

**CONFIDENTIAL**

**DHHS Restrictive Intervention Details Report**

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Provider Agency Name \_\_\_\_\_

Consumer's Name \_\_\_\_\_

Consumer's Social Security No. \_\_\_\_\_

This form is used to report use of restrictive interventions for persons receiving publicly funded mental health, developmental disabilities and/or substance abuse (MH/DD/SA) services. Facilities licensed under G.S. 122C and unlicensed providers of community-based MH/DD/SA services must submit this form or a form with comparable information to the Local Management Entity (LME) responsible for the geographic area in which the service is provided. Failure to submit this report, as required by NC Administrative Code 10A NCAC 27E .0104 and 10A NCAC 27G .0600, may result in administrative actions being taken against the provider's license and/or authorization to receive public funding. This form may also be used for internal documentation of interventions, if required by provider policies or LME contract.

**Instructions:** Complete and submit this form to the local and/or state agencies responsible for oversight within 72 hours to report any restrictive intervention that (1) is administered inappropriately, (2) results in death, injury, discomfort or complaint or (3) is used in an emergency (not included in service plan). ♦ If requested information is unavailable, provide an explanation on the form and report the additional information as soon as possible. ♦ **NOTE:** All use of restrictive intervention, including planned use that is administered appropriately without discomfort or complaint and unplanned emergency use, must be documented in the consumer record, as required by NC Administrative Code 10A NCAC 27E .0104.

**Page 1-2 Instructions:** The direct care staff person who is most knowledgeable about the intervention should complete pages 1-2 of this form as soon as possible and submit to the unit supervisor for review.

**INTERVENTION DETAILS**

Date of intervention: \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m. Consumer's Home LME: \_\_\_\_\_

Facility: \_\_\_\_\_

Intervention Type <i>(Number in order of use)</i>	Duration Hours Minutes	Intervention Specifics: <i>(Check all that apply)</i>	If over 15 minutes, who authorized the additional time?
____ Isolation	_____	<input type="checkbox"/> NCI	Name _____
____ Seclusion	_____	<input type="checkbox"/> CPI	Title _____
____ Restraint–Standing	_____	<input type="checkbox"/> Other _____	Number of restrictive interventions in last 30 days: _____
____ Restraint–Sitting	_____		
____ Restraint–Face Down	_____		

**Purpose of the intervention** *(check all that apply):*  
 Prevent harm to self       Prevent harm to others       Prevent serious property damage  
 Planned intervention (Person-Centered Plan date: \_\_\_\_\_)

**If planned, was intervention reviewed & approved by a Client Rights or Restrictive Intervention Committee prior to the intervention?**  
 Yes  No Agency: \_\_\_\_\_ Committee: \_\_\_\_\_ Date: \_\_\_\_\_

**DESCRIPTION**

**Briefly describe what happened to cause a restrictive intervention, including specifics of the individual's behavior (e.g. frequency, intensity, duration), and actions leading to the behavior. Be specific. (Attach sheets if needed)**

**Positive and/or less restrictive interventions attempted** *(check all that apply):*  
 Verbal Redirection       Distractions (e.g. take a walk)       Impromptu treatment session  
 Removing consumer from situation (verbal and physical prompts)       Separation from group (verbal and physical prompts)  
 Other \_\_\_\_\_

**Description of results:**

**Rationale for using restrictive of intervention** *(Be specific):*

**HEALTH STATUS**

**Significant medical conditions identified previously:**  
 None       Physical disabilities  
 Heart Condition       Asthma  
 High Blood Pressure  
 Other *(specify):* \_\_\_\_\_

**Medications:**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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HEALTH STATUS INFORMATION	ITEM	INITIAL CHECK <i>(Prior to Intervention)</i>	ENDING CHECK <i>(Immediately after Intervention)</i>	FOLLOW-UP CHECK <i>(30 minutes after Intervention)</i>
	<b>Consciousness</b>  <i>Please explain any abnormality:</i>	<input type="checkbox"/> Alert <input type="checkbox"/> Dazed	<input type="checkbox"/> Alert <input type="checkbox"/> Dazed <input type="checkbox"/> Unconscious	<input type="checkbox"/> Alert <input type="checkbox"/> Dazed <input type="checkbox"/> Unconscious
	<b>Speech</b>  <i>Please explain any abnormality:</i>	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
	<b>Breathing</b>  <i>Please explain any abnormality:</i>	<input type="checkbox"/> Normal <input type="checkbox"/> Hard / Irregular	<input type="checkbox"/> Normal <input type="checkbox"/> Hard / Irregular	<input type="checkbox"/> Normal <input type="checkbox"/> Hard / Irregular
	<b>Movement</b>  <i>Please explain any abnormality:</i>	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
	<b>Skin Color</b>  <i>Please explain any abnormality:</i>	<input type="checkbox"/> Normal <input type="checkbox"/> Pale <input type="checkbox"/> Flushed	<input type="checkbox"/> Normal <input type="checkbox"/> Pale <input type="checkbox"/> Flushed	<input type="checkbox"/> Normal <input type="checkbox"/> Pale <input type="checkbox"/> Flushed
	<b>Orientation</b>  <i>Please explain any abnormality:</i>	<input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time	<input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time	<input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time
	<b>Affect / Mood</b>  <i>Please explain any abnormality:</i>	<input type="checkbox"/> Appropriate <input type="checkbox"/> Inappropriate	<input type="checkbox"/> Appropriate <input type="checkbox"/> Inappropriate	<input type="checkbox"/> Appropriate <input type="checkbox"/> Inappropriate
<b>Describe the person's behavior after the intervention:</b>          				
MONITORING	<b>Was the person monitored continuously during the intervention and for 30 minutes afterward?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If not monitored continuously, provide an explanation:   			
	<b>Name/Title of persons providing monitoring (Please print):</b> _____ Signature: _____ Date _____ _____ Signature: _____ Date _____			
<b>Name/Title of staff person documenting intervention (Please print):</b> _____ Signature: _____ Date _____				



