

ADMINISTRATIVE REVIEW FORM FOR UNAPPROVED BEHAVIORAL SUPPORT

Individual's Name: _____

Date of Unapproved Behavior Support: _____

Major Unusual Incident Form: _____

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, describe history.

TYPE OF UNAPPROVED BEHAVIORAL SUPPORT

☐ **Physical Restraint**

- | | |
|---|---|
| <input type="checkbox"/> Basket Hold | <input type="checkbox"/> One Person Carry |
| <input type="checkbox"/> Multiple Person Carry | <input type="checkbox"/> One Person Escort |
| <input type="checkbox"/> Multiple Person Escort | <input type="checkbox"/> Physically Prompted Hands Down With Resistance |
| <input type="checkbox"/> Prone | <input type="checkbox"/> Restraint of Multiple Appendages |
| <input type="checkbox"/> Restraint of One Appendage | <input type="checkbox"/> Side Restraint |
| <input type="checkbox"/> Supine | <input type="checkbox"/> Standing Restraint |
| <input type="checkbox"/> Seated Restraint | <input type="checkbox"/> Time-Out |
| | <input type="checkbox"/> Other: |

☐ **Chemical Restraint**

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

☐ **Mechanical Restraint**

- | | |
|---|--|
| <input type="checkbox"/> Full Body - Papoose Board Wrap | <input type="checkbox"/> Mitts |
| <input type="checkbox"/> Full Body - Seated Position | <input type="checkbox"/> Splints or Tethers |
| <input type="checkbox"/> Full Body - Supine Position | <input type="checkbox"/> Wheelchair Controls Disabled |
| <input type="checkbox"/> Gait Belt | <input type="checkbox"/> Wheelchair for Individual Who Does Not Use Normally |
| <input type="checkbox"/> Helmet | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Locked Seatbelt/Vest - During Transportation | |
| <input type="checkbox"/> Locked Seatbelt/Vest - Not During Transportation | |

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

If yes, please describe.

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? If yes, please describe injuries sustained by the individual.

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

- | | |
|--|---|
| <input type="checkbox"/> Supervision not met | <input type="checkbox"/> 1:1 attention unavailable |
| <input type="checkbox"/> Staff ratio was not appropriate | <input type="checkbox"/> Change in routine or schedule |
| <input type="checkbox"/> Excessive sensory input | <input type="checkbox"/> Control issues - staff/family/peers <input type="checkbox"/> |
| <input type="checkbox"/> Medication change | <input type="checkbox"/> Loss of important relationship |
| <input type="checkbox"/> Illness | <input type="checkbox"/> Individual service plan/behavioral support strategy not followed |
| <input type="checkbox"/> Engaging in self-harm | <input type="checkbox"/> Initiating harm to others |
| <input type="checkbox"/> Others: <div data-bbox="248 611 704 720" style="border: 1px solid black; width: 281px; height: 52px; display: inline-block; vertical-align: middle;"></div> | |

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).

Name of Investigative Agent Completing Form: _____

Date Form Completed: _____