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:**

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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.** |
| **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:** |
| |  |  | | --- | --- | | * **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:** |
| **Unapproved Behavior Support Form V.1 (4-30-13)**  **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** * **Prone** * **Restraint of Multiple Appendages** * **Restrain or One Appendage** * **Seated Restraint** * **Side Restraint** * **Standing Restraint** * **Supine** * **Other:** * **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 ind who does not use normally** * **Other** |