

# 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:

Return to Investigations@ClermontDD.ORG    DUE Due:

## 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:**

- |  |  |
|--|--|
| <input type="checkbox"/> Supervision not met             | <input type="checkbox"/> Outing Cancelled                  |
| <input type="checkbox"/> Staff ratio was not appropriate | <input type="checkbox"/> Control Issues-staff/family/peers |
| <input type="checkbox"/> Diet not followed               | <input type="checkbox"/> Medication Change                 |
| <input type="checkbox"/> Asked to complete task          | <input type="checkbox"/> Illness                           |
| <input type="checkbox"/> Change in Routine               | <input type="checkbox"/> Possible Hallucination            |
| <input type="checkbox"/> Excessive Noise                 | <input type="checkbox"/> Loss of Important Relationship    |
| <input type="checkbox"/> 1:1 Attention unavailable       | <input type="checkbox"/> ISP/BSP Not followed              |
| <input type="checkbox"/> Peer aggression                 |  |

Other:

**PREVENTION MEASURES:**

- |   |  |
|---|--|
| <input type="checkbox"/> Physical/Social Environmental Change   | <input type="checkbox"/> Medication Changes  |
| <input type="checkbox"/> Agency Policy/System Change            | <input type="checkbox"/> Follow up Appointment Scheduled   |
| <input type="checkbox"/> Staff Training                         | <input type="checkbox"/> PT/OT/Speech Referral made to address communication or mobility concern |
| <input type="checkbox"/> Counseling                             | <input type="checkbox"/> Diet Change Ordered   |
| <input type="checkbox"/> Team Meeting to address ISP Changes    | <input type="checkbox"/> Home Health Care  |
| <input type="checkbox"/> Appointment with Medical Care Provider |  |

Other:

**INVESTIGATIVE AGENT REVIEW:**

Comments & Questions:

REVIEW COMPLETED DATE:

IA NAME:

☐ **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**