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| EMERGENCY USE OF MANUAL RESTRAINT INCIDENT REPORT | | |
| **Behavior intervention information**  \*This section to be completed within 3 calendar days by staff who implemented the emergency use of manual restraint (EUMR)**.** | | |
| **Name of person served:        Date of the EUMR:        Time of use:** | | |
| Name and title of staff completing this section:  Date of completion: | | |
| Location type: | | |
| Location address: | | |
| Staff and persons served who were involved in the incident leading up to the emergency use of manual restraint:  First name:        Last name:        Title:  First name:        Last name:        Title:  First name:        Last name:        Title:  Staff (if available) who monitored the person’s health and welfare during the EUMR:  First name:        Last name:        Title:  \*If an additional staff was not available to monitor the EUMR, the staff conducting the EUMR is responsible for monitoring the person’s health and welfare during the EUMR. | | |
| The behavior the person displayed that required the use of an intervention included – choose all that apply:  Physical aggression/physical assault  Self-injury/self-harm  Self-endangerment/risk to personal safety  Property destruction/damage that could harm the person/others | | |
| Describe the behavior intervention used and the resulting outcome:  Length of use: | | |
| Describe the physical and social environment, including who was present *before* and *during* the incident leading up to the emergency use of manual restraint: | | |
| Describe what less restrictive alternative measures were attempted to de-escalate the incident and maintain safety before the manual restraint was implemented:  Identify when, how, and how long the alternative measures were attempted before the manual restraint was implemented:    Time when de-escalation occurred:  Length of time involved in de-escalation efforts:      hours      minutes | | |
| Describe the mental, physical, and emotional condition of the person who was restrained, and other persons involved in the incident *leading up to*, *during*, and *following* the manual restraint: | | |
| Was there any injury to the person who was restrained or other persons involved in the incident, including staff, *before* or *as a result* of the use of intervention?  Yes  No  If yes, indicate who was injured and what their injury(ies) were:  If yes, indicate what care was provided for the injured person(s): | | |
| Following the incident, was there a debriefing with the staff, and, if not contraindicated, with the person who was restrained and other persons who were involved in or who witnessed the restraint?  Staff:  Yes  No  Person served:  Yes  No  Other people:  Yes  No  If yes, describe the outcome of the debriefing:  If no, indicate whether a debriefing is planned: | | |
| Was a PRN psychotropic medication administered?  Yes  No  Was law enforcement or other first responders called?  Yes  No  Was there emergency psychiatric hospitalization?  Yes  No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of staff who implemented the EUMR Date | | |
| **Designated Coordinator review**  \*To be completed by the Designated Coordinator upon receipt and prior to the internal review. This information is used to assist in completion of the *Behavior Intervention Reporting Form (BIRF).* | | |
| NPI/UMPI: Location number: | | |
| Contact person/provider phone number: | | |
| Contact person/provider email address: | | |
| Type of service that was provided at time of behavior intervention: | | |
| First name/middle initial/last name of the person: | | |
| PMI number of person who needed the intervention: | | |
| Date of birth:        Gender: | | |
| County/Tribe Lead Agency funding the service: | | |
| County or Tribe where services are actually provided: | | |
| Diagnosis – choose all that apply:  Developmental Disabilities  Intellectual Disabilities (not from DD, i.e. BI)  Physical/Medical Disabilities  Mental Illness  Elderly with Age-Related Impairments | | |
| Total number of current prescribed psychotropic medications (including PRN psychotropic medications): | | |
| Does the person currently have – choose all that apply:  Positive Support Transition Plan  Functional Behavior Assessment within the past 12 months  Diagnostic Assessment within the past 12 months | | |
| Does this person have any conditions (medical or psychological) for which the physical behavioral intervention is contraindicated?  Yes  No  \*This would be established in consultation with the person’s support team. Please refer to the *Support Plan Addendum* for more information. | | |
| Does the person served require specialized or intensive behavior consultation and/or support services?  Yes  No | | |
| Does the person served require a plan for crisis respite placement?  Yes  No | | |
| Describe the plan to positively support the person and avoid the future use of behavior interventions: | | |
| **Notifications**  \*The guardian/legal representative, designated emergency contact, and case manager must be notified within 24 hours of the emergency use of manual restraint. | | |
| Include who was notified and the date and time of notification for the following persons or entities. Indicate ‘NA’ if it does not apply to the person:  Parent:  Legal representative\*:  Designated emergency contact\*:  Case manager\*:  DHS Licensing:  Common Entry Point (CEP)/MAARC:  Office of the Ombudsman:  Agency designated internal review team:  Expanded support team: | Date:  Date:  Date:  Date:  Date:  Date:  Date:  Date:  Date: | Time:  Time:  Time:  Time:  Time:  Time:  Time:  Time:  Time: |
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| **Internal review of emergency use of manual restraint**  \*Within five (5) working days of the emergency use of manual restraint, the license holder’s designated person who conducts internal reviews will complete the internal review of each report of the emergency use of manual restraint. | | |
| Date of internal review:        This internal review must include an evaluation of the following information:   1. Whether the person’s service and support strategies developed according to sections 245D.07 and 245D.071 need to be revised: 2. Whether related policies and procedures were followed: 3. Whether the policies and procedures were adequate: 4. Whether there is a need for additional staff training: 5. Whether the reported event is similar to past events with the persons, staff, or the services involved:      1. Whether there is a need for corrective action by the license holder to protect the health and safety of persons: | | |
| Based upon the results of the internal review, the license holder must develop, document, and implement a corrective action plan for the program designed to correct current lapses and prevent future lapses in performance by individuals or the license holder, if any.  Describe the corrective action plan here, if any:  \*The corrective action plan, if any, must be implemented within 30 days of the internal review being completed. Date of implementation:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of person completing the internal review Date | | |
| **Expanded support team review**  \*Within five (5) working days after the completion of the internal review, the license holder must consult with the expanded support team following the emergency use of manual restraint. This may be completed by the Designated Coordinator. | | |
| 1. Discuss the incident reported and define the antecedent or event that gave rise to the behavior resulting in the manual restraint and identify the perceived function the behavior served: 2. Determine whether the person’s *Support Plan Addendum* needs to be revised according to sections 245D.07 and 245D.071 to positively and effectively help the person maintain stability and to reduce or eliminate future occurrences requiring emergency use of manual restraint:   Legal representative: Date of discussion:  Case manager: Date of discussion:  Other professional (include name and title): Date of discussion:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of the Designated Coordinator and/or Designated Manager Date | | |
| **Expanded review and reporting**  \*Within five (5) working days of the expanded support team review, the license holder must complete and submit to DHS the *Behavior Intervention Reporting Form* (DHS-5148-ENG-1). This submission meets the reporting requirements for reporting to DHS and the Office of the Ombudsman for Mental Health and Developmental Disabilities. This may be completed by the Designated Coordinator or Designated Manager and can be found on the following website:  <https://edocs.dhs.state.mn.us/lfserver/Secure/DHS-5148-ENG>  Date of information submission:  Date the copy of the *Behavior Intervention Reporting Form* (DHS-5148-ENG-1) was sent to the support team: | | |