

"Major unusual incident" means the alleged, suspected, or actual occurrence of an incident when there is reason to believe the health or welfare of an individual may be adversely affected or an individual may be placed at a likely risk of harm, if such individual is receiving services through the developmental disabilities service delivery system or will be receiving such services as a result of the incident. There are three categories of major unusual incidents that correspond to three administrative investigation procedures delineated in appendix A, appendix B, and appendix C as defined in rule O.A.C. 5123:2-17-02. There are (19) nineteen types of incidents defined in the rule that are considered major unusual incidents (MUIs).

"Unusual incident" means an event or occurrence involving an individual that is not consistent with routine operations, policies and procedures, or the individual's care or individual service plan, but is not a major unusual incident. Unusual incident includes, but is not limited to, dental injuries; falls; an injury that is not a significant injury; medication errors without a likely risk to health and welfare; overnight relocation of an individual due to a fire, natural disaster, or mechanical failure; an incident involving two individuals served that is not a peer-to-peer act major unusual incident; and rights code violations or unapproved behavior supports without a likely risk to health and welfare.

All agency providers and county boards shall direct that staff is trained on all of the requirements of the MUI Rule prior to unsupervised contact with any individual and in all cases, no later than 30 days after employment. Thereafter, all employees shall receive MUI training during each calendar year which shall include a review of health and welfare alerts released since the previous calendar year's training. Health and Safety alerts can be found at <http://dodd.ohio.gov/health/alerts.htm>

All of the incidents require that immediate action is taken to protect individuals from further harm, that an investigation is conducted to determine the cause of the incident and contributing factors, and that a prevention plan is developed to reduce the likelihood of future occurrences.

MUIs are reported to the local County Board of Developmental Disabilities (DD), which then reports the information to the Department of Developmental Disabilities (DODD). County Boards of DD are responsible for immediate action, investigations, and prevention planning for each incident. In order to demonstrate compliance, a provider/county board must be able to evidence the following:

Upon identification of a Major Unusual Incident, the provider took the following immediate actions as appropriate:

- Ensure that individual received immediate and on-going medical attention for injuries (document that action)
- Removal of an employee from direct contact with any at-risk individual when the employee is alleged to have been involved in abuse or neglect until such time as the provider has reasonably determined that such removal is no longer necessary;
- All other necessary measures to protect the health and safety of at-risk individuals.
- Notification to the County Board about the below listed incidents within 4 hours of discovery:
 - Abuse (Physical, Sexual, Verbal)
 - Peer to Peer Acts
 - Failure to Report

Exploitation
Misappropriation
Neglect
Suspicious/Accidental Death
Media Inquiry

[After Hours MUI Contact Information](#) for the county boards and COGs are available through the Department's Website at www.dodd.ohio.gov

Providers must complete a written incident report documenting the major unusual incident or unusual incident. The report must include but is not limited to the following:

- Individual's name;
- Individual's address;
- Date of incident;
- Location of incident;
- Description of incident;
- Type and location of injuries;
- Immediate actions taken to ensure health and welfare of individual involved and any at-risk individuals;
- Name of primary person involved and his or her relationship to the individual;
- Names of witnesses;
- Statements completed by persons who witnessed or have personal knowledge of the incident;
- Notifications with name, title, and time and date of notice;
- Further medical follow-up; and
- Name or signature of person completing the incident report.

A written incident report is submitted to the County Board by 3:00 p.m., the next working day following initial (discovery) knowledge of a potential or determined MUI.

If applicable, the provider makes appropriate notifications to other agencies:

- Children's Services
- Law Enforcement

Documented evidence that the provider made notification on the same day of the incident to the following as applicable:

- Guardian
- Service and Support Administrator
- Residential Provider
- Staff or Family who provide direct supervision in the home

The provider cooperated with the investigation of MUIs by:

- Providing requested information in a timely manner
- Providing results of an internal investigation (if conducted) to county board
- within 14 days of completion
- Providing evidence that a prevention plan was identified, a collaborative team effort by relevant involved parties participated in the prevention plan, and that the prevention plan addressed the causes and contributing factors identified in the investigation.

- Submitted evidence that the prevention plan is being implemented and made part of the plan and that the individual's
- Service Plan was revised if necessary.

Upon identification of an Unusual Incident, the provider took the following immediate actions as appropriate:

- Report was made to the designated person
- The Unusual Incident report was made within 24 hours of the incident
- Appropriate actions were taken to protect the health and safety of the at-risk individual
- Investigation occurred to identify causes and contributing factors and an effective prevention plan.

The provider/County Board as provider conducts a monthly review of Unusual Incidents

The provider/County Board maintains a log of Unusual Incidents which includes, but is not limited to:

- Name of Individual
- Description of Incident
- Injuries
- Time of Incident
- Date of Incident
- Location of Incident
- Preventative Measures to address both the individual incidents and identified trends.
- Review for any missed MUI's

As a best practice, providers may want to consider adding the following information to the log:

- Immediate Actions (for Identification and treatment of Injuries, removal of threat, etc.)
- Causes and Contributing Factors (This is not in the rule but is certainly best practice)
- If no trend exists, provider should indicate that in writing as opposed to just not submitting or documenting outcomes.

Evidence that the provider completed the required review of MUIs as follows:

- Semi-Annual Review (Due by August 31)
- Annual In-Depth Review (Due by February 28)

Evidence that all incidents were reported as either an unusual incident or major unusual incident

For your convenience, additional resources are available on the Department's website at www.dodd.ohio.gov.