ADMH-DDD Restraint Evaluation Review					
GER Form ID:				**Event Date:**	
QA Reviewer:				**GER Region:**	
Event Type:			**Restraint Other Type:**		
Review Date:		**Review Week:**			

Restraint Review Probe	**Respond YES, NO or N/A (Not Applicable)** **Explain Response Below**
1. Does the GER contain the "Specific Location" where the restraint was applied? **(Yes, No, N/A)**	
2. Does the GER contain the "Begin Time" when the restraint was initiated?	
3. Does the GER contain the "End Time" when the restraint was initiated?	
4. Was the restraint implemented as an "emergency" restraint?	
5. Was the restraint implemented as a "programmatic restraint" that was prescribed in a behavior support program approved by the Program Review or Human Rights Committee?	
6. For manual restraints involving an injury, was an Injury Event included in the GER? **(Yes, No, N/A)**	
7. Does the GER describe the specific type of restraint that was used?	
8. Does the GER include the name of the person(s) applying the (Behavior) restraint? **(Yes, No, N/A)**	
9. Does the GER describe the precursors that led up to the restraint usage?	
10. Does the GER describe what types of lesser restrictive techniques were used prior to initiating the restraint?	
11. Does the GER contain information sufficient to determine if the person(s) implementing the restraint followed the applicable steps as outlined in the BSP for restraint use outlined in the Behavior Support Program? **Note: Provider will need to attach BSP to the GER for review.*	
12. Does the "Summary" field on the GER contain information sufficient to determine if the person(s) implementing the restraint (all restraint types) received training on its appropriate and correct use prior to using the technique? **Note: Provider will need to include this as a statement in the summary. For example, Mary DSP is currently certified in PCM to perform this restraint.*	
13. For chemical and mechanical restraints, does the "Summary" field on the GER document that specific approval for use of the restraint was obtained from a QDDP, Program Director, or Physician prior to the restraint being initiated? **(Yes, No, N/A)**	
14. If it was a "mechanical restraint", does the GER include the name of the person(s) removing the restraint? *Note: This will need to be included in the summary.* **(Yes, No, N/A)**	
15. If it was a "mechanical restraint", does the GER describe the specific device used and was the device one of the following: (1) Arm splints, (2) Wrist cuffs, or (3) 4- or 5-point restraint device with a quick	

release (Posey stockinette or Velcro wrist/ankle cuffs)? *Note: This will need to be included in the details of the summary.* **(Yes, No, N/A)**	
16. If it was a "mechanical restraint" or "chemical restraint", does the GER contains details of how the individual was monitored **during** the implementation of the restraint? *Note: This will need to be included in the summary.* **(Yes, No, N/A)**	
17. If it was a "chemical" restraint, does the GER identify the medication used? **(Yes, No, N/A)**	
18. If it was a "chemical" restraint, does the GER identify the dosage of the medication administered? **(Yes, No, N/A)**	
19. Does the GER contain description of needed corrective actions to address any identified issues (ex: injuries, ineffective interventions, etc.) related to the use of the restraint? ***Note: Provider will need to provide details in Actions Taken. (Yes, No, N/A)**	
20. Does the GER identify if the intervention was effective?	
21. If this was an **"emergency" restraint**, was a prevention plan developed as a result of the incident? **(Yes, No, N/A)**	
22. If this was an **"emergency" restraint** used three or more times in a six-month period, does the GER **include a copy of minutes of a team meeting held within five working days from the third restraint** supporting the team's review of the restraint usage pattern and determination of the use of this type of restraint? **(Yes, No, N/A)**	
23. If this was an **"emergency" restraint** used three or more times in a six-month period, **was the behavior support program/plan amended**? **(Yes, No, N/A)**	
24. If a behavior support program/plan does not already exist, and this was an **"emergency" restraint** used three or more times in a six-month period, was a behavior support program/prevention plan developed as a result the restraint? **(Yes, No, N/A)**	
Additional Notes:	

Please Note:

- This form is an internal document designed to provide guidance regarding quality measures related to incident management and performance measures.
- Quality Assurance Specialist will complete all fields in Restraint Evaluation Review section.
- Quality Assurance Specialist will provide a brief explanation to their Yes/No response in the field.
- For questions **1,6,8,13-19**,**21, and 22-24**: "N/A" may be used if the question is not applicable to the reported event.