Unapproved Behavioral Support MUI Form



**Individual’s Name:** **Date Form Completed:**

**Date of UBS: MUI Number:**

**Name of Person Completing Form:**

**Title: Provider:**

**Contact Information:**

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| **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/support used?**  **How long (total) was the individual restrained?** | | | | |
| **BEHAVIOR STRATEGIES** | | | | |
| **Did the individual have behavioral support strategies outlined in their service plan? Did the staff know about the strategies? Was the staff trained on the implementation of the behavioral support strategies?** | | | | |
| **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/support and the reason used. How was it necessary for the health and welfare of individual or other individuals?** | | | | |
| **CAUSE AND CONTRIBUTING FACTORS:** | | | | |
|  | | | | |
|  |                | **Supervision not met**  **Staff ratio was not appropriate**  **Diet not followed**  **Asked to complete task**  **Change in Routine**  **Excessive Noise**  **1:1 Attention unavailable**  **Peer aggression** | * **Outing Cancelled** * **Control Issues-staff/family/peers** * **Medication Change** * **Illness** * **Possible Hallucination** * **Loss of Important Relationship** * **ISP/BSP Not followed** |  |
| **Other:** |  |  |
|  | **PREVENTION MEASURES:** | |  | |
|  |  | |  | |
| * **Physical/Social Environmental Change** * **Agency Policy/System Change** * **Staff Training** * **Counseling** * **Team Meeting to address ISP Changes** * **Appointment with Medical Care Provider** | | * **Medication Changes** * **Follow up Appointment Scheduled** * **PT/OT/Speech Referral made to address communication or mobility concern** * **Diet Change Ordered** * **Home Health Care** |  |
| **Other:** | | |
| **INVESTIGATIVE AGENT REVIEW:**  **Comments & Questions:**          **REVIEW COMPLETED DATE: IA NAME:** | | | | |

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

# DODD MUI – UBS MUI FORM – DECEMBER 2018