

**ADMINISTRATIVE REVIEW FORM
FOR UNAPPROVED BEHAVIORAL SUPPORT
APPENDIX E**



MUI Department

Phone (330) 634-8684 | Fax (330) 634-8553

Individual's Name:

Date of Unapproved Behavioral Support:

Major Unusual Incident Number:

Date Form Initiated:

Name of Person Initiating Form:

Title of Person Initiating Form:

Contact Information for Person Initiating Form:

Provider Name:

PART 1 - TO BE COMPLETED BY THE INDIVIDUAL'S PROVIDER

**DESCRIPTION - Describe the intervention/support in detail and the reason used.
How was the intervention/support necessary for the health and welfare of the
individual or other individuals?
List the staff involved.
How many times was the intervention/support used?
How long (total) was the individual restrained?**

HISTORY/ANTECEDENTS - Does the individual have a history of the behavior? If so,

D40000-008

describe history.

TYPE OF UNAPPROVED BEHAVIORAL SUPPORT

- Physical Restraint
 - Multiple Person Carry
 - Multiple Person Escort
 - One Person Carry
 - One Person Escort
 - Physically Prompted Hands Down With Resistance
 - Prone
 - Restraint of Multiple Appendages
 - Restraint of One Appendage
 - Seated Restraint
 - Side Restraint
 - Standing Restraint
 - Supine
 - Time-Out
 - Other:
- Chemical Restraint
 - Anti-Anxiety
 - Anticonvulsant
 - Antidepressant
 - Antipsychotic
 - Mood Stabilizer
 - Other:
- Mechanical Restraint
 - Full Body - Papoose Board Wrap

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- Full Body - Seated Position
- Full Body - Supine Position
- Gait Belt
- Helmet
- Locked Seatbelt/Vest - During Transportation
- Locked Seatbelt/Vest - Not During Transportation
- Mitts
- Splints or Tethers
- Wheelchair Controls Disabled
- Wheelchair for Individual Who Does Not Use Normally
- Other:

BEHAVIORAL SUPPORT STRATEGIES - Did the individual's service plan outline behavioral support strategies?

Did the staff know about the behavioral support strategies?

Were staff trained on implementation of the behavioral support strategies?

INJURIES - Were there any injuries to the individual or anyone else involved in the unapproved behavioral support?

Did the individual receive timely medical attention?

PART 2 - TO BE COMPLETED BY THE INVESTIGATIVE AGENT IN COLLABORATION WITH THE INDIVIDUAL'S TEAM

CAUSES AND CONTRIBUTING FACTORS

Supervision not met

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Staff ratio was not appropriate
1:1 attention unavailable
Change in routine or schedule
Excessive sensory input
Control issues - staff/family/peers
Medication change
Illness
Loss of important relationship
Individual service plan/behavioral support strategy not followed
Engaging in self-harm
Initiating harm to others
Other:

ADMINISTRATIVE REVIEW SUMMARY AND CONCLUSION

PREVENTION PLAN - Describe the prevention plan being implemented to address causes and contributing factors (e.g., environmental change, staff training, medication changes, or level of supervision).

Contact Information for Person Initiating Form:

Date Form Completed: