P U L S E F O R G O O D

Crisis & Emergency

Behavioral Health Feedback Toolkit

Learn from Crises Without Causing Harm

A specialized toolkit for collecting feedback in the most acute, emotionally intense moments of behavioral health care: after psychiatric emergencies, restraint and seclusion episodes, involuntary commitments, suicidal crises, overdoses, and critical incidents. Contains 10 documents ensuring that the organizational impulse to learn does not override the human need to heal.

10 Crisis-Specific Documents

Timing • Ultra-Short Surveys • Emotional Screening • Ethical Limits • Post-Crisis Learning

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Toolkit Contents

Crisis events in behavioral health — psychiatric emergencies, restraint episodes, involuntary holds, overdoses, suicidal crises — are the moments when the system is most likely to fail people and least likely to ask them about it. Organizations want to learn. Clients need to heal. These goals are not always compatible in the same moment. This toolkit establishes the rules for when learning must wait, how to ask when the time is right, and what to do with what you hear.

DOCUMENT 1

Post-Crisis Timing Decision Guide

When to ask, when to wait, and when to never ask at all

📋 **INSTRUCTIONS:** *After a crisis event, organizations face a tension: the sooner you ask, the more vivid the memory — but also the more vulnerable the person. Wait too long and the memory fades; ask too soon and you cause harm. This guide resolves the tension with specific timing rules for each crisis type.*

The Timing Principle

Recovery Before Research. Stabilization Before Surveying. Healing Before Hearing.

No organizational learning objective justifies asking a person to reflect on a crisis before they have recovered enough to do so safely. The feedback kiosk is passively available at all times — the question is not whether clients CAN give feedback, but when staff should introduce, prompt, or draw attention to it.

The general rule: feedback collection after a crisis is NEVER prompted. The kiosk remains passively available. Staff may mention it only after the minimum safe intervals below have passed AND the person passes the Emotional State Screen (Document 3).

Crisis-Specific Timing Table

CRISIS EVENT	MINIMUM WAIT BEFORE PASSIVE AVAILABILITY	MINIMUM WAIT BEFORE STAFF MAY MENTION KIOSK	NEVER ASK IF...
Restraint episode	24 hours after release from restraint	72 hours; clinical team confirms stabilization	Client has not been debriefed per regulatory requirements first
Seclusion episode	24 hours after return to general milieu	72 hours; same as restraint	Client is still on heightened observation
Involuntary commitment hearing	48 hours after hearing outcome	7 days; legal process must fully conclude	Client is actively contesting the commitment
Suicidal crisis (active ideation, attempt, or	48 hours after safety plan is in place and clinician	7 days minimum; clinical team must approve	Client is still on suicide precautions or 1:1 observation

self-harm)	confirms stabilization		
Psychiatric emergency (acute psychosis, severe mania, catatonia)	Until clinical team determines cognitive capacity has returned	72 hours post-stabilization; clinical confirmation required	Client lacks capacity to give informed consent to any process
Overdose	48 hours after medical stabilization	7 days; SUD clinical team confirms readiness	Client is in medical ICU or medically unstable
Physical assault (client-on-client or staff-on-client)	24 hours for witnesses; 72 hours for the person assaulted	72 hours for witnesses; 7 days for the person assaulted	Investigation is active and feedback could contaminate the process
Client death on unit	Kiosk remains passively available for other clients	Staff do not prompt ANY client for 7 days	Individual clients should never be asked about a peer's death for feedback purposes
Code / medical emergency on unit	24 hours for witnesses	72 hours	Event is still under active medical or regulatory review

The Timing Decision Tree

STEP 1: Has a crisis event occurred in the last 7 days?

→ **YES:** Identify the event type in the table above. Apply the minimum wait periods. Continue to Step 2.

→ **NO:** Standard feedback collection applies. No crisis-specific restrictions.

STEP 2: Has the minimum passive-availability wait period passed?

→ **YES:** The kiosk may remain available but staff do NOT mention it to the affected person(s). Continue to Step 3.

→ **NO:** Do not draw any attention to the kiosk for affected person(s). Wait.

STEP 3: Has the minimum staff-may-mention wait period passed AND does the person pass the Emotional State Screen (Document 3)?

→ **BOTH YES:** Staff may casually mention the kiosk using the Crisis Staff Script (Document 4). No pressure.

→ **EITHER NO:** Continue to wait. Re-screen when the wait period has passed.

DOCUMENT 2

Ultra-Short Feedback Templates (1–3 Questions)

The minimum viable survey for maximum-acuity moments

📋 **INSTRUCTIONS:** *After a crisis, standard surveys are too long, too complex, and too emotionally demanding. These ultra-short templates are designed for a single purpose: capture the person's experience in the fewest possible words with the lowest possible emotional burden. One to three questions. Under 60 seconds. Every word earned its place.*

Design Principles for Crisis-Context Surveys

Fewer Questions, More Meaning

- Maximum 3 questions. Never more.
- No compound questions. One concept per question.
- No reflective or analytical questions ("What could we have done differently?" asks too much cognitive work).
- Every question has "Prefer not to answer." Every survey can be exited instantly.
- The opening screen states: "This is optional. If now is not the right time, that is completely okay."
- No demographic questions. No identifiers. Nothing beyond the core experience.
- The closing screen provides grounding resources and 988 information.

Template 1: Single-Question Check-In (Post-Restraint / Post-Seclusion)

#	QUESTION	RESPONSE	RATIONALE
RS1	Were you treated with dignity and respect during the recent event?	👎 / 👍 / Prefer not to answer	Single most important data point. Captures the person's felt experience of the intervention. Maps to Joint Commission / CMS requirements for post-restraint assessment.

Template 2: Two-Question Post-Crisis Safety Check

#	QUESTION	RESPONSE	RATIONALE

PC1	Do you feel safe right now?	👎 / 👍 / Prefer not to answer	Immediate safety pulse. If the answer is “No,” the system generates an environmental alert (not a client-level alert).
PC2	Is there anything you want staff to know about what happened?	Open text (optional)	Client-controlled disclosure. They share what they choose. No prompting, no probing.

Template 3: Three-Question Post-Crisis Experience

#	QUESTION	RESPONSE	RATIONALE
CE1	Were you treated with respect during the recent event?	👎 / 👍 / Prefer not to answer	Dignity measure.
CE2	Did someone explain to you what was happening and why?	👎 / 👍 / Prefer not to answer	Communication and autonomy. Were they talked to or talked at?
CE3	Is there anything you want us to know?	Open text (optional)	Client-controlled closure.

Crisis-Context Opening and Closing Screens

Opening Screen

Crisis Survey Opening Text

We want to check in with you.

You recently went through something difficult here. We want to understand your experience — only if you’re ready.

This is optional. If now is not the right time, that is completely okay. You can come back later or not at all.

It is anonymous. It takes less than 1 minute.

[I’M READY] [NOT RIGHT NOW]

Closing Screen

Crisis Survey Closing Text

Thank you. What you shared matters.

If you’re feeling unsettled, here are some things that can help:
• Take a slow breath. In for 4, hold for 4, out for 4.
• Talk to any staff member. You don’t have to explain why.
• 988 Suicide & Crisis Lifeline — call or text 988, anytime.

You are not alone.

“Not Right Now” Exit Screen

“Not Right Now” Text

That’s completely fine. There is no deadline.

The kiosk is here if you ever want to come back. And if you never do, that’s okay too.

DOCUMENT 3

Emotional State Screening Checklist

Determining whether a person is ready to give feedback after a crisis event

📋 **INSTRUCTIONS:** *This checklist is completed by a clinical staff member BEFORE any staff person mentions the feedback kiosk to someone who has experienced a crisis event. It is NOT a clinical assessment — it is a readiness screen specific to feedback collection. The question is not "Is this person clinically stable?" (that is the treatment team's job) but "Is this person in a state where being asked for feedback would feel safe, not extractive?"*

The Readiness Standard

The Person Must Be Able to Say No

The minimum threshold for feedback readiness is not cognitive capacity. It is autonomy. The person must be in a state where they could freely choose not to participate without feeling that the refusal itself would have consequences.

If the person is still in acute distress, on heightened observation, under legal hold, or in a state where they feel they cannot refuse anything asked by the institution, they are not ready — regardless of cognitive function.

Pre-Mention Screening Checklist

All items must be checked YES before any staff member mentions the kiosk to this person post-crisis:

#	SCREENING CRITERION	YES / NO	IF NO
ES 1	The minimum wait period for this crisis type has passed (Document 1).	☐	Wait. Re-screen after the period has elapsed.
ES 2	The person is not currently on 1:1 or close observation.	☐	Do not mention the kiosk. Staff proximity makes anonymity impossible.
ES 3	The person is not currently under active legal hold or in a commitment hearing process.	☐	Wait until the legal process concludes.
ES 4	The clinical team confirms the person is psychiatrically stable enough to engage in a voluntary, non-clinical interaction.	☐	Defer to clinical judgment. Re-screen when cleared.

ES5	The person is oriented and able to understand that feedback is voluntary and anonymous.	☐	The person lacks capacity for informed consent to participate.
ES6	The person has been debriefed per regulatory requirements (if applicable — e.g., post-restraint debriefing).	☐	Complete the required debriefing first.
ES7	The person is not exhibiting acute emotional distress (crying, agitation, withdrawal, dissociation) at this moment.	☐	Wait. A person in active distress should be supported, not surveyed.
ES8	The person has not expressed anger at the organization or specific staff in the last 2 hours in a way that suggests approaching them would feel confrontational.	☐	Wait. The kiosk should feel like an outlet, not a provocation.
ES9	No staff member who was directly involved in the crisis event will be the one to mention the kiosk.	☐	Assign a different, neutral staff member to mention it.
ES10	The clinical supervisor has approved mentioning the kiosk to this person.	☐	Obtain clinical supervisor approval.

Screened By

Screener name: _____ Role: _____
Date/time: _____

Clinical supervisor approval: _____ Date/time: _____

DOCUMENT 4

Crisis Staff Response Scripts

What staff say when introducing feedback in the wake of acute events

📋 **INSTRUCTIONS:** *In the aftermath of a crisis, every institutional interaction is magnified. The person may feel violated, afraid, angry, or numb. How staff introduce the feedback option must communicate: we are not asking you to perform. We are offering you a way to be heard. These scripts are written for the specific emotional terrain of post-crisis contact.*

Script 1: Post-Restraint / Post-Seclusion

SITUATION: 72+ hours after restraint or seclusion, person passes Emotional State Screen

STAFF: "[Name], I wanted to check in. I know the last few days have been really hard, and I'm not here to talk about what happened unless you want to."

"I did want to let you know that we have a feedback kiosk. It's anonymous — you can say whatever you want about your experience here, including what happened. Nobody will know what you wrote."

"Using it is completely up to you. If you're not ready, that's fine. If you never use it, that's fine. There's no right time and no pressure."

IF THE PERSON RESPONDS WITH ANGER: "I hear you. You have every right to feel that way. The kiosk is there if you want a place to put that."

IF THE PERSON RESPONDS WITH SILENCE: "That's okay. I just wanted you to know it exists. I'll leave you be."

Script 2: Post-Suicidal Crisis

SITUATION: 7+ days after stabilization, clinical team has approved, person passes screen

STAFF: "[Name], I wanted to mention something that's available to you. We have a feedback kiosk where you can share anything about your experience here. It's anonymous and private."

"I'm not asking you to use it. I just want you to know it's there. Some people find it helpful to have a way to say things they might not say out loud. Others don't want to, and that's completely fine."

"Nothing you write on it will affect your treatment or your safety plan. It's separate from everything else."

DO NOT: Reference the suicidal event. Do not say "after what happened." Do not frame the kiosk as therapeutic. It is an option, not an intervention.

Script 3: Post-Involuntary Commitment

SITUATION: 7+ days after hearing, legal process concluded, person passes screen

STAFF: "[Name], I know you've been through a lot with the process here. I wanted to let you know about something completely separate from all of that."

"We have a feedback kiosk. It's anonymous. Nothing goes to the court, your attorney, or your treatment team. It's just a way to tell us how things are going."

"If you want to use it, it's in [location]. If you don't, that's completely fine. Nobody will ask."

KEY: Clients under involuntary commitment are acutely sensitive to anything that feels like an extension of the legal process. Repeat the separation from legal systems explicitly.

Universal Post-Crisis Response Rules

☐	The staff member introducing the kiosk was NOT directly involved in the crisis event
☐	The introduction is brief (under 1 minute), casual, and ends with the staff member leaving
☐	The staff member does not reference the specific crisis event ("after what happened" is too much)
☐	The staff member does not frame the kiosk as therapeutic ("It might help you process" is inappropriate)
☐	The staff member does not follow up ("Did you end up using the kiosk?" is prohibited)
☐	If the person declines or is silent, the staff member accepts it without comment and moves on
☐	The introduction is documented in the Emotional State Screen (Document 3) as completed

DOCUMENT 5

Anonymity Guidance for Crisis Contexts

Protecting identity when the pool of possible respondents is vanishingly small

📋 **INSTRUCTIONS:** *Anonymity after a crisis event faces a unique mathematical problem: if only one person was restrained this week, any response about restraint is effectively identified. This document provides specific strategies for preserving anonymity when the respondent pool is too small for traditional approaches to work.*

The Small-Pool Problem

When Everyone Knows Who Had the Crisis, "Anonymous" Means Nothing Without Protections

On a 15-bed inpatient unit, if one person was restrained on Tuesday, a feedback response that mentions restraint is effectively de-anonymized. Staff know. Peers know. The math doesn't protect the person.

Traditional anonymity works by hiding a response in a crowd. In crisis contexts, there is no crowd. The protections must be structural, procedural, and absolute.

Crisis Anonymity Protections

PROTECTION	HOW IT WORKS	YOUR STATUS
Time-delay reporting	Crisis-related responses are held and only included in aggregate reports after a delay (minimum 2 weeks). This prevents temporal identification.	☐
No event-type tagging	The system does not tag or categorize responses by crisis type. A response about restraint is stored identically to a response about food quality.	☐
Aggregate-only access	NO individual crisis-related response is ever shared with unit staff. Only aggregate themes are reported, and only when N≥5 for the theme.	☐
Open-ended redaction	All open-ended responses are reviewed for identifying details before any staff access. Dates, room numbers, shift descriptions, and staff names are removed.	☐
No real-time alerts to unit staff	If a crisis-related response is flagged as urgent, the alert goes to the clinical supervisor or	☐

	compliance officer — NOT to unit staff who were involved in the event.	
Response pooling	Responses from clients who experienced crisis events are pooled with ALL responses, not separated into a “crisis feedback” bucket that is inherently small and identifiable.	☐
No timestamps in reports	Reports shared with any staff never include response timestamps that could be cross-referenced with incident logs.	☐

The Critical Rule

⚠ If Fewer Than 5 People Experienced This Type of Crisis Event This Quarter, Do Not Report Crisis-Specific Data

Suppress the data entirely. Include the responses in overall program data but do not break them out by event type. Note in your report: “Crisis-related feedback was received but is suppressed due to small sample size to protect respondent anonymity.”

This is not a loss of data. It is a protection of trust. The data will accumulate over time and become reportable when the pool is large enough.

DOCUMENT 6

Ethical Limits on Feedback Collection

When the duty to not ask overrides the desire to learn

📋 **INSTRUCTIONS:** *There are situations where collecting feedback is not just premature but wrong. This document names those situations explicitly. The organizational impulse to "learn from every experience" must be tempered by the ethical principle that some moments belong to the person, not to the organization.*

The Bright Lines

⚠ DO NOT Collect, Prompt, Mention, or Facilitate Feedback In These Situations

✘ While a person is actively suicidal, self-harming, or in a psychiatric emergency

✘ While a person is in restraint or seclusion

✘ While a person is in a medical emergency (overdose, seizure, acute medical event)

✘ Immediately following a client death — do not approach peers for "feedback" about the event

✘ During or immediately after an involuntary medication administration

✘ While a person is under the influence of substances to the point of impaired judgment

✘ During a legal proceeding (commitment hearing, forensic evaluation, court-ordered assessment)

✘ When the person has explicitly stated they do not want to participate, for any reason, at any time — their refusal is permanent unless they initiate re-engagement

The Ethical Framework

PRINCIPLE	WHAT IT MEANS	HOW TO APPLY
Non-maleficence	The feedback process must not cause harm. If asking could re-traumatize, activate distress, or feel coercive, do not ask.	Use the Emotional State Screen (Document 3) before every post-crisis mention. Err on the side of waiting.
Autonomy	The person's right to refuse is absolute and does not require justification.	A single "no" is permanent. Never revisit, re-invite, or re-prompt a person who has declined.
Beneficence	Feedback should serve the person and people like them, not just the organization.	If the data will only be used for accreditation compliance, reconsider whether the collection is justified.

Justice	The burden of feedback must not fall disproportionately on the most vulnerable.	Track who is being asked. If crisis clients are the primary feedback source, the system is extractive.
Proportionality	The emotional cost of giving feedback must be proportionate to the benefit it will produce.	A 15-minute survey after a restraint episode fails this test. A 1-question dignity check may pass it.

The Extraction Test

Ask This Question Before Any Post-Crisis Feedback Initiative

If this person never gives us feedback about this crisis, will we treat them exactly the same? Will their care be identical? Will their discharge be unaffected? Will no one think less of them?

If the answer to any of these is “no” — or even “maybe” — the feedback request is extractive, not empowering.

The standard is not just that feedback is voluntary. It is that not giving feedback is equally valued, equally respected, and completely invisible.

When Passive Availability Is the Only Ethical Option

In most post-crisis situations, the only appropriate approach is passive availability:

☐	The kiosk is accessible in the environment as it always is
☐	No staff member draws special attention to it in connection with the crisis event
☐	No signage or prompt changes after a crisis to encourage crisis-related feedback
☐	If the person uses the kiosk of their own volition, that is honored
☐	If the person does not use the kiosk, that is equally honored
☐	The organization does NOT track whether crisis-affected individuals use the kiosk at higher or lower rates than other clients

DOCUMENT 7

Data Interpretation Guardrails

What crisis feedback can and cannot tell you

📋 **INSTRUCTIONS:** *Crisis feedback is emotionally charged, contextually complex, and often comes from a small number of respondents. Interpreting it requires different rules than standard program feedback. This document prevents the two most common errors: over-interpreting small data and dismissing uncomfortable data.*

What Crisis Feedback CAN Tell You

DATA	VALID INTERPRETATION	EXAMPLE
A “No” on the dignity question after restraint	At least one person experienced the intervention as undignified. That is a data point worth investigating.	One “No” on RS1 justifies a review of restraint procedures and staff training.
Open-ended description of what happened	The person’s subjective experience of the event. This is their truth. It may not match the incident report.	A client describes being held down roughly. The incident report says “safe restraint per protocol.” Both may be true.
A trend of low dignity scores after crisis events	Your crisis interventions may not be meeting the standard of care you believe they are.	Three consecutive quarters of <70% “Yes” on dignity after restraint = systemic concern.
An open-ended response expressing gratitude	The crisis response was experienced as humane and caring by this person.	This is worth sharing with staff (anonymously) for morale and modeling.

What Crisis Feedback CANNOT Tell You

DATA	INVALID INTERPRETATION	WHY IT’S WRONG
One negative response	The staff involved did something wrong.	A single response from a person in acute distress cannot be used to evaluate specific staff performance.
No responses after a crisis event	The person had no concerns about the event.	Silence is not satisfaction. Non-response in crisis contexts reflects emotional state, not experience quality.
A low score from a person who was restrained	Restraint should be done differently for this person.	Feedback is program-level learning, not individual treatment planning. Do not use anonymous feedback to modify a specific person’s care.

High dignity scores across the board	Your restraint / seclusion practices are flawless.	Response bias in crisis contexts is significant. Positive feedback does not prove the absence of problems.
Feedback that contradicts the incident report	The incident report is wrong.	Both perspectives are valid data. Investigate the discrepancy rather than choosing one over the other.

Interpretation Rules

☐	Never attribute a crisis-related response to a specific staff member, even if the content seems to identify them
☐	Never use a single crisis response to justify a policy change — use it to justify an investigation
☐	Never dismiss a negative response because the person was “in crisis and not thinking clearly”
☐	Never treat the absence of negative feedback as evidence of quality
☐	Always compare crisis feedback to incident reports and look for discrepancies worth investigating
☐	Always track crisis feedback trends over time — single data points are signals, patterns are evidence
☐	Always present crisis feedback alongside the context: sample size, time period, and event type

DOCUMENT 8

CQI Integration Workflow

Moving crisis feedback into quality improvement without losing its urgency or its nuance

📋 **INSTRUCTIONS:** *Crisis feedback occupies an awkward space in quality improvement: too urgent for the next quarterly review, too small-sample for statistical analysis, and too sensitive for standard reporting. This workflow ensures crisis feedback reaches the right people at the right pace with the right protections.*

The Dual-Track System

Crisis Feedback Follows Two Paths Simultaneously

TRACK 1 — IMMEDIATE (Safety): If the feedback reveals an active safety risk, it follows the escalation pathway in Document 9. This happens within hours.

TRACK 2 — SYSTEMATIC (Learning): All crisis feedback, regardless of urgency, also feeds into the CQI process for pattern analysis, trend monitoring, and systemic improvement. This happens quarterly.

Both tracks are active for every crisis response. Track 1 handles the immediate. Track 2 captures the learning.

Track 2: Systematic CQI Workflow

STEP	ACTION	OWNER	TIMELINE
1. Capture	Crisis-related response is received and stored. No event-type tagging. No individual attribution.	Feedback system (automatic)	Real-time
2. Review	A trained data reviewer reads the response within 48 hours. Applies Document 9 thresholds. Flags for Track 1 if needed.	Designated feedback reviewer	Within 48 hours
3. Redact	Open-ended responses are reviewed for identifying details. Names, rooms, shifts, and dates are removed before any aggregation.	Feedback reviewer	Before any staff access

4. Pool	Response is added to the overall feedback pool. Crisis-specific themes are tagged internally for trend monitoring but not separated into a visible “crisis” category.	Feedback reviewer	Within 1 week
5. Trend	Crisis-related themes are tracked over time per Document 7. Trends are reviewed quarterly.	Data analyst / QI coordinator	Quarterly
6. Report	Crisis feedback themes are included in quarterly CQI reports. Data suppression rules apply (N<5 = suppress).	QI coordinator	Quarterly
7. Act	CQI committee reviews crisis feedback themes alongside incident data, restraint/seclusion data, and client grievances. Actions are assigned.	CQI committee	Quarterly meeting
8. Close	Actions are tracked to completion. Results are shared with staff (not clients, given sensitivity). Impact is measured in subsequent quarters.	QI coordinator	Ongoing

CQI Reporting Template for Crisis Feedback

SECTION	CONTENT THIS QUARTER
Total crisis-related responses received	
Response types (restraint, seclusion, suicidal crisis, involuntary hold, other)	[Report only if N≥5 per type; otherwise: “Data suppressed for anonymity”]
Dignity question results (% Yes / % No / % Prefer not to answer)	[Report only if total N≥10]
Top themes from open-ended responses	[Summarize themes, not verbatim quotes, unless N≥15]
Comparison to prior quarter	
Discrepancies between feedback and incident reports	[Note any patterns where client experience differs from documentation]
Actions recommended	
Status of actions from prior quarter	

DOCUMENT 9

Leadership Escalation Thresholds

When crisis feedback must reach leadership immediately

📋 **INSTRUCTIONS:** *Most crisis feedback follows the standard quarterly CQI track. Some demands immediate attention from leadership. This document defines the specific thresholds that trigger immediate escalation — bypassing the quarterly cycle — and the exact information that reaches each leadership level.*

Immediate Escalation Triggers

⚠ Notify Leadership Within 24 Hours If Crisis Feedback Contains:

- An allegation of staff assault or sexual misconduct during a crisis intervention
- A description of restraint or seclusion that appears to violate organizational policy or regulatory standards
- A disclosure of suicidal intent or self-harm that is ongoing and identifiable
- An allegation that a client was denied emergency medical treatment
- A description of a crisis event that was not documented in the incident reporting system
- A pattern of negative dignity scores after crisis events (3+ consecutive “No” responses on the dignity question within a single quarter)
- Any response suggesting a client was retaliated against for their behavior during a crisis

Escalation Routing

TRIGGER	NOTIFY	WITHIN	INFORMATION SHARED
Staff assault / sexual misconduct allegation	Executive Director + HR Director + Compliance Officer	4 hours	Theme description only. No verbatim text. No respondent identification.
Policy / regulatory violation in restraint or seclusion	Clinical Director + Compliance Officer	24 hours	Summary of concern. Reference to relevant policy/regulation. No individual identifiers.
Ongoing suicidal intent (identifiable)	Clinical Supervisor + Medical Director	Immediate	Concern identified. Environmental safety response activated. No kiosk content shared verbatim with unit staff.

Undocumented crisis event	Clinical Director + Risk Management	24 hours	Feedback suggests an event occurred that is not in the incident reporting system. Investigation warranted.
Pattern of negative dignity scores (3+ in a quarter)	Clinical Director + Executive Director	At time of pattern recognition	Trend data. No individual responses. Systemic concern framing.
Retaliation allegation	Executive Director + HR Director + Patient Rights	24 hours	Theme description. Investigation initiated. Respondent anonymity protected absolutely.

Leadership Notification Template

FIELD	CONTENT
Subject	Crisis Feedback Alert — [Trigger Type] — [Date]
Classification	[Immediate / 24-Hour / Pattern]
Summary	[2–3 sentences describing the concern. Factual. No verbatim feedback text. No respondent identification.]
Regulatory implication	[Mandatory reporting triggered? Accreditation standard at risk? State licensing concern?]
Actions already taken	[Environmental response, safety check, investigation initiated]
Actions requiring leadership authority	[Specific ask: staffing change, policy suspension, external investigation, board notification]
Reported by	[Name, role, date, time]

DOCUMENT 10

Post-Crisis Learning Summary Template

Capturing institutional learning from crisis feedback cycles so the organization gets smarter

📋 **INSTRUCTIONS:** *Individual crisis responses are signals. Quarterly data is evidence. Annual learning summaries are wisdom. This template captures what your organization has learned from crisis feedback over time, tracks whether interventions are working, and identifies the systemic patterns that no single response can reveal.*

Annual Post-Crisis Learning Summary

SECTION	CONTENT
Reporting period	[Date range]
Total crisis events this period	[From incident reports, not from feedback]
Total crisis-related feedback responses received	[Count. Note: these will always be a fraction of total events.]
Response rate (feedback / events)	[Percentage. Low rates are expected and not a failure — note this in context.]

Dignity Outcomes

METRIC	Q1	Q2	Q3	Q4	ANNUAL	TREND
Dignity question (% Yes)						
Dignity question (% No)						
Dignity question (% Prefer not to answer)						
“Did someone explain what was happening?” (% Yes)						

Thematic Analysis

THEME	FREQUENCY	TREND VS. LAST YEAR	ACTIONS TAKEN	OUTCOME

Key Learnings

Summarize the 3–5 most important insights from this year's crisis feedback:

#	LEARNING	EVIDENCE	ACTION TAKEN	RESULT
1				
2				
3				
4				
5				

Feedback-Incident Report Discrepancy Analysis

Where Client Experience Diverged From Documented Events

One of the most valuable functions of crisis feedback is revealing discrepancies between what was documented and what was experienced. Track these patterns:

DISCREPANCY TYPE	FREQUENCY THIS YEAR	INVESTIGATION OUTCOME	SYSTEMIC CHANGE MADE
Client reported force not documented in incident report			
Client reported no debriefing when records show debriefing occurred			
Client described event differently than staff documentation			
Client reported medication was administered without explanation			

Client reported staff member not documented as being present			

System Effectiveness Self-Assessment

Rate each dimension of your crisis feedback system (1–5):

DIMENSION	RATING (1–5)	EVIDENCE	ACTION FOR NEXT YEAR
Timing: are we waiting long enough before mentioning the kiosk?			
Template: are our questions capturing what matters in 60 seconds?			
Screening: are we reliably screening emotional readiness?			
Anonymity: are respondents truly unidentifiable in crisis contexts?			
Ethics: have we avoided extractive or harmful collection?			
Interpretation: are we reading the data accurately and humbly?			
CQI: is crisis feedback reaching the quality improvement process?			
Action: are we changing practices based on what we hear?			
Trust: do clients and staff believe this system is safe and useful?			

Sign-Off

Summary completed by: _____ Date: _____

Clinical director review: _____ Date: _____

Executive director review: _____ Date: _____

Board quality committee: _____ Date: _____

End of Toolkit

Learn from crises without causing harm.

For implementation support, contact your Pulse For Good account manager or visit pulseforgood.com