

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.

Name of person served:

Date of the EUMR:

Name and title of staff completing this section:

Date of completion:

Date of use:

Time of use:

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:

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:

This information can be made available
in an alternate format upon request.
Our TTY phone number is 651-365-3736.
Equal Opportunity Employer.

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

Signature of staff who implemented the EUMR _____ Date _____

Service Coordinator review

*To be completed by the Service Coordinator upon receipt and prior to the internal review.

NPI/UMPI: _____

Contact person/provider phone number: _____

Contact person/provider email address: _____

Type of service that was provided 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: _____

Diagnosis – choose all that apply: Developmental Disabilities Intellectual Disabilities (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 Rule 40 Plan
 Functional Behavior Assessment within the past 12 months Diagnostic Assessment within the past 12 months

Does this person have any conditions for which the physical behavioral intervention is contraindicated? Yes No

*This would be established in consultation with the person's physician and regards a medical condition that limits, restricts, or prohibits the use of physical intervention.

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:

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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:

Date:

Time:

Guardian/legal representative*:

Date:

Time:

Designated emergency contact*:

Date:

Time:

Case manager*:

Date:

Time:

DHS Licensing:

Date:

Time:

Common Entry Point (CEP):

Date:

Time:

Office of the Ombudsman:

Date:

Time:

Agency designated internal review team:

Date:

Time:

Expanded Support Team:

Date:

Time:

Signature of person completing the notifications

Date

Send to:

Lifeworks Services, Inc.

Attn: HR Department

2965 Lone Oak Drive, #160

Eagan, MN 55121

Or fax to Lifeworks Services, Inc.

Attn: HR Department

Fax: 651-365-3787

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Compliance Committee's internal review of emergency use of manual restraint

*Within five (5) working days of the emergency use of manual restraint, an internal review will be completed for each report of the emergency use of manual restraint.

Date of internal review:

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:
6. 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:

Compliance Committee Member

Date

Expanded support team review

*Within five (5) working days after the completion of the internal review, the Service Coordinator must consult with the expanded support team following the emergency use of manual restraint.

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 *Coordinated Service and 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:

Signature of Service Coordinator or designee

Date

Expanded review and reporting

*Within five (5) working days of the expanded support team review, the Service Coordinator will complete and submit to DHS the *Behavior Intervention Reporting Form* (DHS-5148-ENG-1). This may be found on the following website:

<https://edocs.dhs.state.mn.us/lfserver/Secure/DHS-5148-ENG> Date of information submission: