

Unapproved Behavior Support Form

Individual's Name:

Date Form Filled Out:

Date of UBS:

MUI Number:

Name of Person filling out Form:

Title:

Agency:

Contact Information:

UBS / HISTORY / ANTECEDENTS

Please list what led to UBS. Provide a timeline and whether this individual has a history of this behavior. Provide details of prevention measures from prior incidents.

How many times was the intervention used?
How long (total) was the individual restrained?

BEHAVIOR SUPPORT PLAN

Did the individual have a Behavior Support Program? Did the staff know about the BSP? Was the staff trained on the implementation of the BSP?

INJURIES:

Were there any injuries to the individual or anyone else involved in the UBS? Did the individual receive timely medical attention?

DESCRIPTION:

Describe in detail the intervention and the reason used. How was it necessary for the health and welfare of individual or other individuals?

CAUSE AND CONTRIBUTING FACTORS:

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><input type="checkbox"/> Supervision not met<input type="checkbox"/> Staff ratio was not appropriate<input type="checkbox"/> Diet not followed<input type="checkbox"/> Asked to complete task<input type="checkbox"/> Change in Routine<input type="checkbox"/> Excessive Noise<input type="checkbox"/> 1:1 Attention unavailable<input type="checkbox"/> Peer aggression | <ul style="list-style-type: none"><input type="checkbox"/> Outing Cancelled<input type="checkbox"/> Control Issues-staff/family/peers<input type="checkbox"/> Medication Change<input type="checkbox"/> Illness<input type="checkbox"/> Possible Hallucination<input type="checkbox"/> Loss of Important Relationship<input type="checkbox"/> ISP/BSP Not followed |
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Other:

PREVENTION MEASURES:

- | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><input type="checkbox"/> Physical/Social Environmental Change<input type="checkbox"/> Agency Policy/System Change<input type="checkbox"/> Staff Training<input type="checkbox"/> Counseling<input type="checkbox"/> Team Meeting to address ISP Changes<input type="checkbox"/> Appointment with Medical Care Provider | <ul style="list-style-type: none"><input type="checkbox"/> Medication Changes<input type="checkbox"/> Follow up Appointment Scheduled<input type="checkbox"/> PT/OT/Speech Referral made to address communication or mobility concern<input type="checkbox"/> Diet Change Ordered<input type="checkbox"/> Home Health Care |
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Other:

INVESTIGATIVE AGENT REVIEW:

Comments & Questions:

REVIEW COMPLETED DATE:

IA NAME:

PLEASE CHECK ALL THAT APPLY

Physical Restraint:

- Baskethold**
- Multiple Person Carry**
- Multiple Person Escort**
- One Person Carry**
- One Person Escort**
- Other Restraint**
- Physically Prompted Hands down with resistance**

- Restraint of Multiple Appendages**
- Restrain or One Appendage**
- Seated Restraint**
- Side Restraint**
- Standing Restraint**
- Supine**
- Other:**

- Time-Out List details of time-out, including length of time**

Chemical:

- Anti-Anxiety**
- Anticonvulsant**
- Antidepressant**
- Antipsychotic**
- Mood Stabilizer**
- Other:**

Mechanical:

- Full Body-papoose board wrap**
- Full Body-seated position**
- Full Body-supine position**
- Gait Belt**
- Helmet**
- Locked Seat Belt/vest-not during transportation**
- Mitts**
- Others**
- Splints**
- Transportation-locked seatbelt/vest/others**
- Wheelchair controls disabled**
- Wheelchair for individual who does not use normally**
- Other**