

# Cause and Contributing Factors and Prevention Planning



Department of  
Developmental Disabilities

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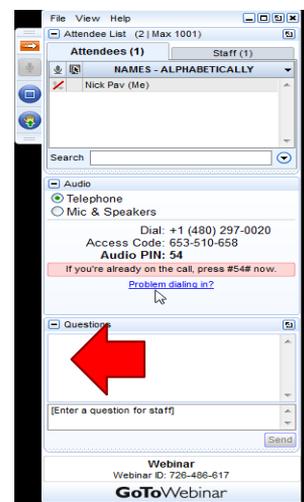
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## Housekeeping

- Proof of Continuing Professional Development Units will be emailed for those who **actively** participated in the Webinar within **1 month** of webinar
- Follow up by email or phone to MUI office at 614-995-3810.

**Thank you for your participation!**

## Rule References

### For Major Unusual Incidents

**O.A.C. 5123:2-17-02 (K) (2):**The individual's team, including the county board and provider, *shall collaborate on the development of preventive measures to address the causes and contributing factors to the major unusual incident. The team members shall jointly determine what constitutes reasonable steps necessary to prevent the recurrence of major unusual incidents.* If there is no service and support administrator, individual team, qualified intellectual disability professional, or agency provider involved with the individual, a county board designee shall ensure that preventive measures as are reasonably possible are fully implemented.

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## Rule References

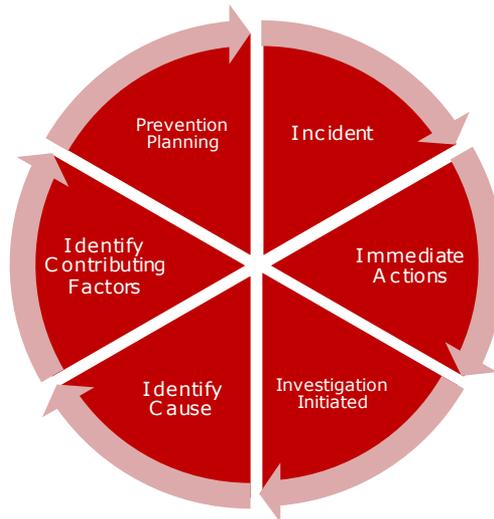
### For Unusual Incidents

**O.A.C. 5123:2-17-03 (M)(2)(d):** Requires the agency provider to investigate unusual incidents, identify the cause and contributing factors when applicable, and develop preventive measures to protect the health and welfare of any at-risk individuals.



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# Incident Investigation and Follow up



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## Identifying Causes and Contributing Factors

### Process

Lack of policies, procedures not followed, or ineffective policy

### People or Human Factors

like training, communication, scheduling, and other factors lead to incident

### Equipment

required tools to support individuals or carry out job tasks are not available or operational

### Environment

may contribute to incident due to line of sight issues, etc.

### Materials

needed to provide support are not available such as medications and depends

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## Elements of a Good Prevention Plan

- Based on a thorough investigation which gives an explanation of “cause”. The prevention plan should attempt to address each cause identified not just “the obvious case.”
- Addresses other significant factors that played a role in the incident.
- Is not just “a plan to plan,” but is specific in identifying WHO is going to do WHAT, WHEN, WHERE, and HOW.

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## Elements of a Good Prevention Plan

- Takes into account not only “people” issues, but “systems” issues.
- One that not only addresses immediate action, but attempts to address long term planning towards a desired outcome.
- Includes involvement of the person and their guardian (as applicable) in the planning process.
- Shared across a variety of settings and includes feedback from a variety of disciplines for a holistic approach to a desirable outcome.

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## **Elements of a Good Prevention Plan**

- Are not developed in a vacuum and should not be a means to an end
- Are both specific for the individual case and far reaching system

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## **Elements of a Good Prevention Plan**

- Address the cause of the incident
- Is within the control of responsible person
- Ensures that necessary resources available
- If effectively implemented, can minimize the recurrence of the incident

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## Prevention Planning

*Prevention Planning should address:*

- *How can we decrease the chances of this incident occurring again?*
- *How can we prevent injury?*
- *What happened, what should have happened?*

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## Prevention Planning

- **Staff support is not the only way to address health, welfare and risk.**
- **Plans may include technology, adaptations, and other supports and should balance what is important to a person to promote satisfaction and achievement of desired outcomes and what is important for the person to maintain health and welfare.**
- **It is in everyone's best interest to clearly know and understand what the support is, why it is needed, and what is expected of staff.**

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## Have you ever?

- Wished it won't happen again
- Crossed your fingers
- Said you would "Monitor"
- Ignored the underlying issue
- Continue to do the same thing over and over again producing the same results

You will increase your chances of success if you are specific and clear in prevention plan.

Example: Instead of "Provide Training", say something like "All Residential and Workshop Staff will be provided training on Susan's new diet by 7/18/14 by the Program Director.



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## Breaking Down a Choking Incident

MUI	Human	Process	Environment	Equipment
<b>MEDICAL EMERGENCY</b>	<ul style="list-style-type: none"> <li>• Staff not trained on individual's needs</li> <li>• Supervisor did not update staff on change in diet orders</li> <li>• Misunderstanding of what mechanical soft meant</li> <li>• 1:1 Staff was not available to sit with individual at lunch as required by plan</li> <li>• Individual refused to have his/her food per diet</li> <li>• Substitute Staff</li> <li>• Peers giving individual their lunch items</li> <li>• Individual getting items from vending machines</li> </ul>	<ul style="list-style-type: none"> <li>• There is no policy in place to inform staff of diet changes</li> <li>• ISP Addendum was not available to staff</li> <li>• No listing of which individual uses which adaptive equipment</li> <li>• No process for home and work staff to document and communicate changes in orders</li> </ul>	<ul style="list-style-type: none"> <li>• Staff can not visually monitor individual due to assisting in another area of home</li> <li>• Work area is large making it difficult to visually monitor all individuals</li> </ul>	<ul style="list-style-type: none"> <li>• Food Processor was not available at the restaurant</li> <li>• Food was not prepared properly at home and Day Program does not have a food processor</li> <li>• Adaptive Equipment (nosey cup, spoon, high sided plate) are not available at the work</li> <li>• Adaptive Equipment was lost and never replaced</li> <li>• The work provider was not supplied with the adaptive equipment</li> </ul>

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## Medical Emergency Prevention Plan

- What is the person's current medical condition?
- Are any follow-up medical orders/ recommendations being implemented? Who is responsible? What are the specific timeframes?
- Are any changes required for the ISP? Who is following up? What are the specific timeframes?
- Choking Incidents - diet textures, Supervision, meal pace, adaptive equipment.

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## Causes and Contributing Factors Examples

MUI	Human	Process	Environment	Equipment
<b>NEGLECT</b>	<p><b>Training</b></p> <ul style="list-style-type: none"> <li>• Transportation staff are not aware that individual cannot be home alone</li> <li>• Staff that took individual on medical appointment did not have necessary information and was not able to explain individual's past medical history.</li> <li>• Scheduled staff is not Medication Administration trained as required and so medication is not administered</li> </ul> <p><b>Scheduling</b></p> <ul style="list-style-type: none"> <li>• No staff scheduled, Staff doesn't show or staff leaves</li> <li>• Not two staff to do lift as required</li> <li>• There was a traffic accident and scheduled staff was running 15 minutes late for shift</li> <li>• Staff scheduled to take individual to the doctors did not know them well and could not provide a good medical history, this contributed to the person not getting adequate care</li> <li>• Staff was rushing around to complete all job duties and passed medication to wrong individual</li> <li>• Staff Turn Over</li> </ul>	<ul style="list-style-type: none"> <li>• There is no clear instruction on who to contact if you cannot reach your supervisor</li> <li>• Staff are instructed to call supervisor prior to seeking emergency medical care</li> <li>• Bus driver did not follow procedure for checking bus and left child on bus</li> <li>• There are many staff assigned to a group and so it is believed another staff person is caring for that person</li> </ul>	<ul style="list-style-type: none"> <li>• Individual's family home has been condemned and they are still living there</li> <li>• There was no available mat which was to be placed on the floor to prevent injury from falling</li> <li>• Door Alarms that are outlined in the plan are not turned on or not operational</li> <li>• Medications are not secure per plan</li> <li>• Individuals home is not accessible and they cannot safely evacuate</li> </ul>	<ul style="list-style-type: none"> <li>• Tie Downs on van are not operational</li> <li>• Hoyer Lift is broken</li> <li>• Wheel chair is not working</li> <li>• Lights are burned out in hallway making it difficult to maneuver</li> <li>• Harness/Seatbelt was not fastened</li> <li>• Food Processor is not available</li> </ul>

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## Causes and Contributing Factors Examples

MUI	Human	Process	Environment	Equipment
<b>NEGLECT</b>	<p><b>Staff Factors</b></p> <ul style="list-style-type: none"> <li>Staff fell asleep on their awake overnight because they had worked 20 consecutive hours</li> <li>Staff works two-three jobs with little rest</li> <li>Staff is not feeling well but came to work because no coverage</li> <li>Staff is distracted; texting while driving, talking on cell phone, having personal issues</li> <li>Staff is impaired</li> <li>Driving Recklessly</li> <li>Staff doesn't take action in a medical situation due to fear of doing something wrong</li> </ul> <p><b>Team Dynamics</b></p> <ul style="list-style-type: none"> <li>Team did not address individual's supervision</li> <li>Perceived lack of Management Support</li> <li>Poor Judgment</li> <li>Lack of Oversight by Management</li> <li>Staff dislike each other</li> </ul> <p><b>Communication</b></p> <ul style="list-style-type: none"> <li>There was confusion about what the diet was supposed to be</li> <li>Language Barrier</li> <li>Family instructed staff to do something differently than plan states</li> </ul>	<ul style="list-style-type: none"> <li>No agency limit on the amount of hours you can work in a row</li> <li>No system in place to make sure that staff are appropriately reporting</li> <li>Staff did not follow reporting policy</li> <li>No reliable system to ensure that notifications from Day Program and Home staff are made.</li> <li>Unclear what staff/natural supports are to provide</li> </ul>	<ul style="list-style-type: none"> <li>Individual engages in hoarding behaviors, home is unsafe-no one acts on this information</li> <li>Family home poses a health and safety risk due to animal feces, bugs, no running water, and unsanitary conditions.</li> </ul>	<ul style="list-style-type: none"> <li>Bed Alarm was not utilized</li> <li>Car seat not secured</li> <li>Back up wheelchair is not outfitted with a safety belt</li> </ul>

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## Neglect Prevention Plan

- Separation of family/staff (PPI)/ individual during investigation.
- Immediate medical assessment (as applicable).
- Disciplinary action for specific offense.
- Staff training – **ISP** (supervision levels, treatment requirements).
- Special Team Meetings with recommendations.
- Guardian/family notification/feedback.
- Specify who is responsible for what follow-up (evaluation, team meeting, staff training, revising the ISP, etc.).

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## Causes and Contributing Factors Examples

MUI	Human	Process	Environment	Equipment
<b>MISAPPROPRIATION</b>	<ul style="list-style-type: none"> <li>Individual's family is payee and has access to large lump sum payment with no oversight</li> <li>Home Manager is well trusted and therefore no one sees need to provide additional oversight</li> <li>Eight people have keys to the Individual's home</li> <li>Family/Staff has addiction to medication and was taking from individual for personal use</li> <li>Staff person was given debit card to shop for the individual</li> <li>Several people have access to Food Stamp Card</li> <li>Individual has lots of friends and family who come in and out of her home who have access to belongings</li> <li>Individual wants staff to like them agrees to sell their PlayStation for \$5.</li> </ul>	<ul style="list-style-type: none"> <li>Home Manager is the only one with access to individual funds</li> <li>There is no policy that large purchases are verified</li> <li>There is no company policy to address what to do when a staff person separates from the agency and still has keys or access to individual's belongings/accounts</li> <li>Agency doesn't have Code of Ethics that addresses borrowing funds or property from individuals</li> <li>Narcotic Counts are not being conducted</li> <li>No routine verification of individual funds</li> <li>Change of address did not occur</li> </ul>	<ul style="list-style-type: none"> <li>Individual's Personal records are all over the home and many people have access to them, placing them at risk for identity theft</li> <li>Garage was often left unlocked</li> <li>Money was left in an unlocked drawer in a desk at the Day Hab Site</li> <li>Gift Cards were left on kitchen table and not secured</li> </ul>	<ul style="list-style-type: none"> <li>I pad was always left out and so it went unnoticed when it went missing</li> <li>Lock on Safe was broken</li> <li>Key to Lock box is kept on the refrigerator</li> </ul>

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## Misappropriation Prevention Plan

- Has a system problem been identified?
  - Locking the lockbox
  - Keys to the home
  - Lack of accounting for funds used
  - Accessibility of funds to numerous people
- Have outcomes been reviewed for all homes, not just the one identified in the MUI?
- Administrative oversight/review of system.
- Are policies/procedures revised as a result of these changes?

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## Causes and Contributing Factors Examples

MUI	Human	Process	Environment	Equipment
<b>ABUSE</b>	<ul style="list-style-type: none"> <li>• Staff was overwhelmed by responsibilities</li> <li>• History of Domestic Violence</li> <li>• Abuser is impaired</li> <li>• Staff are embarrassed when individual has an outburst in public</li> <li>• Staff has worked 20 hours straight</li> <li>• Control Issues</li> <li>• Lack of value and positive culture training</li> <li>• Abuser does not have empathy for the individual being served</li> <li>• Individual has poor relationship with neighbors which leads to physical altercations</li> <li>• Individual refuses to be "complainant"</li> </ul>	<ul style="list-style-type: none"> <li>• No real mentoring or on the job shadowing</li> <li>• Lack of reporting due to retaliation by co-workers</li> <li>• Staff unclear who to call if they have a concern with their supervisor</li> <li>• Agency doesn't have a solid system for supporting staff</li> </ul>	<ul style="list-style-type: none"> <li>• Staff work by themselves and may feel isolated</li> <li>• Staff works with a group of unhappy workers which has created a culture where people are constantly looking for the worst in each other</li> </ul>	<ul style="list-style-type: none"> <li>• Wheel chair is not functioning which causes frustration</li> </ul>

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## Physical Abuse Prevention Plan

### Immediate Action and Prevention:

- Separation of family/staff (PPI) from individual.
- Immediate medical assessment (as applicable).
- LE and CSB Notifications
- Counseling for the individual victim.



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## Physical Abuse Prevention Plan

### Immediate Action and Prevention:

- Training on crisis intervention COPE, PACES.
- Monitoring of staff providing services
- Special team meetings to get team input into support for the victim/peer (if consumer)
- Education for all staff indicating that physical abuse will not be tolerated
- Discussion of Abuser Registry/outcomes

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## Sexual Abuse Prevention Plan

### Immediate Actions

- Get the individual appropriate medical attention.
- Take immediate action to protect the person from further assault
- Report immediately to law enforcement or CSB
- Report to the County Board immediately but within 4 hours
- Sexual assault assessment, when appropriate, should be sought immediately.
- Remember to NOT imply blame on the victim.

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# Sexual Abuse Prevention Plan

## Immediate Actions

- **Take action** if an individual communicates that he or she has been abused.
- Do not ignore or dismiss any such reports regardless of whether or not they appear plausible. The proper authorities will determine what occurred.
- **Report according to O.A.C. 5123:2-17-02 to Law Enforcement or CSB immediately. Reports to County Board should immediate but within 4 hours. Immediately protect the individual from continued contact with the Primary Person Involved (PPI).** If the PPI is a staff member, the staff member should be removed from a position of direct contact with individuals. If the alleged PPI is someone other than staff, necessary precautions should be taken to protect others who may be at risk.

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# Sexual Abuse Prevention Plan

## Immediate Actions

- Ask questions like “Were you able to...?” instead of “Why didn’t you?” when talking to the individual.
- Emotionally support the alleged victim
- Remember to refer the individual for counseling and victim’s assistance as appropriate.
- Notify DODD MUI Unit if the alleged PPI is a County Board Employee. Screen the individual for pregnancy and/or sexually transmitted disease.

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## Verbal Abuse Prevention Plan

- Separation of family/staff/(PPI) from individual.
- Counseling, if necessary, for the individual victim.
- Training on crisis intervention, sensitivity training for employees
- Administrative oversight/monitoring of staff interventions.
- Special team meeting to get team input into the supports for the peer/victim (if consumer).
- Education of all staff indicating verbal abuse will not be tolerated.

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## Causes and Contributing Factors Examples

MUI	Human	Process	Environment	Equipment
<b>PEER TO PEER ACTS</b>	<p><b>Staff Factors</b></p> <ul style="list-style-type: none"> <li>• Supervision level not followed</li> </ul> <p><b>Team Dynamics</b></p> <ul style="list-style-type: none"> <li>• Staff have favorites</li> <li>• Guardian does not want to address individual's sexuality or safe ways for individual to meet their sexual needs</li> </ul> <p><b>Training</b></p> <ul style="list-style-type: none"> <li>• Behavior Plan Not Implemented</li> <li>• Staff not Trained on Supervision</li> </ul> <p><b>Communication</b></p> <ul style="list-style-type: none"> <li>• Individual is unable to communicate</li> <li>• Team isn't aware of individual's history (stealing, offending or physical aggression)</li> </ul> <p><b>Individual Factors</b></p> <ul style="list-style-type: none"> <li>• Roommates incompatible</li> <li>• Individual may be trying to get attention from staff</li> <li>• No appropriate ways to meet sexual needs.</li> <li>• One of the individuals may have more family contact and this causes rift with roommate who does not.</li> <li>• One individual is given items and gifts from family and these items may be taken from roommate.</li> <li>• Lack of meaningful personal relationships</li> </ul>	<ul style="list-style-type: none"> <li>• Change in Routine</li> <li>• Provider does not have a procedure for reviewing incidents with staff (debriefing)</li> <li>• There is no accurate/updated inventory and so items go missing are unnoticed</li> </ul>	<ul style="list-style-type: none"> <li>• Peers live together, ride the bus together and work together</li> <li>• Individual's belongings not secured</li> <li>• Individual does not have opportunity to have alone time</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of Electronic Items; maybe 1 TV in the home</li> <li>• Alarms not functional</li> <li>• Staff do not test equipment to make sure it is functioning. I.e. batteries are not working and alarm not functioning</li> </ul>

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## Peer to Peer Acts Prevention Plan

- Assess living arrangement of peers involved in physical abuse; any patterns, appropriateness of roommate selections.
- Is the BSP appropriate/interventions understood?
- Is supervision maintained/appropriate?
- Training interventions, program revisions for peers involved in verbal act of one another.
- Assess the placement situation.
  - Are the individuals compatible?
  - Is the placement a nice fit for those involved?
  - Is the guardian included in discussions
  - Does there continue to be unresolved health/safety issues?

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## Causes and Contributing Factors Examples

MUI	Human	Process	Environment	Equipment
<b>SIGNIFICANT INJURY-FALL</b>	<p><b>Staff Factors</b></p> <ul style="list-style-type: none"> <li>• Staff rushing to get the individual somewhere</li> <li>• Staff ask other individuals to help peer with walking and dressing</li> <li>• Not providing level of support in kitchen or bath which results in burns</li> </ul> <p><b>Team Dynamics</b></p> <ul style="list-style-type: none"> <li>• Staff may have own mobility issues or barriers that enable them to assist individuals</li> </ul> <p><b>Communication</b></p> <ul style="list-style-type: none"> <li>• <i>There is a lack of communication about what happened on previous shift</i></li> </ul> <p><b>Training</b></p> <ul style="list-style-type: none"> <li>• Staff not trained on adaptive equipment which could lead to falls</li> <li>• Not trained on level of assistance needed</li> </ul> <p><b>Individuals</b></p> <ul style="list-style-type: none"> <li>• Individual refuse adaptive equipment such as helmet, walker, wheelchair, cane contributing to unsteady gait and higher risk for injury</li> <li>• Individuals losing balance and vision due to aging or disability</li> </ul>	<ul style="list-style-type: none"> <li>• There is no procedure of who is to clear walkways during inclement weather</li> <li>• Agency does not link with OT and PTs to evaluate an individuals environment for safety</li> <li>• Assessing individual needs i.e. need for bedrails, handrails, shower chair, lifts and other adaptive equipment</li> <li>• Staff working do not call for assistance when someone has fallen and they cannot get person up. The individual is left lying on the floor for hours.</li> </ul>	<ul style="list-style-type: none"> <li>• Low Lighting</li> <li>• Change in Flooring that could cause trip hazards</li> <li>• Rugs that slip easily</li> <li>• Rain, snow, ice</li> <li>• Walk way not clear</li> <li>• Carrying objects while going down stairs that may limit visibility</li> <li>• Not using hand rails</li> </ul>	<ul style="list-style-type: none"> <li>• Adaptive Equipment not provided</li> <li>• Bed or Chair Alarm malfunctioned</li> <li>• Staff do not test equipment to make sure it is functioning. i.e. batteries are not working and alarm not functioning</li> <li>• No anti-scald valves</li> <li>• Malfunctioning water heater</li> <li>• Whirlpool tub not functioning</li> </ul>

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## Significant Injury (Unknown) Prevention Plan

- Has the source of the injury been identified?
- Are there suspicions as to how the injury occurred?
- Has the environment been modified to address the source of the injury? (Actual/suspected); (coffee table, corner of bed, light fixture, etc.) e.g., bruises match up to the corner of the coffee table, etc.

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### Causes and Contributing Factors Examples

MUI	Human	Process	Environment	Equipment
<b>UNAPPROVED BEHAVIOR SUPPORT</b>	<p><b>Staff Factors</b></p> <ul style="list-style-type: none"> <li>• Control Issues</li> <li>• Power Struggle</li> <li>• Staff take a "Parental Role"</li> <li>• Staff are afraid for their safety and for the safety of others</li> <li>• Staff incompatible</li> </ul> <p><b>Team Dynamics</b></p> <ul style="list-style-type: none"> <li>• Lack of relationship with individual</li> <li>• Individual has lack of control in lives</li> </ul> <p><b>Communication</b></p> <ul style="list-style-type: none"> <li>• There is a lack of communication between shifts and work about the person's day when maybe giving person time/space could avoid frustration for all</li> <li>• Lack of respectful communication</li> <li>• Individual unable to communicate feelings</li> </ul> <p><b>Training</b></p> <ul style="list-style-type: none"> <li>• Staff are not trained on Positive Interventions and Less Restrictive Interventions</li> <li>• Staff are not trained on Mental Health Symptoms</li> <li>• View everything as a "behavior"</li> </ul>	<ul style="list-style-type: none"> <li>• Provider does not have a procedure for reviewing incidents with staff (debriefing)</li> <li>• Change in Routine</li> <li>• Lack of Agency training program on specific syndromes and diagnosis which would enable them to understand/empathize better with those they serve</li> </ul>	<ul style="list-style-type: none"> <li>• Peers live together, ride the bus together and work together</li> <li>• Lack of space for individuals to get away in their own home</li> <li>• Loud Noises</li> <li>• Lots of other people in environment like workshop or day program</li> <li>• Unsafe Environment-close to street and traffic</li> </ul>	<ul style="list-style-type: none"> <li>• Alarms not functional</li> <li>• Staff do not test equipment to make sure it is functioning. I.e. batteries are not working and alarm not functioning</li> <li>• Safety Locks not engaged in car per plan</li> </ul>

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## **Unapproved Behavior Support Prevention Plan**

- Are staff trained appropriately in crisis intervention?
- Are the behavior plan/interventions addressing the problematic behaviors?
- Are staff trained on the plan? If not, who is responsible and when will it be done?
- Has a risk assessment been conducted regarding the intervention techniques?

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## **Unapproved Behavior Support Prevention Plan**

- Has a physician reviewed the program for any intervention that may be contraindicated?
- Is a plan necessary to address the behavior?
- Is a revision to a current plan required?
- Has a team meeting been held? Are there any outcomes? Who, what, when? Be specific and include timeframes and deadlines.

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## Causes and Contributing Factors Examples

MUI	Human	Process	Environment	Equipment
<b>MISSING PERSON</b>	<p><b>Staff Factors</b></p> <ul style="list-style-type: none"> <li>Inattentive staff</li> </ul> <p><b>Team Dynamics</b></p> <ul style="list-style-type: none"> <li>Lack of relationship with individual</li> <li>Lack of activities</li> <li>Individual has lack of control in lives</li> </ul> <p><b>Communication</b></p> <ul style="list-style-type: none"> <li>Lack of respectful communication</li> <li>Individual unable to communicate feelings</li> </ul> <p><b>Training</b></p> <ul style="list-style-type: none"> <li>Staff are not trained on individual's supervision level</li> </ul>	<ul style="list-style-type: none"> <li>There is no process for handing off/assigning staff to certain individuals</li> </ul>	<ul style="list-style-type: none"> <li>Staff are responsible for large areas and cannot adequately monitor</li> <li>Staff to individual ratio in community</li> </ul>	<ul style="list-style-type: none"> <li>Alarms not functional</li> <li>Staff do not test equipment to make sure it is functioning. i.e. batteries are not working and alarm not functioning</li> </ul>

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## Missing Person Prevention Plan

- Have supervision levels been addressed? Are they appropriate?
- What are the risk factors? How is the team addressing the absence to avoid future situations like this?
- Is the person really missing? Are adjustments required to the ISP regarding community involvement? This is clearly related to the risk/analysis.

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## Verification of a Prevention Plan Examples

Verification was received that indicated that the following preventative measures have been put in place:

- The provider spoke with the alarm company and was able to get the master code changed.
- All codes for the house alarm were deactivated and new codes for current staff in the home were set on 6-2-15.
- Staff were directed not to share their alarm codes with anyone.
- The key to the home was placed in a different spot.
- The PPI no longer works for the provider and no longer has access to the home and individual funds/property.
- The individual's money was reimbursed by the company on 6-15-15. The other items stolen have been replaced. A detailed record is maintained in each individual's file.

## Verification of a Prevention Plan Examples

ICF Summary:

- Staff A to receive corrective action and retraining on seatbelt safety.
- All staff to be retrained on seatbelt safety.
- ICF is to receive report from Occupational Therapy and implement.
- Update Care tracker profile that seatbelt needs to be fastened while in the wheelchair.

All the recommendations below have been completed.

- Staff A received her corrective action and retraining on 7/25/15.
- All staff received seatbelt safety on 07/27/15
- Received current O.T. report on 07/23/15
- Team meeting scheduled 7/24/15 to discuss OT recommendations and how to implement.
- Profile was changed on 07/27/15."

## Test Your Knowledge

### 1. When Should Prevention Planning begin?

- A. Immediately Following the Incident
- B. Only After the Investigation has been completed
- C. After the MUI has been closed
- D. When Chuck Davis says

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## Test Your Knowledge

### 2. Who Develops the Prevention Plan?

- A. The County Board or COG
- B. The Provider
- C. The Individual and guardian (if applicable)
- D. The individual's team including the County Board and provider

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## Test Your Knowledge

### 3. Prevention Plans...

- A. Create More Work for Everyone
- B. Always Require a Special Team Meeting
- C. Place Blame
- D. Prevent or minimize future adverse incidents or even close calls

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## Best Resources/References

- People that know the individual best (family, friends, direct care professional)
- Experts (Self-Advocates, Physicians, Psychiatrist, Speech Therapist, Occupational Therapist, Counselors, Etc.)
- Provider Community
- Local County Boards
- DODD's website [dodd.ohio.gov](http://dodd.ohio.gov)
  - SSA Work Space*
  - Health and Safety Tool Kit*
  - Health and Welfare Alerts*
  - Behavior Support Strategies Work Space*
- Steady U <http://aging.ohio.gov/steadyU/>
- U.S. Department of Veterans Affairs  
[www.patientsafety.va.gov/professionals/onthejob/rca.asp](http://www.patientsafety.va.gov/professionals/onthejob/rca.asp)
- Trauma Informed Care
- <http://mha.ohio.gov/Portals/0/assets/Initiatives/TIC/Disabilities/Health%20challenges%20facing%20Ohioans%20with%20disabilities.pdf>

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## Questions and Answer Session



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