



Department of
Developmental Disabilities

Office of MUI/Registry Unit

Ted Strickland, Governor
John L. Martin, Director

Health & Safety Alert #01-02-07

Safely Transporting Individuals Who Use Wheelchairs

The purpose of this Alert is to increase the awareness of staff and administrators responsible for transporting individuals who use wheelchairs.

Injury can occur when a person hits something, something hits the person, or the person is ejected from their seat. At an impact speed of 30 mph, the front of the vehicle comes to a complete stop within one tenth of a second, but unrestrained occupants and objects continue to move toward the point of the crash at 30 mph. It becomes critical; therefore, that your professionals or key staff develop good safety guidelines and all staff pay close attention to ensure the guidelines are being followed.

Basic Safety Steps

1. Ensure the person's seatbelt and any other wheelchair straps are secured.
2. Check seating and position straps to make sure they are not pressing on sensitive areas where there are shunts, G-tubes, etc.
3. Ensure that the wheelchair is properly secured in the vehicle.
4. Check the strap, clips, locks, and other securing items for damage or improper working order.
5. Ensure staff assignments are clearly identified as to who is responsible for securing and checking.
6. Ensure staff are properly trained and can demonstrate a proficiency of securing individuals and wheelchairs in vehicles.
7. Do not transport individuals with a lap tray on the wheelchair.
8. Be sure the individual's head and neck are protected from whiplash.
9. Do not transport in a tilted or reclined position.
10. Put anti-tippers down during transport, if available
11. Do not transport someone in a side-facing position.

For questions or comments regarding the above Alert, please contact the MUI/Registry Unit at (614) 995-3810.

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Health & Safety Alert #2-05-11

**Keeping Safe in the Summer
Part II**



**TOO MUCH SUN CAN CAUSE SUNBURN,
DEHYDRATION, AND SUN/HEAT STROKE.
ALL ARE PREVENTABLE WITH A LITTLE CARE!**

WHAT IS A SUNBURN?

A sunburn is a painful skin condition, which occurs as a result of over exposure to the ultraviolet rays of the sun.

THE RISK OF SUNBURN IS HIGHER FOR:

- ❖ Persons with fair skin, blue eyes, and red or blonde hair;
- ❖ Persons taking some types of medications (check with the Doctor);
- ❖ Persons exposed to a lot of outdoors sunlight; and
- ❖ Persons whose skin is already compromised



PREVENTION:

- ❖ Avoid the sun between 10 AM and 4 PM
- ❖ Protect the skin using sun block with a sun protection factor (SPF) of 15 or more: the lighter the skin, the higher the SPF should be. Apply sun block 15 – 30 minutes before going in the sun and every 1 to 1 ½ hours thereafter
- ❖ Use a lip balm with sunscreen in it
- ❖ Wear muted colors such as tan

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- ❖ Wear a hat (the looser the better) especially if hair is thin on top!
- ❖ Wear sunglasses that absorb at least 90% UV rays (check the label on sunglasses)
- ❖ Clouds and particulate matter in the air scatter sunlight. You can receive a "surprise sunburn" even on a cloudy day!
- ❖ Come in out of the sun when you first start to notice that your skin is getting pink

WHAT IS DEHYDRATION?

Dehydration is the loss of body fluids and electrolytes due to profuse sweating and inadequate intake of water. Alcohol consumption aggravates dehydration.

SIGNS OF DEHYDRATION INCLUDE:

- ❖ Heat exhaustion
- ❖ Headaches
- ❖ Nausea and/or vomiting
- ❖ Fainting
- ❖ Blurred vision
- ❖ Confusion
- ❖ Urine output decreases & becomes concentrated and appears dark
- ❖ Sunken eyes
- ❖ Wrinkled or saggy skin – elasticity decreases
- ❖ Extreme dryness in the mouth
- ❖ Fever or temperature over 102 degrees
- ❖ Severe pain or blistering of skin



IF DEHYDRATION IS SUSPECTED, REHYDRATION IS THE KEY TO PREVENTING FURTHER COMPLICATIONS. REMEMBER TO DRINK LOTS OF FLUIDS!

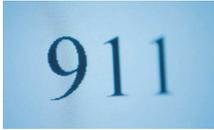
WHAT IS SUN STROKE OR HEAT STROKE?

Sun/heat stroke is a serious life-threatening condition. It is the consequence of a series of events:

It begins with dehydration. (Also usually a lack of sweating)

- ❖ As the core body temperature rises, heat exhaustion becomes more serious.

- ❖ **If not rectified quickly, heat stroke is the final shutdown of the body's organs from lack of these vital fluids and nutrients, and can lead to delirium, coma, and death!**



**IF SUN/HEAT STROKE IS SUSPECTED,
GET EMERGENCY MEDICAL ATTENTION
IMMEDIATELY!**



Risk factors for heat related illnesses

- ❖ Elderly, chronically ill or incapacitating illness, very young
 - Chronic medical conditions include cardiac (heart) disease, hypertension (high blood pressure), obesity, diabetes, kidney and lung disease
- ❖ Poor physical conditioning
- ❖ High environmental temperature and humidity
- ❖ Poor ventilation or cooling in buildings
- ❖ Poor fluid intake
- ❖ Alcohol use (increases fluid loss)
- ❖ Medications that inhibit perspiration or increase fluid loss, including:
 - Those used to treat movement disorders (antiparkinsonian drugs, including Cogentin)
 - Those used to treat allergies (antihistamines such as Benadryl [diphenhydramine])
 - Diuretics (water pills) such as Lasix (furosimide), bumetanide, hydrochlorothiazide
 - Those used to treat psychiatric conditions including, but not limited to:
 - Clozaril (clozapine)
 - Compazine (prochlorperazine)
 - Elavil, Limbitrol, Triavil (amitriptyline)
 - Haldol (haloperidol)
 - Loxitane (loxapine)
 - Phenergan (promethazine)
 - Seroquel (quetiapine)
 - Wellbutrin (bupropion)
 - Zyprexa (olanzapine)

“KEEP COOL THIS SUMMER”

Help avoid heat related illnesses

- ❖ Maintain hydration with cool water and sports drinks; provide extra fluids at meal times
- ❖ Drink at least 8 glasses of water a day, more in hot weather
- ❖ Avoid caffeinated beverages and alcohol (both increase fluid loss)
- ❖ When outdoors, seek open, shaded areas, avoid crowds
- ❖ Use fans and air conditioning indoors
- ❖ Open windows at night when air is cooler outside to allow cross ventilation if no air conditioning
- ❖ During heat of the day, keep blinds drawn and windows shut, and move to cooler rooms
- ❖ If no air conditioning at home, go to a shopping mall or public library
- ❖ Take frequent breaks when outside in hot sun or from physical activity
- ❖ Wear light-colored loose-fitting clothing (dark colors absorb heat, loose clothing helps the body to cool); wear a hat and sun glasses
- ❖ Eat regular light meals to ensure you have adequate salt and fluids
- ❖ Take a cool shower or bath
- ❖ Be aware of individuals with risk factors for heat related illness; observe them at regular intervals.

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REISSUED: May 2011



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Health & Safety Alert #02-05-11

**Keeping Safe in the Summer
Part I**



**SUMMER SUN MEANS FUN
BUT**



FOOD POISONING

Those great picnics in the sun can be the cause of a trip to the hospital because of food that is eaten. Be sure to refrigerate all food; don't let any of it sit in the sun! **Use the two-hour rule – Discard food that has been left out of a refrigerator or well-chilled ice chest longer than two hours.** Your Mother was right – wash your hands! Be sure food is served on clean plates and use clean utensils. Cover your food; insects can spread diseases. **Remember: "When in doubt, throw it out!"**



CREEPY CRAWLERS & FLYING CRITTERS

Bees, wasps & hornets can cause medical emergencies if they sting – **know whether anyone is allergic and be prepared ~ know the protocol that must be followed!** For everyone else, it is important to remove the stinger promptly. Use a flat edge, such as a credit card, to scrape it from the place it is imbedded. Wash and apply ice. **Deer ticks** are tiny insects that live in low brush and can spread Lyme disease. Be sure to use insect repellent with DEET in it (the higher the amount, the more protection) when out and about. If a tick becomes attached – get medical help immediately! Usually, a Lyme disease carrying tick has to be attached for at least 24 hours to spread the disease.

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WEST NILE VIRUS

West Nile Virus (WNV) was first diagnosed in 1999 in New York City and has since spread across the country more quickly than expected. It is primarily a disease of birds. It grows inside an infected bird and is spread to other birds, animals, and people through mosquito bites. Be sure to use insect repellent with DEET in it, when out and about. Spray not only exposed areas, but clothing also. Wearing long sleeved clothing and pants help protect the person. **Hint: If the mosquitoes are chasing you, use insect spray and wear light clothing – mosquitoes prefer dark colors.**



WATER SAFETY RULES

- Assess each individual's capabilities and needs for different water areas, such as pools, rivers, or the ocean.
- Assess staff's capabilities in responding to water safety needs.
- Someone should always be designated as a "life guard" to keep watch for any problems.
- Do not chew gum or eat while swimming as you could easily choke.
- Use caution when swimming after a large meal.
- Make sure the person you are supporting is using an approved life jacket or other flotation device if needed.
- **Watch out for the "Dangerous TOO's" ~ TOO tired, TOO cold, TOO far from safety, TOO much sun, TOO much strenuous activity.**



SUMMER CAMPS

Proper planning is important when individuals are attending camp. The following steps may assist with ensuring an enjoyable experience:

- Be familiar with the camp and possible dangers for the individual(s) attending.
- Know who will be supervising the individual and what experience they have. Be sure you are comfortable with what will be occurring.
- Communicate face-to-face with the camp director on any dietary requirement, supervision requirements, medical needs, or behavior issues. Provide a written copy of the information needed (e.g. ISP, Behavior Plan, etc.).
- Be sure lotion for sunburn and bug bites is provided or available. Be aware of any medications that increase a person's sensitivity to the sun and communicate this to the camp staff.
- If there is a pond, lake, or pool discuss the individual's abilities in the water with the camp director and any special needs that exist. Provide a written copy of those needs.
- Be aware of the camp activities and how they match with the individual's physical or health needs.



BAREFOOT/SANDALS

- Be mindful of potential injuries when going barefoot or wearing sandals



OUTDOOR GRILLS

Outdoor grills can result in burns if proper safety requirements and supervision are not provided and followed.

- Be sure lid is open before lighting a gas grill.
- Don't squeeze extra fire starter on coals when they are already burning.
- Check grills for proper working order.
- Supervise individuals closely when grilling.

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REISSUED: MAY 2011



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Health & Safety Alert #03-11-02

Notification of Coroner/Autopsies

This alert is to inform families and people who work in this field about issues that impact the health and safety of people for whom we provide services.

Notification of Coroner / Autopsies

Situation: Several recent situations arose where there was confusion as to whether an autopsy should be requested. This alert is to provide information on when it is expected that an autopsy will be completed.

Alert: The most relevant piece of statute appears to be Ohio Revised Code 313.12, which governs notice to the coroner of any violent, suspicious, unusual or sudden death. The precise language of that statute states:

When any person dies as a result of criminal or other violent means, by casualty, by suicide, or in any suspicious or unusual manner, or when any person, including a child under two years of age dies suddenly when in apparent good health, the physician called in attendance, or any member of an ambulance service, emergency squad, or law enforcement agency who obtains knowledge thereof arising from his/her duties, shall immediately notify the office of the coroner of the known facts concerning the time, place, manner and circumstances of the death, and any other information which is required pursuant to Section 313.01 to 313.22 of the ORC. In such cases, if a request is made for cremation, the funeral director called in attendance shall immediately notify the coroner.

The Ohio State Coroners Association web site (<http://www.osca.net/generalinfo.asp>) lists types of death reportable to the coroner's office: accidental, homicidal, suicidal, occupational, sudden deaths, therapeutic deaths, deaths occurring under special circumstances, or any death where there is a doubt, question, or suspicion. This web site also provides information on how to report a death to the coroner's office. Persons other than physicians, members of ambulance or emergency squads, or law enforcement personnel may report deaths. *Call the coroner's office if you are uncertain if a death has*

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been reported to the coroner's office, or you feel the death should be reported to the coroner's office.

For a death which the coroner has ruled as not a “coroner’s case” (e.g., no foul play suspected and evidence of a natural death is present) there are circumstances in which an autopsy may prove beneficial. These include, but may not be limited to, a sudden unexplained death, particularly in a young person; those situations in which surviving family members’ health and longevity may be improved by investigating for a cause of death which may be genetically related; and legitimate medical inquiry.

The Ohio Revised Code (ORC) Section 2108.50 governs the question of who may consent to an autopsy. Generally a licensed physician or surgeon may perform an autopsy with the written consent of the individual or any close relative, with preference to the closest surviving relative’s wishes. 2111.13 provides for the guardian of the person to consent to an autopsy. Section 2108.51 provides immunity from liability to a surgeon who acts in good faith based upon written consent to an autopsy. However, no consent is necessary when the autopsy is ordered by the coroner. See ORC 2111.13 regarding the guardian of the person to consent to an autopsy. *Note: See exceptions in ORC 313.131, regarding religious beliefs.*

For questions or comments regarding the above Alert, please contact the MUI/Registry Unit at (614) 995-3810.

January 2004



Health & Safety Alert #04-01-05

Actions Needed Following the Death of a Consumer

This Alert has been significantly revised and replaces Alert#: 02-09-18 entitled, *Actions Needed Following the Death of a Consumer*. The major change relates to what information is required if the individual resided in a facility where the Ohio Department of Health (ODH) has jurisdiction, if the person lived at home with their family or if the person died of cancer or were in a hospice program at the time of their death.

All deaths of individuals with Developmental Disabilities in our system will continue to be reviewed; however, the Mortality Review Committee will focus more on those individuals served by the Department of Developmental Disabilities employees. Through this process, we will continue to identify system issues and individual-specific issues that will assist in continuing to improve the care of persons with Developmental Disabilities. Please note that in any situation where abuse/neglect is alleged or concerns are expressed by the family, county board, provider or Department, additional information identified in (D) of this alert will be required.

Following is a listing of what is required to be reported based upon the circumstances outlined:

- A. Individuals whose residence was with entities under the jurisdiction of ODH (Nursing Homes, ICFs/MR not licensed by the Ohio Department of Developmental Disabilities):
 1. Copy of the death certificate.
 2. Location of death (e.g., emergency room, hospital inpatient, home, nursing home).
 3. Whether the death was expected or unexpected.
 4. Provide reason death was reported to the Department of Developmental Disabilities (DODD). (What services were being provided?).

- B. Cases involving children and adults who live at home and who had access to health care and died in a hospital. (Access to health care is defined as having access to a primary care physician or advanced practice nurse on some recurring basis--at least annually.) Note that there is a statutory requirement (ORC 307.621) for all children less than 18 years of age to be reviewed by local counties.

1. Copy of death certificate.
2. Location of death (e.g., emergency room, hospital inpatient, home, nursing home).
3. Whether the death was expected or unexpected.
4. Enter a narrative on the Incident Tracking System (ITS) regarding the circumstances surrounding the death whenever possible. This would include whatever occurred during the 72 hours prior to the hospitalization (e.g., events, activities).

C. Persons who died of cancer or were in a hospice program at the time of death:

1. Copy of death certificate.
2. Location of death (e.g., emergency room, hospital inpatient, home, nursing home).
3. Indicate if DNR order in effect; type of DNR order (DNR Comfort Care, DNR Comfort Care-Arrest, other), reason for DNR order, and involvement of individual/guardian in obtaining the DNR order.
4. Enter into the ITS pertinent past medical treatment indicating health care screening that was conducted and dates and results of health care screenings (cancer screenings).

D. All other deaths not covered in the above categories:

1. Copy of death certificate.
2. Copy of autopsy (if done).
3. A copy of the Coroner's verdict page or ruling in cases where the Coroner ruled on the cause of death but no autopsy was done.
4. Outcome of law enforcement investigation (when they are involved).
5. Location of death (e.g., emergency room, hospital inpatient, home, nursing home).
6. Whether the death was expected or unexpected.
7. Enter on ITS the medical diagnoses prior to death.
8. Enter on ITS the psychiatric diagnoses prior to death.
9. Enter on ITS the medications individual was taking prior to death or hospitalization (if died in a hospital).
10. Enter on ITS pertinent past medical history (e.g., surgeries, recent treatments, illness, and chronic medical problems).
11. Enter on ITS A narrative on the circumstances surrounding the death. This would include whatever occurred during the 72 hours prior to the hospitalization (e.g., events, activities).
12. Name of primary physician.
13. Indicate if DNR order is in effect, type of DNR order (DNR Comfort Care, DNR Comfort Care-Arrest, other), reason for DNR order, and involvement of individual/guardian in obtaining the DNR order.
14. Enter on ITS a list of services that the person received if unable to answer or provide information relative to number 5 through 13.

Reminder: All deaths of persons with Developmental Disabilities are to be reported to the Coroner by the attending physician, EMS staff and involved law enforcement officers. It is important to ensure that this is done.

For questions or comments regarding the above Alert, please contact the MUI/Registry Unit at (614) 995-3810.



Health & Safety Alert #05-01-02

Moving Adult Individuals Away from Abuse/Neglect

Immediate health and safety issues surround cases where an individual with MRDD is being allegedly abused or neglected. One of the standard responses is to separate the alleged individual victim and the primary person involved (suspect). This is necessary in every situation with immediate jeopardy to ensure the health and safety of the individual, even those allegations that will most likely later on turn out to be unfounded. There are several ways in which to separate the alleged victim and the suspect. One way is to remove the suspect from the area during the time of the investigation. This is commonly referred to as administrative leave. A second way is to assign duties to the suspect that do not involve contact with individuals.

There are certain times in which removing the primary person involved (suspect) will not be an option. For example, the suspect provides a home for the individual or the alleged abuse or neglect is a systemic problem with the provider as a whole. In situations like these the individual with MRDD should be removed from the environment where the abuse or neglect has been alleged or proven. The individual could be served by an immediate temporary respite.

Ohio Revised Code (ORC) Sections 5126.31 and 5126.33 provide for the situations in which it is necessary for an adult individual with MRDD to leave their home. The steps needed to help someone move will be different based on whether the individual or the individual's guardian consents to the move. The individual still has the capacity to consent to the move even if they have been found incompetent ORC under Chapter 2111 of the ORC. If the individual or their guardian refuses to move or withdraws their consent, a complaint must be filed with the Probate Court. A complaint must also be filed if the individual has no guardian and lacks the capacity to consent to the move. A description of the two methods follows.

Method #1 – Consent of the Individual or the Individual's Guardian - ORC 5126.31

Step #1: Obtain the consent of the individual or the individual's guardian.

- Step #2: Provide temporary respite as needed to ensure health and safety.
- Step #3: If a more permanent move would require expenditures by ODMRDD or the county board, receive approval from the Department or the county board.
- Step #4: Individual's Service Plan is revised in keeping with emergency placement options.
- Step #5: Individual moves to the new residence.

Please note an additional option is available to remove an individual from a licensed facility when there is an immediate danger of physical or psychological harm and the individual/guardian consents. ORC section 5123.19(D) and Ohio Administrative Code section 5123:2-3-16 provide a process for the county board to file an MUI and seek an order from the Director to remove an individual(s) from

a dangerous situation. This option is most appropriate where there is a systemic problem with the provider and all of the individuals residing at the facility share the same risk.

Method #2 – No Consent from either Individual or Individual's guardian; Individual has no guardian and lacks capacity to consent; Consent is withdrawn by either individual or individual's guardian - Court Order is Obtained – ORC 5126.33

- Step #1: Individual or individual's guardian withdraws consent or refuses to move from the home or individual has no guardian and lacks capacity to consent.
- Step #2: A complaint is filed with the Probate Court in the county in which the individual resides seeking the court to intervene and order an alternative placement. The document must include:
- Name, age and address of individual.
 - Facts describing nature of abuse and neglect.
 - Facts supporting the county board's belief that services are needed.
 - Proposed services set forth in the ISP.
 - Facts showing the county board's attempts to obtain consent of individual or the individual's guardian.
- Step #3: Give notice to the individual, individual's caretaker, individual's legal counsel and the Ohio Legal Rights Services.
- Step #4: A court hearing is held at least 24 hours, but no later than 72 hours after the notice. The court must determine by clear and convincing evidence that the individual:
- Has been abused or neglected.

- Is incapacitated.
- Has a substantial risk of immediate physical harm or death.
- Has a need for the services.
- Has no one authorized by law or court order available or willing to consent.

Step #5: Standard for move from home ORC 5126.33(E):

If the court finds that all other options for meeting the adult's needs have been exhausted, it may order that the adult be removed from the adult's place of residence and placed in another residential setting. Before issuing that order, the court shall consider the adult's choice of residence and shall determine that the new residential setting is the least restrictive alternative available for meeting the adult's needs and is a place where the adult can obtain the necessary requirements for daily living in safety. The court shall not order an adult to a hospital or public hospital as defined in section 5122.01 or a state institution as defined in section 5123.01 or the Revised Code.

Step #6: The Court issues an order and the individual moves to a new residence.

Method #3 – Involuntary Civil Commitment – ORC 5123.71

While the Court cannot order an individual to a state institution (developmental center) pursuant to ORC 5126.33, a county board could utilize the process set forth in ORC 5123.71 for individuals that meet the criteria for involuntary civil commitment when such placement is the least restrictive alternative.

Method #4 – Immediate Removal by Law Enforcement to Protect from Further Injury or Abuse – ORC 5123.61(I)

An adult about whom a report of abuse or neglect is made may be removed from his/her residence by a law enforcement officer if the officer determines immediate removal is essential to protect the adult from further injury or abuse.

For questions or comments regarding the above Alert, please contact the MUI/Registry Unit at (614) 995-3810.

January 2002



Health & Safety Alert #06-02-02

Risk of Airway Obstruction in Prone Position

Risk of Airway Obstruction

Situation - A recent review of several cases showed that there is a risk of airway obstruction during therapeutic prone positioning for some individuals. These situations are identified in the alert. Please share this with staff providing services to individuals in your county, as well as health care staff, physical and occupational therapy staff and managers.

Alert - Risk of Airway Obstruction During Therapeutic Prone Positioning

- Individuals placed in a therapeutic prone position (e.g., treatment of contractures, postural drainage of lung) may suffer an obstruction of their airway if they are fully dependent on staff for positioning, or become fatigued, or have a seizure.
- No person who has epilepsy or who may quickly become unable to lift and reposition their head can be left unattended when placed in the prone position for therapeutic reasons.
- Visual contact with these individuals is to be maintained at all times while they are in the prone position for therapeutic reasons.

*Service Coordinators should ensure that potential safety issues are addressed in all settings.

For questions or comments regarding the above Alert, please contact the MUI/Registry Unit at (614) 995-3810.

February 2002

MUI Rule Definitions Interpretation

For questions call: 614-995-3810
 For Hotline call: 1-866-313-MRDD (6733)

Revised 8/3/07

MUI means the alleged, suspected or actual occurrence of an incident when there is reason to believe the health or safety of an individual may be adversely affected or an individual may be placed at a reasonable risk of harm.

For persons served by the Developmental Disabilities system, MUIs are filed in all cases of Abuse, Neglect, Exploitation, Misappropriation, Prohibited Sexual Relations, and Failure to Report. Other categories of MUIs are filed when the incident occurs with an Developmental Disabilities license or certified provider or in county board operated programs.

TYPE/ DEFINITION	PROBES	EXAMPLES
<p><u>Abuse</u></p> <p>Physical force that can reasonably be expected to result in physical harm or serious physical harm as defined in section 2901.01, through actions that include but are not limited to, hitting, slapping, pushing or throwing objects at an individual.</p>	<p>~The level of force could reasonably result in harm.</p> <p>~Law enforcement is contacted when the situation is an alleged crime.</p>	<p>~The care provider allegedly slaps the individual in the face leaving a red mark.</p> <p>~Staff pulls the individual's arm behind the individual's back, dislocating the individual's shoulder.</p> <p>~The individual was held under water for about a minute.</p> <p>~Staff threw a wooden-handled brush at the individual, hitting the individual's forehead.</p> <p>~A neighbor is seen kicking an individual repeatedly in the back.</p> <p>~Staff roughly pushed the individual against locker, causing the individual to hit his head on the locker.</p> <p>~Teacher noted what appears to be cigarette burns on a 7-year-old individual's shoulder blades.</p> <p>~Staff throws a punch at the individual, the individual ducks the punch.</p>
<p><u>Sexual Abuse</u></p> <p>Unlawful sexual conduct or sexual contact as defined in ORC 2907.01 and the commission of any act prohibited by ORC 2907.09, such as, public indecency, importuning and voyeurism.</p>	<p>~Did the support staff person expose themselves to the individual?</p> <p>~Contact involves touching of an erogenous zone for purpose of arousal or gratification of either person.</p> <p>~Conduct includes oral sex or penetration including digital or with objects.</p>	<p>~The individual alleged an uncle kept touching his "privates."</p> <p>~Staff person is masturbating in front of an individual.</p> <p>~An individual alleges staff made the individual touch the roommate's "private area."</p> <p>~Staff seen stroking the individual's inner thigh in a manner to arouse the individual.</p> <p>~Staff is reported to be fondling individual's breast.</p>
<p><u>Verbal Abuse</u></p> <p>Purposely using words or gestures to threaten, coerce, intimidate, harass or humiliate an individual.</p>	<p>~What was the intent of the words or gestures along with individual's reaction?</p> <p>~What specific words were used?</p> <p>~Were the words threatening, coercive, intimidating, harassing or humiliating to the individual?</p> <p>~Yelling or cursing isn't necessarily verbal abuse.</p>	<p>~The individual alleges that their father threatened to punch him if he did not do the dishes.</p> <p>~Staff threatens to give the individual's dog away if he tells on them for slapping another individual.</p> <p>~Staff reports a co-worker yelling at individuals, swearing and calling them derogatory terms.</p> <p>~Staff reports hearing another staff tell an individual, "If you tell anyone about this, I will throw all of your movies away."</p> <p>~Staff tells the individual, "If you don't go to bed with me, you won't be going to the picnic this weekend."</p>

MUI Rule Definitions Interpretation

For questions call: 614-995-3810
 For Hotline call: 1-866-313-MRDD (6733)

Revised 8/3/07

<p><u>Misappropriation</u></p>	<p>~ Was there intent to deprive or defraud?</p>	<p>~The individual's bank account shows several unauthorized withdrawals.</p>
<p>Depriving - Defrauding - Obtaining real or personal property of an individual by means prohibited by ORC 2911 and 2913.</p>	<p>~Value of the item does not matter. ~Length of time, if replaced, does not matter. ~Were items or money taken from the individual? ~Does the property belong to the individual? ~Is there reason to believe the money or item was taken?</p>	<p>~The individual's certificates of deposit (CD's) are withdrawn/cashed without individual's knowledge. ~Sister gets a cellular phone with the individual's identification and then runs up bill with personal calls. ~Friend used the individual's ATM card to make unauthorized cash withdrawals. ~Staff eats the T-bone steaks purchased with the individual's funds. ~Staff is seen taking four (4) pairs of jeans out of the individual's closet and placing them in her car. ~There is \$314 unaccounted for when balancing the checkbook. Receipts are missing and the individual denies making or authorizing any purchases; theft is alleged. ~It was discovered someone used the individual's name and SS number to open a credit card account without the individual's knowledge and \$2,199 was charged to the account.</p>

MUI Rule Definitions Interpretation

For questions call: 614-995-3810
 For Hotline call: 1-866-313-MRDD (6733)

Revised 8/3/07

MUI means the alleged, suspected or actual occurrence of an incident when there is reason to believe the health or safety of an individual may be adversely affected or an individual may be placed at a reasonable risk of harm.

For persons served by the MRDD system, MUIs are filed in all cases of Abuse, Neglect, Exploitation, Misappropriation, Prohibited Sexual Relations, and Failure to Report. Other categories of MUIs are filed when the incident occurs with an MRDD license or certified provider or in county board operated programs.

TYPE/ DEFINITION	PROBES	EXAMPLES
<p><u>Abuse</u></p> <p>Physical force that can reasonably be expected to result in physical harm or serious physical harm as defined in section 2901.01, through actions that include but are not limited to, hitting, slapping, pushing or throwing objects at an individual.</p>	<p>~The level of force could reasonably result in harm.</p> <p>~Law enforcement is contacted when the situation is an alleged crime.</p>	<p>~The care provider allegedly slaps the individual in the face leaving a red mark.</p> <p>~Staff pulls the individual's arm behind the individual's back, dislocating the individual's shoulder.</p> <p>~The individual was held under water for about a minute.</p> <p>~Staff threw a wooden-handled brush at the individual, hitting the individual's forehead.</p> <p>~A neighbor is seen kicking an individual repeatedly in the back.</p> <p>~Staff roughly pushed the individual against locker, causing the individual to hit his head on the locker.</p> <p>~Teacher noted what appears to be cigarette burns on a 7-year-old individual's shoulder blades.</p> <p>~Staff throws a punch at the individual, the individual ducks the punch.</p>
<p><u>Sexual Abuse</u></p> <p>Unlawful sexual conduct or sexual contact as defined in ORC 2907.01 and the commission of any act prohibited by ORC 2907.09, such as, public indecency, importuning and voyeurism.</p>	<p>~Did the support staff person expose themselves to the individual?</p> <p>~Contact involves touching of an erogenous zone for purpose of arousal or gratification of either person.</p> <p>~Conduct includes oral sex or penetration including digital or with objects.</p>	<p>~The individual alleged an uncle kept touching his "privates."</p> <p>~Staff person is masturbating in front of an individual.</p> <p>~An individual alleges staff made the individual touch the roommate's "private area."</p> <p>~Staff seen stroking the individual's inner thigh in a manner to arouse the individual.</p> <p>~Staff is reported to be fondling individual's breast.</p>
<p><u>Verbal Abuse</u></p> <p>Purposely using words or gestures to threaten, coerce, intimidate, harass or humiliate an individual.</p>	<p>~What was the intent of the words or gestures along with individual's reaction?</p> <p>~What specific words were used?</p> <p>~Were the words threatening, coercive, intimidating, harassing or humiliating to the individual?</p> <p>~Yelling or cursing isn't necessarily verbal abuse.</p>	<p>~The individual alleges that their father threatened to punch him if he did not do the dishes.</p> <p>~Staff threatens to give the individual's dog away if he tells on them for slapping another individual.</p> <p>~Staff reports a co-worker yelling at individuals, swearing and calling them derogatory terms.</p> <p>~Staff reports hearing another staff tell an individual, "If you tell anyone about this, I will throw all of your movies away."</p> <p>~Staff tells the individual, "If you don't go to bed with me, you won't be going to the picnic this weekend."</p>

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<p><u>Misappropriation</u></p>	<p>~ Was there intent to deprive or defraud?</p>	<p>~The individual's bank account shows several unauthorized withdrawals.</p>
<p>Depriving - Defrauding - Obtaining real or personal property of an individual by means prohibited by ORC 2911 and 2913.</p>	<p>~Value of the item does not matter.</p>	<p>~The individual's certificates of deposit (CD's) are withdrawn/cashed without individual's knowledge.</p>
	<p>~Length of time, if replaced, does not matter.</p>	<p>~Sister gets a cellular phone with the individual's identification and then runs up bill with personal calls.</p>
	<p>~Were items or money taken from the individual?</p>	<p>~Friend used the individual's ATM card to make unauthorized cash withdrawals.</p>
	<p>~Does the property belong to the individual?</p>	<p>~Staff eats the T-bone steaks purchased with the individual's funds.</p>
	<p>~Is there reason to believe the money or item was taken?</p>	<p>~Staff is seen taking four (4) pairs of jeans out of the individual's closet and placing them in her car.</p>
		<p>~There is \$314 unaccounted for when balancing the checkbook. Receipts are missing and the individual denies making or authorizing any purchases; theft is alleged.</p>
		<p>~It was discovered someone used the individual's name and SS number to open a credit card account without the individual's knowledge and \$2,199 was charged to the account.</p>

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TYPE/ DEFINITION	PROBES	EXAMPLE
<p><u>Neglect</u></p> <p>When there is a duty to do so, failing to provide an individual with any treatment, care, goods, supervision or services necessary to maintain health and safety.</p>	<p>~Person has a duty to provide "care" and it is not provided by them or others.</p> <p>~Maintain health and safety means the situation places the person at a <u>reasonable risk of harm</u> based on the circumstances that include but are not limited to, weather conditions, health conditions, behavior concerns, identified risk behaviors, or neighborhood.</p> <p>~Law enforcement contact is required if person is placed at a <u>substantial risk of harm</u> or there is actual harm.</p>	<p>~An individual who runs off when the situation presents itself is left on the van for one minute while staff run back inside to find the keys.</p> <p>~An individual whose seizure disorder is fragile is placed in a warm bath and left while staff go out for a cigarette.</p> <p>~Staff fail to secure an individual's wheelchair in the bus and when the bus stops, the individual tips over resulting in multiple abrasions.</p> <p>~The individual's diet requires all food to be cut into dime-sized pieces and staff gives the individual a slice of pizza.</p> <p>~Individual is left on the bus for 3 hours with the temperature 32 degrees outside.</p> <p>~Individual with eyes-on supervision for aggression against others is left alone in the living room with other housemates while support staff takes a break.</p>
<p><u>Death</u></p> <p>Any cause.</p>	<p>~Person must meet the criteria of being served.</p>	<p>~Individual on the waiver is placed temporarily in a nursing home and dies there.</p>
<p><u>Law Enforcement</u></p> <p>Results in arrest, filing of charges or incarceration.</p>	<p>~Was the individual arrested, charged or incarcerated?</p>	
<p><u>Attempted Suicide</u></p> <p>Actual physical attempt that results in ER treatment, inpatient observation or hospital admission.</p>	<p>~Did the individual make an actual physical attempt to end life?</p> <p>~No harm is required.</p> <p>~In-patient observation at a hospital or hospital admission.</p> <p>~Receives treatment at the ER.</p>	<p>~After the individual stated she was going to kill herself, she stabs herself with scissors and is hospitalized for a puncture wound.</p> <p>~The individual tries to hang himself and is admitted to the psychiatric hospital.</p> <p>~The individual jumps off a fire escape onto the paved road below after threatening to kill himself and is admitted to the hospital with a broken leg.</p> <p>~The individual attempts to commit suicide by swallowing 30 Tylenol pills; her stomach is pumped at the ER and she is released.</p>

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TYPE/ DEFINITION	PROBES	EXAMPLE
<p><u>Missing Individual</u></p> <p>The individual cannot be located for a period of time longer than specified in the ISP, cannot be located after actions specified in the ISP are taken and a search of the immediate surrounding area is complete or if circumstances indicate immediate jeopardy or law enforcement has been called to assist in the search.</p>	<p>~Rule out neglect.</p> <p>~If LE is contacted to assist in a search, it is an MUI.</p> <p>~Individual not located after actions specified in ISP and search of immediate, surrounding area.</p> <p>~If not needed in ISP, are there other circumstances that make immediate discovery of whereabouts of the individual critical to the health/safety of the individual?</p>	<p>~The individual leaves home after argument with caregivers and does not return home for 2 days.</p> <p>~The ISP allows for 4 hours unsupervised time. John goes out at 1 p.m and has not returned by 6 p.m.; staff do not know where he is.</p> <p>~ISP indicates 24-hour, 7 day per week supervision and the individual cannot be located in the immediate surrounding area.</p> <p>~The individual leaves the residence, whereabouts are unknown. The individual is overdue for time-sensitive medication administration critical to cardiac health problem. (Example for immediate jeopardy.)</p>
<p><u>Medical Emergency</u></p> <p>When emergency medical intervention is required to save an individual's life.</p>	<p>~ Was the medical condition of a sudden onset?</p> <p>~ Were emergency medical interventions given, such as Heimlich, CPR, surgery, resuscitation, IVs? (Note: this does not include first aid)</p> <p>~ Was the emergency medical intervention necessary to prevent the likelihood of death?</p>	<p>~ The individual is on the bus traveling from the workshop to residence and suffers an apparent heart attack; CPR is performed.</p> <p>~Individual is stung by a bee and Epi Pen is administered.</p> <p>~The individual chokes on a hotdog and receives the Heimlich maneuver to clear airway.</p> <p>~The individual complains of severe pain on side, vomiting and difficulty breathing. Individual is transported by EMS to ER and treated with IVs due to dehydration.</p> <p>~An individual with a diagnosed heart condition is taken to the ER for treatment of chest pain and diagnosis confirms a heart attack; the individual receives Nitro tablets.</p> <p>~Individual having multiple seizures taken to ER; Ativan given by IV to stop seizures.</p>
<p><u>Unscheduled Hospitalization</u></p> <p>Any hospital admission that is not scheduled unless it is due to a condition specified in the ISP or nursing care plan indicating the specific symptoms and criteria that require hospitalization.</p>	<p>~Is the hospital admission unscheduled or unplanned?</p> <p>~Is the hospitalization to treat an exacerbation of a previously identified medical condition requiring immediate hospital admission not addressed in the ISP?</p> <p>~If criteria for hospital admission with existing conditions is clearly defined in the ISP, it is not an MUI.</p> <p>~If there is a life threatening event, even with criteria, it is an MUI.</p>	<p>~The individual has a history of high blood pressure, but was hospitalized unexpectedly due to pneumonia.</p> <p>~The individual reports severe pain and is admitted for surgery to remove kidney stones.</p> <p>~The individual has labored breathing and rapid heartbeat and is admitted to the hospital with a diagnosis of pneumonia.</p> <p>~The individual has a history of heart problems with criteria identified in the ISP for when hospitalization is likely; individual has a heart attack.</p> <p>~The individual is lethargic and unsteady, goes to the ER and is hospitalized for a possible medication error.</p>
<p><u>Unknown Injury</u></p> <p>An injury of an unknown cause not considered to be abuse/neglect and requires treatment by a physician, physician assistant or nurse practitioner.</p>	<p>~Unknown and is not abuse or neglect.</p> <p>~Did the injury require treatment only a physician, physician assistant or nurse practitioner can provide?</p>	<p>~The individual sustains a laceration on their left arm that requires 3 stitches and the cause of the laceration is unknown.</p> <p>~The individual is diagnosed with a broken little toe.</p>

<p><u>Known Injury</u></p> <p>An injury from a known cause that is not abuse or neglect and requires immobilization, casting, 5 or more sutures or equivalent, 2nd/3rd degree burns, dental injuries or an injury that prohibits participation in daily tasks for more than 2 consecutive days.</p>	<p>~Known origin (witnessed or as stated by victim) with significant impact.</p> <p>~Results in injuries requiring a total of 5 or more sutures or the equivalent.</p> <p>~Broken bones, regardless of treatment, dislocation, loss of teeth, serious burns, altered level of consciousness from an injury or any other serious injury.</p>	<p>~The individual states he fell down the basement stairs and broke his arm.</p> <p>~The individual sustains a large 2nd degree burn on neck from using a curling iron. Burn is treated by a physician.</p> <p>~The individual sustains a laceration to the head requiring 5 sutures for closure and resulted from a fall observed by staff.</p> <p>~The individual falls, which is observed by staff, and 2 teeth are knocked out.</p> <p>~The individual sprains ankle while playing basketball ; a soft cast is put on for immobilization and individual is ordered by the doctor to stay off foot for 5-7 days</p>
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TYPE/ DEFINITION	PROBES	EXAMPLE
<p><u>Unapproved Behavior Support</u></p> <p>Means the use of any aversive strategy or intervention implemented without approval by the Human Rights Committee or Behavior Support Committee or without informed consent.</p> <p>ICFs/MR follow 5123: 2-3-25. All other programs follow the county board administrative rule 5123: 2-1-02.</p>	<p>~Was the used technique prohibited by state or federal regulations?</p> <p>~Behavior support methods used without consent of the individual or legal guardian are MUIs.</p> <p>~Medication must be prescribed for a specific purpose by and under the supervision of a licensed physician who is involved in the ID Team.</p> <p>~Was time out used as a crisis?</p> <p>~ICFs follow 5123: 2-4-25 and file MUIs when there are restraints or aversive interventions not permitted in the rule.</p>	<p>~The individual is physically aggressive at worksite and is locked in a room to calm down.</p> <p>~The individual's arms are strapped to wheelchair on the bus to stop the individual from grabbing others' hair during bus ride.</p> <p>~Workshop nurse gives an individual medication to calm behaviors, but medication was not prescribed for this purpose.</p> <p>~Staff tackle an individual as he runs toward the street.</p> <p>~Staff go directly to a baskethold when verbal prompts are to be used; there is no plan for physical intervention.</p>
<p><u>Rights Violation</u></p> <p>Any violation of the rights enumerated in section 5123.62 of the Revised Code that creates a reasonable risk of harm to the health or safety of an individual.</p>	<p>~Did the act create a reasonable risk of harm?</p>	<p>~Staff takes the individual to a movie, he does not want to go, he becomes upset and bangs his head against the wall.</p> <p>~Staff padlocks the refrigerator and the individual sustains a laceration trying to break the lock.</p>
<p><u>Failure to Report</u></p> <p>A person who is required to report, per section 5123.61, and has reason to believe an individual has suffered or faces a substantial risk of suffering any wound, injury, disability or condition of such a nature as to reasonably indicate abuse (including misappropriation) or neglect and does not immediately report to LE or a county board.</p>	<p>~May also be a criminal act that needs reported to law enforcement.</p> <p>~Registry: MRDD employee unreasonably failed to report and knew or should have known not reporting would result in a substantial risk of harm for the individual because the individual has been placed back into the situation again.</p>	<p>~Individual at work reports home staff keep hitting his legs with a broom handle. Discoloration and red marks are noted on his calves. Workshop staff do not report and the individual is allowed to go home after work.</p> <p>~A female individual reports another individual with a history of sexual aggression raped her in the back bathroom at the workshop. She returns to workshop the next day without any one reporting the incident.</p>
<p><u>Exploitation</u></p> <p>The unlawful or improper act of using an individual or an individual's resources for monetary or personal benefit, profit or gain.</p>	<p>~Is the individual used in some way for personal benefit, profit or gain?</p> <p>~Was the individual a willing participant?</p>	<p>~Staff has an individual stand outside the mall collecting donations with a bucket stating, "Please help the mentally retarded." At the end of the day, staff pockets the money.</p> <p>~A "friend" has an individual co-sign for a loan even though the individual doesn't understand what he/she is signing for.</p> <p>~Staff take an individual to their home and have him move furniture all day. The individual receives no compensation and states he didn't want to be there at all.</p>

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TYPE/ DEFINITION	PROBES	EXAMPLE
<p><u>Peer to Peer Acts</u></p> <p>Acts committed by one individual against another when there is physical abuse with intent to harm; verbal abuse with intent to intimidate, harass or humiliate; any sexual abuse; any exploitation; or intentional misappropriation of property of significant value.</p>	<p>~Ensure that harm or risk is not due to Neglect by staff (NOTE: Neglect does not apply to a person without duty of care such as a peer).</p> <p>~Was there enough physical force to result in harm and did the individual plan or mean to hurt the other?</p> <p>~Law enforcement is to be contacted anytime the situation reaches the level of an alleged crime.</p> <p>~Misappropriation of \$10.00 or more or an item of significant value to the individual.</p> <p>~Was there unlawful sexual conduct or contact?</p>	<p>~Individual threatens housemate if they come out of their room, they will get a beat down (individual has a history of physical abuse).</p> <p>~Individual goes into peer's bedroom, uses a screwdriver to open the lock box kept under the peer's bed and takes \$32.31 from the lock box.</p> <p>~Individual with a BSP for physical abuse tells a peer to go get him a soda or he'll beat him up. When peer states, "you're not my boss," individual punches peer in the face before staff can intervene. Victim has a bloody nose.</p> <p>~Individual keeps touching a female individual's breasts despite her telling him to stop.</p> <p>~Individual is mad at his housemate, when he sees him walk by, he runs over and slams him into the wall.</p>
<p><u>Prohibited Sexual Relations</u></p> <p>An MR/DD employee engaging in consensual sexual conduct or having consensual sexual contact with an individual who is not the employee's spouse and for whom the MR/DD employee was employed or under contract to provide care at the time of the incident and includes persons in the employee's supervisory chain of command.</p>	<p>~Note: Any sexual contact between a provider and a consumer receiving services from that provider is an MUI if the provider is not the individual's spouse"</p>	



Health & Safety Alert #8-3-02

MUI Rule

Frequently Asked Questions

OBSOLETE

Below are some frequently asked questions gleaned from the Department's MUI Rule training sessions:

1. A. Concerning the requirement of annual MUI training, does "all county board staff" literally mean every person employed by the county board of MRDD?
ANSWER: Yes, all staff should be trained annually.
- B. May anyone conduct the annual training?
ANSWER: It is recommended that persons knowledgeable with the MUI Rule and process be the trainers.
- C. Are there any requirements regarding the content of the training?
ANSWER: Yes, at a minimum, Rule requirements are to be covered annually. Outside of that, the content is open to the county board.
2. Will the ICFs/MR or provider agency's investigative agent have to meet the same training criteria and the same training content as the county board investigative agent?
ANSWER: No, however, the department plans to offer training in the future that will include provider investigators.
3. Who trains the independent providers?
ANSWER: County boards are responsible for ensuring they are trained.
4. If the incident could be coded as more than one type, which code should be used?
ANSWER: It is to be coded to the more severe of the codings. For example, abuse is a more severe classification than rights.
5. Is any medication error a reportable MUI?
ANSWER: By itself, it is only a UI. If the result is unexpected hospitalization or emergency medical intervention, then it would be an MUI because of the result of the action versus the action itself.
6. Does the criteria of five stitches to be an MUI mean that the stitches must be in one injury site or can the criteria apply regardless of how many suture sites?
ANSWER: The criteria is five stitches or more from an incident, regardless of how many suture sites (e.g., three on the head and two on the arm, etc.).
7. A wristband to prevent biting has been ordered by the physician; however, the plan has been written but not yet approved. If the band is used, would it be an MUI?
ANSWER: If the wristband is under a doctor's order to allow the injury to heal, it would be acceptable until the plan is approved (reasonable time period). If it is tethered and restricts movement without consent, it would be an MUI.
8. Is it an MUI if a consumer refuses to take their medication?
ANSWER: It could be in situations such as the following:
 - a. If person is forced to take medication.
 - b. If refusal results in another MUI category such as unplanned hospitalization, emergency medical intervention.
 - c. Failure of the Team to address a behavior, which is recurring.
 - d. The team does not initiate emergency guardianship when it is realized that the refusal is affecting the consumer's health and safety.

Simple refusal of medication without any problems would be an unusual incident (UI) that is addressed by the team before it becomes serious.

9. If I filed a series of incidents as an MUI, should I continue to file a new MUI every time one more incident occurs?

ANSWER: No, an MUI would be filed where there are three *new* incidents determined from the weekly review or five *new* incidents in a month.

10. How do you handle consensual sex between an individual and a staff person?

ANSWER: It is reported as an MUI under sexual abuse. Providers and county boards shall make it clear in their policies and procedures that sexual conduct or contact with consumers by employees is prohibited.

11. Suppose there is a pattern of med errors that does not affect health and safety, does this fall under neglect?

ANSWER: Normally, med errors would be filed as an MUI under a series of unusual incidents. When there is a serious impact or malicious intent, then it should be filed as neglect.

12. What do you do about the agencies that don't provide services due to the fact that Medicaid does not cover that service?

ANSWER: If the service is identified as part of the IP, then failing to provide the service is neglect if that service affects health and safety.

13. The county board determines that the individual needs attention/treatment (broken bones) and the provider has them wait. What would you do with this?

ANSWER: The key is to ensure immediate action such as immobilization has occurred, and the person is protected from further injury. The delay should be minimal and for a valid reason.

14. A. If a provider has five homes and there are five or more medication errors in a month across the homes, is this an MUI?

ANSWER: No, consider the home or a living unit as an entity.

- B. If the provider runs a large ICF/MR and there are five or more medication errors in a month across the ICF/MR, is it an MUI?

ANSWER: No, consider each living unit as a separate entity.

15. If you have a direct care staff giving an individual insulin and the staff is not trained on giving the insulin, do you file an MUI?

ANSWER: No, unless the result was unexpected hospitalization or medical emergency. The issue would be coded as a UI and appropriately addressed.

16. When is a missing person considered neglect due to lack of supervision?

ANSWER: It depends on what the plan says about the level of supervision that needs to be given to that person to protect the individual's health and safety, or whether any specific facts were present that suggest that the person providing services to the individual should have known that the individual's health and safety were in danger.

17. If preventive measures are in place but a consumer continues to have seizures and/or falls, then does the provider/county board need to report this as an MUI for series or similar incidents?

ANSWER: Yes, when the MUI criteria for a series of unusual incidents is met.

18. Can a trend or series of incidents as outlined in the rule be applied to a facility or a staff person?

ANSWER: It is to be applied to both.

19. Do ICFs/MR licensed by the Department of Health have to report MUIs?
ANSWER: Yes.
20. For family resources where the CB pays the family and the family pays the provider, who is required to report?
ANSWER: The family would be required to report in this case, as they are directly receiving CB funds.
21. Is a family member who is also guardian a required reporter?
ANSWER: A family member who is also a guardian is only required to report abuse and neglect. Otherwise, they do not meet the definition of a provider.
22. What do you expect out of the independent providers in terms of reporting?
ANSWER: The expectation for reporting is the same for all providers.
23. If the county board becomes aware of an MUI involving consumers in nursing homes/families/schools, then is the county board required to report the incident even though the nursing homes/families/schools are not?
ANSWER: Yes, the county board is required to report.
24. Is the county board required to report all abuse/neglect/theft to law enforcement?
ANSWER: Law enforcement is to be notified when the abuse, neglect or theft is of a criminal nature as identified in 2903, 2907, 2911 and 2913 of the ORC. Generally, it includes any time physical harm is a result.
25. If a consumer has a Behavior Support Plan (BSP), then does every incident of aggression have to be reported either as a UI or MUI? If so, what is the determining factor when the incident becomes an MUI rather than a UI?
ANSWER: No. It would not automatically be an MUI or UI. Agencies may use systems other than UIs to document targeted behaviors, but must review them monthly. These systems need to collect the relevant data so proper adjustments to the BSP can be made. Aggression incidents become an MUI when:
 - i. The result of the behavior meets one of the existing MUI definitions (e.g., injury, abuse, unanticipated hospitalization, etc.).
 - ii. If one person is the target of the aggressive acts, then it is filed as a "series of incidents."
26. When the CSB has a case and they won't share information, can the case be closed?
ANSWER: Ensure the steps listed below are taken and then close the case:
 - A. Make sure the individual is protected.
 - B. Prevention plan is in place.
 - C. Monitoring of the situation is taking place.
27. If the local CSB does not want reports on cases of individuals 18-21, what should the county board do, if they would normally report the incident to the CSB?
ANSWER: It is the county board responsibility to send the report; however, CSB can choose not to investigate.
28. Is the county required to send a written summary to the family upon closing "death" cases? -
ANSWER: The department suggests a letter of sympathy be sent immediately after the death. The letter could include or must be followed by a second letter indicating that all deaths are reviewed and closed by ODMRDD, and that should those family members designated by law wish to request a copy of the completed report, they should contact a specifically identified county board employee. This expanded letter of sympathy or second letter would suffice as the written summary. =

29. In the Licensure rule, the provider must investigate in order to let someone work after an abuse allegation is made. How does this work if the county board is conducting the investigation?
ANSWER: The provider makes the decision as to when an individual can come back to work by conducting an investigation. This can be done independently, with the county board or done by the county board.
30. At what point should we look for the providers to produce evidence that their reviews have been conducted?
ANSWER: The weekly reviews are to start January 1, 2002. The quarterly reviews are expected to begin in April 2002. I would start reviewing right away to ensure compliance with the rule.
31. Are the independent providers expected to write their own policy/procedures or can they follow the county boards?
ANSWER: The department recommends having independent providers follow the county 's policies and procedures.
32. Since the rule did not come about until November 23, 2001, at what point do you require the providers to have their unusual incident logs?
ANSWER: The Rule went into effect on November 23, 2001, which required the keeping of a log; but, no consequences will result as long as providers began keeping a log as of January 1, 2002.
33. Prior to the state mediating a disagreement between the provider and county board regarding actions to ensure health and safety, does the county board have the authority to request the provider to take specific actions and does the provider have to comply with the request?
ANSWER: Yes, the county board needs to ensure the person is safe and the provider is responsible for taking the necessary action to ensure this to their satisfaction. The facts and evidence at hand need to be the determining factors.
34. If the county board determines that a PPI (Primary Person Involved) needs to be removed from contact with any consumers to ensure health and safety, then does the county board have the authority to request the provider to remove the staff and does the provider have to comply with the request?
ANSWER: The provider needs to ensure the safety to the satisfaction of the county board. It could mean reassignment to a non-direct role, assigning a supervisor to work side-by-side, etc.
35. If an incident occurred at the workshop, then how detailed does the county board have to be in sharing the information with the residential provider?
ANSWER: The rule specifies that the county board needs only to notify the residential provider that an MUI occurred. It should include what happened and the immediate action to prevent further injury.
36. Is the county board required to provide the investigation information to a provider upon the provider's request?
ANSWER: No, the written summary is provided at the 25th working day from the county board's knowledge of the incident.
37. Does the county board need to maintain an on-call system for accepting reports for after working hours and weekends?
ANSWER: Yes. County boards must ensure immediate action and in some instances initiate the investigation immediately. It is the responsibility of the county board to let the provider know what that on-call system is.

38. Is the presence of a provider administrator with a PPI (Primary Person Involved) during an investigation interview allowed?

ANSWER: No, unless there is a provision in the contract between the county board and provider that says the county board can't interview provider staff without having someone else from the provider present. It's more likely that if a contract says anything about this, it says the provider has to provide access to provider staff as part of MUI investigations. It would be poor policy to allow provider administrators to sit in on interviews with staff, since having a provider administrator present could be intimidating and likely to impede the investigation.

39. What if the provider can't afford to remove the staff? What if it is a case of verbal abuse?

ANSWER: The provider needs to provide for the health and safety of the person. The money is not the consideration. Verbal abuse is the same as other types where the person should not be allowed to work with consumers until the investigation is complete or a supervisor is assigned to work side-by-side with them.

40. Do investigative agents have to review and investigate all MUIs even if the rule does not require an investigation? Can another staff person handle the "review" cases?

ANSWER: All MUIs are to be investigated by the investigative agent. Certain types of MUIs require the investigative agent to use the protocol specified in the rule. Other types of MUIs do not require the same level of intensity and may, at times, be a matter of reviewing all documentation and developing the report based upon that review. Other staff can assist by gathering information that the investigative agent needs. The investigative agent is responsible for the review of all information related to the MUI.

41. How long should a county board maintain MUI records?

ANSWER: Seven years.

For questions or comments regarding the above Alert, please contact the MUI/Registry Unit at (614) 995-3810.

01/04



Health & Safety Alert #09-03-02

Seizure Triggers

The Ohio Department of Mental Retardation and Developmental Disabilities is providing alerts to the field with the goal of preventing or reducing the possibility of future serious incidents. (Note: This alert was originally sent in the Vision Newsletter on December 22, 2000. It has been updated and is now being sent through this means to ensure a broader distribution and more lasting access.) Please share this alert with all staff involved in planning, providing or overseeing services.

Situation: A number of MUIs have resulted in serious injury or hospitalizations related to seizures. Seizure triggers include missed medications, fatigue, lack of sleep, stress, poor diet, excessive use of alcohol, withdrawal from alcohol, use of illicit drugs (particularly cocaine), illnesses, increased body temperature and fever, hormone changes in females, and for some individuals, flickering light patterns.

There are many factors that affect the excitability of neurons in the brain and the propensity to subsequent development of seizure activity. In some individuals, seizures can be caused by the presence of a precipitating factor. This concept is referred to as a seizure trigger, or exceeding the seizure threshold of the individual. Each individual with epilepsy has a unique seizure threshold and a distinct response to potential seizure triggers.

Alert: Interventions to minimize the effect of seizure triggers:

- Take anti-epileptic medication as prescribed.
- Exercise, but not to the point of “over doing it.”
- Plenty of rest and good sleep habits.
- Avoid extended periods without food or drink.
- Avoid use of alcohol or illicit substances.
- Maintain regularly scheduled medical checkups; seek treatment for illness; treat fevers.
- Avoid situations that may increase body temperature, such as hot tubs or hot baths, or high environmental temperatures.
- For individuals with photosensitive epilepsy, avoid or minimize exposure to precipitating factors (e.g., television).

Some general precautions for persons with epilepsy and seizure triggers:

- Turn down household water temperature to avoid scalding and burns if seizures occur in bathtub, and to avoid marked increase in body temperature while bathing.
- Consider taking showers to avoid risk of drowning in tub.
- Always have someone available who can provide help if a seizure occurs while bathing or swimming, and supervise young children closely.
- Wear a life jacket while swimming or if near water.
- Discuss with your physician appropriate exercise and sports participation.

For questions or comments regarding the above Alert, please contact the MUI/Registry Unit at (614) 995-3810.

January 2004



Health & Safety Alert #10-03-02

Automated Teller Machines (ATMs)

Automated Teller Machines (ATMs)

Situation - Theft and fraud of consumer funds through unauthorized access to consumer ATM accounts is a concern that warrants heightened oversight. Consumers' bank accounts can be accessed with debit cards and credit cards that allow cash advances. The primary person involved (PPI) may steal the ATM card of the consumer or may even apply for a separate card by assuming the identity of the consumer.

Alert - The Department recommends tight fiscal accountability and measures be implemented to protect each individual's personal funds. The ATM card is viewed by a PPI as a signed blank check. With this in mind, an ATM card should be accounted for and protected. There should also be consideration of the security of the individual's personal identification number (PIN) access code. Controls that can be established include but are not limited to:

- Locking the ATM card away in a safe when not in use.
- Securing the personal identification number (pin) so that a very limited number of staff that work directly with the consumer have access to it.
- Maintain a sign-out/in sheet for the ATM card so a staff member becomes responsible for it when it is removed from the facility.
- Have the staff member and consumer sign the ATM receipt acknowledging the cash withdrawal of funds.
- Establish a system to ensure that purchases made with ATM funds are supported by receipts.
- Perform a monthly reconciliation of the account to which the ATM card is attached, by someone other than the staff member that takes care of the consumer.

For licensed facilities, ATM transactions fall under the same requirements as checking, savings, or petty cash account transactions established in O.A.C. 5123:2-3-14:

(K) ALL PERSONAL FUNDS EXPENDED BY THE LICENSEE ON BEHALF OF AN INDIVIDUAL SHALL BE ACCOMPANIED BY A RECEIPT FOR THE EXPENDITURE. THE RECEIPT SHALL IDENTIFY THE ITEM(S) PROCURED, THE DATE, AND THE AMOUNT OF THE EXPENDITURE. THE LICENSEE SHALL OBTAIN OTHER PROOF OF PURCHASE IF A RECEIPT IS UNAVAILABLE.

(L) WHEN AN INDIVIDUAL EXPENDS PERSONAL FUNDS ON HIS/HER OWN BEHALF OR WHEN PERSONAL FUNDS ARE EXPENDED FOR THE INDIVIDUAL BY A PARENT OR CUSTODIAN IF THE INDIVIDUAL IS A MINOR OR GUARDIAN, AS APPLICABLE, A RECEIPT IS REQUIRED FOR A SINGLE EXPENDITURE OF FIFTY DOLLARS OR MORE UNLESS OTHERWISE SPECIFIED IN THE INDIVIDUAL'S PLAN. WHEN A RECEIPT IS UNAVAILABLE, THE LICENSEE SHALL OBTAIN OTHER PROOF OF PURCHASE.

Indications that the individual may be subject to this type of theft or fraud may be unexplained ATM withdrawals, a pattern of ATM withdrawals at the maximum allowed, the individual's mailing address being changed, and the issuance of replacement cards with a new PIN.

For questions or comments regarding the above Alert, please contact the MUI/Registry Unit at (614) 995-3810.

January 2004



Department of
Developmental Disabilities

Office of MUI/Registry Unit

Ted Strickland, Governor
John L. Martin, Director

Health & Safety Alert #11-03-08

Excessive Psychotropic Medication & Psychotropic Medication Side Effects

It is not unusual for individuals with developmental disabilities to also experience mental illness. The incidence of mental illness among people with mental retardation has been estimated at 30 to 40 percent. The evaluation and treatment of individuals dually-diagnosed with mental retardation and mental illness is the same as for persons without mental retardation. An overview of such evaluation and treatment is provided in the monograph "Clinical Best Practices for Serving People with Developmental Disabilities and Mental Illness," published in a collaborative effort by the Ohio Department of Mental Retardation and Developmental Disabilities, and the Ohio Department of Mental Health. It can be accessed on the Department's Website: <http://odmrdd.state.oh.us>

The treatment of mental illness with medications is termed psychopharmacologic treatment. In choosing treatment we must always recognize the right of a person with mental retardation to receive appropriate care and treatment in the least intrusive manner, and the right to be free from unnecessary chemical or physical restraint.

Medications which are prescribed to improve a person's mental health or their behavior symptoms of mental illness are referred to as psychotropic medications. Anti-depressants, anti-psychotics, mood stabilizers, anti-anxiety agents, sleep agents, stimulants, anti-parkinson and anti-cholinergic agents are such medications. If used for psychotropic purposes, anti-convulsants and cardiac medications are also considered psychotropics.

An individual who is taking psychotropic medications may be unable to adequately verbally express symptoms or medication side effects. Therefore, observation for possible side effects is necessary. Side effects may result from the use of a single medication, or from the interaction of multiple medications. Some side effects are minor, such as the sensation of thirst or increased need for fluids. Side effects such as these can be tolerated when the medication is effective in treating the mental illness while other side effects are more severe. Potential side effects of a specific medication should be provided by the pharmacy.

Many serious side effects are common to most psychotropic medications and include the following:

- A. Allergic reaction (difficulty breathing, swelling of lips/face/tongue, rash or fever).
- B. Change in level of alertness (excess sleepiness, insomnia or confusion).
- C. Eating problems (nausea, vomiting, weight gain or loss).
- D. Change in stool pattern (constipation, diarrhea).
- E. Change in heartbeat (slow, fast, irregular) or blood pressure (high or low).
- F. Fainting or dizziness, especially with change in positions such as upon standing.
- G. Abnormal posture, movements, or gait.
- H. Yellowing of eyes or skin.
- I. Unusual bruising or bleeding.

It is important for staff and families to be well informed about the medications that are needed. The Food and Drug Administration (FDA) has adopted a “black-box” label warning. In the United States, a **black box warning** (also sometimes called a **black label warning**) is a type of warning that appears on the package insert for prescription drugs that may cause serious adverse effects. It is so named for the black border that usually surrounds the text of the warning.

A black box warning means that medical studies indicate that the drug carries a significant risk of serious or even life-threatening adverse effects. The U.S. Food and Drug Administration (FDA) can require a pharmaceutical company to place a black box warning on the labeling of a prescription drug, or in literature describing it. It is the strongest warning that the FDA requires.

“Many of the atypical antipsychotics have the black-box label warning”
--

Keep in mind that people with heart disease and elderly individuals with dementia have a higher likelihood of serious side effects or sudden death. Some of the antidepressants are contraindicated for these persons.

Below is a list of psychotropic medication commonly used that have a black-box label warning:

- Anafranil
- Asendin
- Aventyl, Pamelor
- Celexa
- Desyrel
- Effexor
- Elavil
- Lexapro
- Ludiomil
- Marplan
- Nardil
- Norpramin, Pertofrane
- Pamate
- Paxil
- Prozac
- Remeron
- Serzone
- Surmontil
- Tofranil
- Vivactil
- Wellbutrin
- Zoloft

What to Do:

- A. Be informed about the black-box warnings and side effects of medication that are being received.
- B. Obtain immediate medical treatment for serious signs and symptoms of possible medication side effects.
- C. Keep the health care provider and guardian informed of any and all side effects.

For questions or comments regarding the above Alert, please contact the MUI/Registry Unit at (614) 995-3810.

REISSUED: March 2008



Department of
Developmental Disabilities

Office of MUI/Registry Unit

Ted Strickland, Governor
John L. Martin, Director

Health & Safety Alert #12-04-02

Department of Developmental Disability Abuser Registry is Now Operational and Must be Used

I. Background

Senate Bill 171 created an Abuser Registry so that those few employees, who commit substantial acts of abuse, neglect, or misappropriation against individuals with Developmental Disability, would be ineligible to work in the field again. This Registry is one of the key components of our system of ensuring the health and safety of individuals with Developmental Disability in the State of Ohio. The Abuser Registry statute is found in Ohio Revised Code §5123.50 - 5123.54. The accompanying Abuser Registry Rule is in the Ohio Administrative Code 5123:2-17-03. The effective date of the bill was **November 22, 2000**. Employees that commit offenses on or after that date can be considered for possible Registry placement.

II. Current Status and Location

The Abuser Registry website is now fully operational. The Internet site is found at the Department of Developmental Disability home web page at <http://www.dodd.ohio.gov/>. Click on any of the four (4) portals: provider, advocate, citizen, or county board. The Abuser Registry is linked to each of the four portals and can be found as a direct link at the following Internet address:

https://odmrd.state.oh.us/apps/extranet/its_revise/abr_default.aspx

*Please note the space between **abuse and default** above is underscored.*

The Department expects to be placing names on the Registry in the immediate future.

III. New Hire Requirements

*Employers are now required to check the Registry before hiring an applicant to confirm that they are **not** on the Registry.*

Timing – How far in advance may the employer check the Registry?

The employer may check the Registry up to 14-calendar days before the hiring of the applicant. If the hiring date and the start date of the applicant's employment are 2 different dates, the employer may check the Registry either 14-calendar days prior to the hiring or one month prior to the start date of employment.

If you are an employer in the Developmental Disability field and have an applicant or employee with a positive match to the Registry, you must call (614) 995-3810 to alert the Department.

If you have questions about the accuracy of a search of the Registry, you should contact the Department.

IV. How to Check the Registry

There are two ways to search the Registry, either by the Internet or by telephone.

Internet Site Check

The Abuser Registry site is located at:

https://odmrdd.state.oh.us/apps/extranet/its_revise/abr_default.aspx

It provides both full listing and targeted search functionality.

1. Complete List

To obtain a list of all individuals on the Registry, simply click the "submit" button without entering any name or social security number. A listing of all names on the Registry will be alphabetically displayed.

2. Searches

→ **Last Name and SSN:** To execute this search, enter the first four characters of the last name *and* a full social security number. This will minimize the effect of spelling errors and nicknames. Any matches on either SSN or Name will be returned. While all perpetrator SSNs may not be included on the Registry, the inclusion of the SSN provides additional protection against the use of alias and the detection of possible identity theft. ***This is the preferred method to search the list.*** The examples below use the hypothetical name and SSN of Smith, 123456789.

ODMRDD may not be able to obtain the person's SSN prior to placing the person's name on the Registry, therefore a search by SSN alone is not allowed.

All matches will return the following information:

Name - DOB - Abuse Category - Date Perpetrator Placed on Registry

If the last name/SSN is not matched when using the Internet search of the Registry, the following message will appear:

The following matches were returned by your search for: **smith** or **123456789**.
No matching records found.

→ **Last Name:** This search should be done by entering first four characters of the last name. As in the combined search, this will minimize the effect of spelling errors and nicknames. If a name or names matches the search criteria then the following information will be seen:

Name / DOB / Abuse Category / Date Perpetrator Placed on Registry

If the last name is not matched when using the Internet search of the Registry, the following message will appear:

The following matches were returned by your search for: smith
No Matching Records found for: smith

You will be instructed if there is a match that:

If you are an employer in the MRDD field and have an applicant or employee with a positive match to the Registry, you must call (614) 995-3810 to alert the Department.

For questions or comments regarding the above Alert, please contact the MUI/Registry Unit at (614) 995-3810.

January 2004



Health & Safety Alert #13-04-02

Bed Safety

There is a risk of suffocation and strangulation in bed for certain individuals depending on bed type, bed accessories, and bed positioning.

- Individuals who are fully dependent on staff for positioning, whose movements are restricted, who may suffer a seizure, or who may suffer a hypoglycemic episode in bed are at risk for obstruction of their airways by entrapment in bed structures.
- Examples of entrapment (regular bed mattress and waterbed):
 - Wedging between mattress and wall.
 - Wedging between mattress and bed frame, headboard, footboard.
 - Entrapment between mattress and adjacent furniture.
 - Strangulation between bed railings.
 - Entrapment between portable bed rails and mattress.
- Example of breathing obstruction due to position:
 - Suffocation on waterbed mattress (unable to move self from face down position on waterbed mattress).
- What to do:
 - Survey positioning of bed in relation to wall and other furniture to decrease likelihood of wedging between mattress and wall or other furniture.
 - Ensure good fit of mattress to bed frame, headboard and footboard (alternative is to remove headboard and footboard).
 - Avoid use of bed rails when possible; defined perimeter mattress is an alternative to bed rails.
 - Avoid use of waterbeds for individuals who are at risk of airway obstruction; individuals who choose to sleep in a waterbed, either directly or through their guardian, should be apprised of and agree in writing to the risks associated with this choice.

Responsible staff including, but not limited to, Service and Support Coordinators should ensure that potential safety issues are addressed in *all* settings and avoid these hazards, which can be fatal.

Please share this alert with staff providing services to individuals in your facility/county, as well as health care staff, physical and occupational therapy staff and managers.

For questions or comments regarding the above Alert, please contact the MUI/Registry Unit at (614) 995-3810.

Reference: USCPSC Release #99-175

January 2004



Department of
Developmental Disabilities

Office of MUI/Registry Unit

Ted Strickland, Governor
John L. Martin, Director

Health & Safety Alert #14-11-02

New Toll-Free Hotline Number

The Ohio Department of Developmental Disabilities has a new toll-free hotline number for reporting abuse/neglect and other MUIs. The new number is **1-866-313-6733**.

Please note that MUIs are to be reported to the county board. However, it is understood that at times a consumer, staff or family member may feel it is a conflict or that potentially the county board is involved in the allegation. The hotline number should be reserved for reporting when a potential conflict exists.

This replaces the 1-800-231-5872 number that was formerly used. This change provides the Department with significant savings of over 50 percent on the monthly phone charge.

The Department will be promoting the new number during this time through various methods. We would also ask that you share this change with your staff, consumers, families and providers.

For questions or comments regarding the above Alert, please contact the MUI/Registry Unit at (614) 995-3810.

January 2004

Below is a “cut out” that can be used for your bulletin board.



DODD Toll-Free Hotline #:

1-866-(313)-6733

1800 Sullivant Avenue
Columbus, Ohio 43222
dodd.ohio.gov

(614) 995-3810 (Phone)
(614) 995-3822 (Fax)
(866) 313-6733 (Hotline)



**Department of
Developmental Disabilities**

Office of MUI/Registry Unit

John R. Kasich, Governor
John L. Martin, Director

Health & Safety Alert #15-05-11

Head Injuries

Head injuries are a significant cause of accidental injury to individuals with developmental disabilities. Monitoring any injury to the head is important because even what appears to be a minor bump on the head can result in injury to the brain. The neck and spinal cord can also be injured at the same time. This health and safety alert will help you recognize signs and symptoms that indicate the need for an individual to be evaluated by a physician after a fall or direct blow to the head.

Signs and Symptoms of Head (and Brain) Injury

If you see any of the following signs after a head injury, call for immediate medical attention/call 911:

- Loss of consciousness (even if the person appears to be normal after regaining consciousness).
- Change in level of consciousness, unusual drowsiness, or difficult to awaken.
- Head pain or headache, getting worse or not getting better within 4 hours of head injury.
- Individual does not remember head injury event (amnesia).
- Feeling dizzy, falling or staggering, dropping objects, loss of coordination.
- Inability to move any part of body without injury or pain to that part of the body.
- Speaking difficulties including slowing or slurring of speech.
- Blurred or double vision.
- Bleeding from ears or nose, fluid drainage from nose or ears.
- Obvious abnormal behavior, confusion, asking same question repeatedly, restlessness, altered awareness.
- Seizure/convulsion.
- Vomiting (may be projectile) that lasts longer than 15 minutes, or that occurs more than 3 times, or that continues after the initial 2 hours.

Signs of neck (spinal cord) injury include:

- Neck pain or back pain.
- Inability to move any part of body without injury or pain to that part of the body.
- Weakness, tingling, numbness in arm(s) or leg(s).

What to do in case of a head injury:

- First Aid: **A-B-C-D**
 - **A = Airway:** Assess, clear and manage airway as taught in your CPR class, being mindful of proper neck (cervical spine) alignment and immobilization.
 - **B = Breathing:** Assess and if necessary assist breathing (mouth-to-mask, bag-valve mask, oxygen supplementation).
 - **C = Circulation:** Control bleeding with pressure, being mindful of possibility of skull fracture; bleeding not controlled in 15 minutes should be evaluated by a physician.
 - **D = Disability:** Assess level of consciousness (alert, responds to talking, shouting, or pain such as pinching arm, or does not respond, is unconscious).
 - If your assessment indicates any problem with airway (including neck), breathing, or circulation, call 911 (alert emergency medical services), and get the individual immediate medical attention.
- If the person is unconscious, call 911.
- Remember the potential for a neck injury, which can occur with a head injury, including from a fall from a distance as short as falling out of bed.
 - Unless their airway is blocked, do not move a person until medical personnel (EMS, nurse or physician) have checked for neck (spinal cord) injury.
 - Support their head in a neutral (in-line) position until EMS arrives.
- Watch the individual closely in the 24 hours following a head injury. Every two hours check for level of alertness, lethargy (sleepiness, ability to arouse), confusion, vomiting, unequal pupils.
- Tylenol (acetaminophen) only for pain for 24 hours following a head injury (if ok with physician).

Signs and Symptoms of brain injury that may continue for weeks or months after a head injury should be reported to the individual's physician and include:

- Headache.
- Difficulty sleeping.
- Feeling dizzy.
- Behavior or psychological changes such as irritability, depression, restlessness, problems concentrating, and personality change.

For questions or comments regarding the above Alert, please contact the MUI/Registry Unit at (614) 995-3810.

Reissued: May 2011



Health & Safety Alert #16-08-02

Diabetes - Risk & Complications

Diabetes Mellitus is the full name for the disease most commonly called “Diabetes.” In this condition a person cannot produce enough or effectively use insulin to control their blood sugar (glucose) level. The earlier that Diabetes is found and treated, the fewer the complications will be. As the incidence of Diabetes in the United States is increasing rapidly, everyone should be aware of this potentially fatal disease.

Risk factors include: family history; inactive lifestyle; and obesity. A fasting blood glucose above 125 on more than one occasion can indicate a person has Diabetes. The American Diabetes Association recommends that all adults have a fasting blood glucose test by age 45 and if normal, retest at least every three years. If any of the above risk factors are present, testing should begin earlier and be done more often. Elevated blood sugar can develop so slowly that many persons are unaware of the symptoms.

Symptoms of Diabetes can include:

- Hunger.
- Extreme thirst.
- Frequent urination.
- Unexplained weight loss.
- Fatigue.
- Blurry vision.
- Frequent infections.

Complications of high glucose levels occur in all body systems and, when left uncontrolled, will lead to death.

- Diabetes kills more than 193,000 Americans each year.
- Two out of three people with Diabetes die from heart attacks, strokes or peripheral vascular disease.
- Diabetes causes nerve damage that makes painless heart attacks more likely and harder to diagnosis.
- Heart attacks are more likely to be fatal in persons who have Diabetes than in those who don't.
- Uncontrolled Diabetes can also lead to blindness, kidney disease and amputations.

Prevention of diabetic complications depends upon the close control of blood glucose levels through diet, exercise, monitoring and medications. Excess weight strains the heart, raises blood pressure, and is usually associated with elevated cholesterol and triglyceride levels. The right balance of foods will help insulin and/or Diabetes medications keep glucose levels lower. Physical activity helps control weight and build muscle mass, which makes insulin and Diabetes medications work more effectively. Glucose levels need to be monitored frequently, sometimes multiple times daily. If insulin injections and/or medications are needed, they must be taken with regularly scheduled meals and snacks.

Screening exams and physician ordered laboratory tests can detect early complications:

- Eye disease (diabetic retinopathy); annual screening should be done by medical provider.
- Foot lesions and nerve problems (peripheral neuropathy); annual exam and daily self-exams are essential.
- Heart disease: will affect nearly every person with Diabetes; all diabetics should be examined regularly for signs such as high blood pressure, lipid levels, EKG changes, impaired circulation, shortness of breath or chest pain.
- Laboratory screening tests include the **Glycated hemoglobin test (A1C)**, which shows average blood glucose and should be done twice a year; **cholesterol and lipids** (control of these reduces heart disease risk) should be done annually; and **urine protein** (sign of kidney disease or nephropathy), check annually.

Information for those with Diabetes can be obtained from:

- American Diabetes Association (ADA) 1-800-DIABETES. www.Diabetes.org
- American Heart Association 1-800-242-8721. www.americanheart.org/Diabetes
- National Diabetes Education Program. <http://ndep.nih.gov>
- Centers for Disease Control and Prevention. www.cdc.gov/Diabetes
- Local county or city health department.
- Ohio Department of Mental Retardation and Developmental Disabilities “Every Healthy Person” document, under Diabetes care guidelines for individuals. <http://www.odmrdd.state.oh.us>

For questions or comments regarding the above Alert, please contact the MUI/Registry Unit at (614) 995-3810.

January 2004



Health & Safety Alert #17-03-07

Enteral Tube Feeding

This alert is to inform families and people who work in this field about issues that impact the health and safety of people for whom we provide services. There have been a number of serious issues arise associated with complications of feeding tubes.

Basic Facts:

Enteral feeding tubes are tubes placed in the gastrointestinal tract through an opening in the upper abdominal wall into the stomach. Gastric tubes (G-tube, PEG) are placed in the stomach and jejunostomy tubes (J-tube) are placed in the small intestine. These feeding tubes are used for a variety of reasons, including problems swallowing, recurrent aspiration and pneumonia, and inability to maintain adequate nutrition or fluid intake. Most of the research on the efficacy of tube feeding has been done in the long-term care setting (nursing homes). The populations studied are somewhat dissimilar to the individual with developmental disabilities who develops dysphagia and difficulty swallowing. However, the decision process to proceed with placement of a tube for feeding, the complications of the procedure and subsequent feeding, and, the long-term outcomes are similar between the nursing home population and the adult population with developmental disabilities. It is important for all stakeholders to have the opportunity to understand the benefits and risks of initiating enteral tube feeding for dysphagia or malnutrition (see list of articles at end of alert).

1. Critical steps to take following enteral feeding tube placement:
 - ◆ Discuss with the physician performing the procedure when to start using the feeding tube and the type of tube feeding to use.
 - ◆ Leakage from the gastrostomy site (opening in the abdominal wall through which the tube enters the stomach) is a potential complication of feeding tube placement.
 - ◆ Some advocate feeding tubes not be used for 24-48 hours after placement, to allow for healing of the gastrostomy site to begin. However, this is not universal practice, and many persons do well with more immediate initiation of tube feedings. If use of an enteral feeding tube is delayed, then other means of providing adequate fluids is necessary.

2. Potential complications of enteral tube feedings

- ◆ Gastroesophageal reflux (reflux of tube feeding from stomach into esophagus)
- ◆ Aspiration (of tube feed, of saliva, into airway)
- ◆ Peritoneal leak, peritonitis (irritation or infection in the abdomen, causes abdominal pain, change in behavior, fever, vomiting)
- ◆ Infections, as the insertion of the tube and the feeding tube solutions are not necessarily sterile
- ◆ Agitation
- ◆ Gastric perforation (another hole in the stomach in addition to the hole for placement of the feeding tube)
- ◆ Migration or displacement of tube
- ◆ Clogging of tube
- ◆ Bleeding at insertion site
- ◆ Hematoma (bruising) of abdominal wall
- ◆ Erosion of bumper/button into abdominal wall
- ◆ Wound dehiscence (separation of the wound in abdominal wall where feeding tube enters stomach)
- ◆ Cellulitis (infection of the skin around the feeding tube opening in the abdominal wall)
- ◆ Closure or stenosis of stoma (opening through the abdominal wall into the stomach)
- ◆ Ileus (bowel stops working, may have abdominal pain, vomiting, constipation, fever, dehydration)
- ◆ Diarrhea
- ◆ Fluid and electrolyte imbalance
- ◆ Nutritional concerns
- ◆ Altered sense of self (loss of social aspects of eating, loss of dignity)

3. Positioning during feeding and afterwards.

To reduce the danger of food and fluid coming back up out of the stomach and causing aspiration, keep the individual in a position which elevates their head and shoulders at least 30 degrees from horizontal during feeding and at least one hour afterwards. Please note that some individuals may need to be raised to a 45 degree angle.

4. Obtain medical help immediately if the individuals have any of the following symptoms

- ◆ Vomiting
- ◆ Abdominal pain
- ◆ Leakage or bleeding from the tube site
- ◆ Leakage from the tube
- ◆ Constipation or diarrhea
- ◆ Fever
- ◆ Individual exhibits unusual behavior

Recent literature concerning benefits and risks of tube feeding:

1. Gillick M. Sounding Board: Rethinking the Role of Tube Feeding in Patients with Advanced Dementia. *NEJM*. 2000;342(3):206-210.
2. Finucane TE, Christmas C, Travis K. Tube feeding in patients with advanced dementia: a review of the evidence. *JAMA*. 1999;282:1365-1370.
3. Lo B, Dornbrand L. Editorial: Understanding the Benefits and Burdens of Tube Feedings. *Arch Intern Med*. 1989;149:1925-1926.
4. Marik PE. Aspiration Pneumonitis and Aspiration Pneumonia. *NEJM*. 2001;344(9): 665-671.
5. McCann R. Lack of Evidence About Tube Feeding-Food for Thought. *JAMA*. 1999;282(14):1380-1381.

For questions or comments regarding the above Alert, please contact the MUI/Registry Unit at (614) 995-3810.

March 2007

Health and Welfare Alert
Choking #18-04-13

Purpose

The purpose of this Alert is to provide critical information to caregivers on choking prevention. People with developmental disabilities are at a high risk for choking. Those providing care can help reduce these risks, provide timely care, and potentially save a life. This Alert will provide some signs that may indicate a person is choking and what you can do to help.

All DD Employees are required to be trained, annually, on identification and reporting of Major Unusual Incidents and Unusual Incidents prior to unsupervised contact. This training includes the review of any **Health and Welfare Alerts** released since the previous calendar year's training.

For questions or comments regarding this Alert, please contact the MUI/Registry Unit at (614) 995-3810.

Last year, nine Ohioans with developmental disabilities passed away due to choking related accidents. We believe prevention is the key to saving lives. While nine people lost their lives, many more were saved by the fast action of others. In fact in over 350 other cases, a caregiver (family member, staff member or friend) successfully intervened by performing abdominal thrusts or back blows and saved that person's life. We want to provide some information to you about choking and urge you to be prepared in the event that someone you are caring for chokes.

What is Choking? When you breathe air goes through your nose or mouth and then down a tube called the trachea (sometimes called the "wind pipe") and then into your lungs. If food or something else gets into your wind pipe and gets stuck, then the air you need cannot get to your lungs. When that happens, you are choking.

Who is in danger of Choking?

Anyone can choke, but choking is more likely for someone who:

- Has cerebral palsy or a seizure disorder.
- Has few or no teeth, or wears dentures.
- Has trouble chewing or swallowing.
- Does not sit up while eating.
- Someone who is prescribed medications such as muscle relaxants, anticonvulsants or psychotropics, which may delay swallowing or suppress protective gag and cough reflexes.
- Has Gastroesophageal Reflux Disorder (GERD) which may cause aspiration of refluxed stomach contents.

What Causes Choking? Certain behaviors can cause choking. These behaviors include:

- Eating too quickly.
- Not chewing food completely, so that large pieces remain in the mouth.
- Talking or laughing while eating.

How can you tell if someone is Choking:

- Trying to speak, but are not able.
- Coughing weakly.
- Breathing noisily or making high pitched sounds.
- Turning blue in the face.
- Nail beds turning blue.
- Fainting.
- Moving around a lot and looking very upset.
- Not responding.
- Slumped over in chair where they were eating.
- Wide -Eyed Look on face.



Choking Prevention:

- Cut food into small pieces.
- Encourage individuals to chew slowly and completely before swallowing.
- Do not talk or laugh while you have food in your mouth.
- Use any needed adaptive equipment.
- Do not run or play while you have food in your mouth.
- Eat with other people who can help you.
- Make sure proper supervision is provided.
- Serve food in proper diet texture

Steps to Take if someone is choking:

- **Always follow your First Aid training**
- **If an individual's airway is blocked, have someone call 911 immediately (if another person is unavailable, call 911 yourself) and perform Abdominal Thrust (formerly known as the Heimlich maneuver). This has been extremely successful in dislodging foods.**
- **If an individual is in a wheelchair or has physical characteristics that make it difficult to do Abdominal Thrust, move the individual to a flat, hard surface to ensure the greatest success. Be ready to initiate quick chest compressions to help unblock airway.**
- **Even if the Abdominal thrust is successful, immediately notify a health care professional. It is advisable to have the individual physically checked by a health care professional following the use of these procedures.**

More Info

For further assistance regarding Choking Prevention, please contact:

American Red Cross

<http://www.redcross.org/take-a-class>

American Heart Association

<http://www.heart.org/HEARTORG/>

SafeKids USA

<http://www.safekids.org/>

For Questions or Comments

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