with the immediate aftermath and practical outcomes of the incident. They could not take part in debrief or post-incident support because of pressing mandatory tasks. Some explained that debrief would take place on request, but that people were reluctant to request it when the ward was busy to avoid increasing staff’s workload. In one ward, staff mentioned that it could be difficult to provide or receive debrief of support immediately after an incident if a second incident had happened shortly after. Shift changes and not being on shift to attend debriefs were cited as further barriers.

Informing carers
Carers spoke of a lack of mutual expectations being a barrier when communicating with staff and receiving support. When patients were asked who should inform carers of incidents and how, responses varied, but all participants agreed that it was important to discuss and agree this before a crisis arose. Staff felt that it was important to have regular and good communication with carers to determine how to speak to them regarding incidents.

Actions

Reflective groups
The findings have allowed us to identify staff support needs; for example, on one ward that tends to witness several incidents during one shift, it has been identified that staff need protected time to discuss these incidents, as there may not always be time to do this during shifts.

Reflective groups have been set up for staff on wards across the trust with the aim of giving them a place to express and constructively work on their feelings. ‘Talk 1st’ aims to minimise restrictive interventions with preventative strategies and primary interventions (Northumberland, Tyne and Wear Trust, 2017b). Data is used to encourage staff to consider antecedents and patterns. It is gathered through incident reporting and enables staff to view the number of incidents that have taken place for their ward on a dashboard, the nature of these incidents and restraints as

Box 1. Key points to explore after an incident

For patients
- Progress notes
- Understanding
- Feelings
- Wishes

For staff
- Debrief sheet
- What was the incident?
- Feelings
- Learning/action points

If there was no pre-existing positive relationship with the person facilitating the debrief or providing the support, all participants were generally more reluctant to engage, but they would usually be happy to engage with anyone they had a positive relationship with.
well as patterns. This enables staff to think about why these patterns may occur and discuss how to address them.

**Awareness sessions**

Based on the outcomes of the evaluation, voluntary awareness training sessions have been set up jointly for patients and staff in all five wards and the frequency depends on the need/request.

The aim of the sessions is to raise awareness of the rights of people who have been involved in incidents and of the benefits of debriefing and post-incident support. The sessions outline what to explore after an incident, including antecedents, what happened during the incident, the feelings and wellbeing of those involved, and learning points. They also explain how to record this information as briefly as possible to avoid too much extra paperwork (Box 1) and emphasise the importance of support being provided away from busy wards.

It has been identified that the terms ‘debrief’ and ‘post-incident support’ were being used interchangeably, so the awareness sessions also clarify definitions and explain the difference between the two processes (Box 2), as well as how to use them effectively.

Staff have been asked to consider facilitating post-incident support and/or debrief for any incident that could cause ongoing stress or distress to those involved. Participants at awareness sessions have made suggestions of which types of incidents should trigger post-incident support and/or debriefing including verbal aggression, safeguarding incidents, medical emergencies and abscondions.

When staff feel they lack time and resources, it is suggested that non-ward-based colleagues – including doctors and psychologists – are drafted in to either support the ward or facilitate a debrief, as this strategy has been effective in other areas at the trust.

The awareness sessions encourage staff to discuss with carers, preferably in advance, how the latter would like to be informed and supported after an incident.

Feedback is collected after each awareness session and has been predominantly positive. All staff who have given feedback have reported that the training has changed the way they now experience or facilitate debriefing or post-incident support.

Participants have described the awareness sessions as helping them to understand a different perspective and being highly informative; 78% reported that the sessions have been very helpful. Staff have reported that, after the sessions, they feel more confident in taking part in debrief and/or post-incident support.

The sessions are reactive: what is discussed is directly fed back to participants. Joint staff/patient awareness sessions were a new concept and received mixed responses at first, but ultimately most people found them positive and helpful in breaking down barriers. They are helping people understand the effects of incidents on others: patients speak of having a better understanding of the emotions staff may experience and vice-versa. The joint sessions emphasise the similarities of emotions felt by staff, patients and carers, creating mutual empathy and respect.

One awareness session has been held for carers but no carers attended, possibly due to snow. Further efforts are needed to explore carers’ experiences of post-incident support and debrief, raise their awareness of these processes, and elicit their feedback and recommendations.

Non-clinical staff are welcome to attend the awareness sessions. It is acknowledged that the fact that they were not included in the evaluation was an oversight. In the future, data could be gathered from non-clinical staff.

Senior management on the wards involved have reported that, since the awareness sessions have been rolled out, debrief has been mentioned in a greater number of incident reports. There are also regular reflective groups being run in the five wards.

**Conclusion**

The evaluation has highlighted that post-incident support is sometimes limited to serious incidents and that what is considered a ‘serious’ incident is entirely subjective. It has also unearthed concerns that staff may not always have the time, resources and confidence to take part in debriefing or post-incident support. These issues are now being further explored at the ongoing awareness sessions.

The sessions described have opened a dialogue and promoted the idea of ‘joint debriefing’, when appropriate. This could be more time-effective and help foster transparency and understanding. This raises the question of whether more joint sessions with staff and patients would be beneficial. Such sessions could help break down barriers between staff and patients, reduce feelings of isolation, and support the current move towards coproduction of care.

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**References**


Northumberland, Tyne and Wear Trust (2017a) Incident Policy Practice Guidance Note: Supporting Staff Involved in an Incident VO41. Bit.ly/NTWIncident


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**Box 2 Post-incident support and debrief: definitions and differences**

**Debrief**

- Enables feedback and reflection
- Identifies areas for improvement
- Is a mixture of support and teaching
- Aims to understand what has happened and why

**Post-incident support**

- Usually occurs immediately after an incident
- Is a way of ‘checking in’ with all those involved
- Takes stock of the situation
- Can include dealing with practicalities, such as injuries
- Identifies necessary actions
- Is a genuine enquiry capturing key issues

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