2016
MUI Training for the Administrator

Ohio | Department of Developmental Disabilities

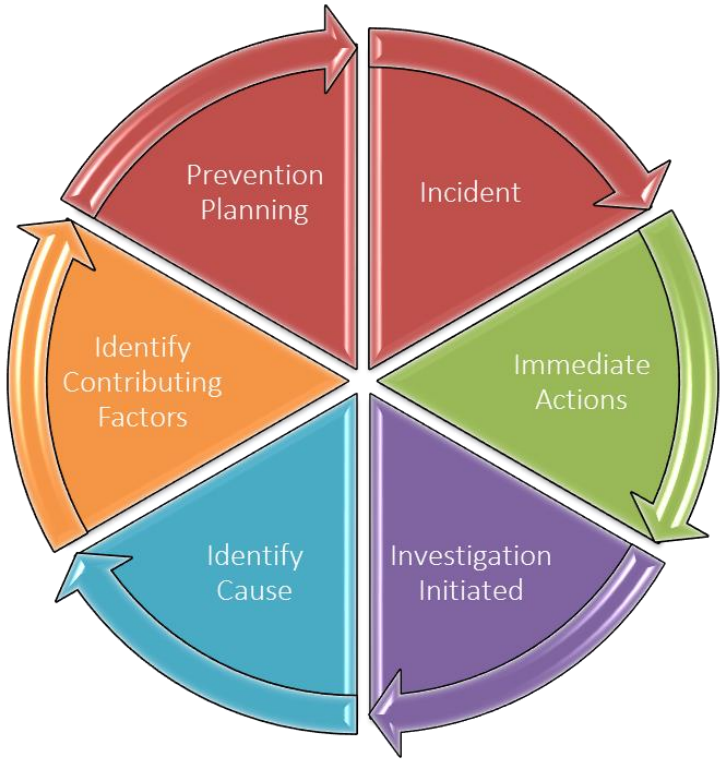
Purpose of Training

- This training is intended for professionals who work in an administrative capacity and are responsible for the oversight of reporting and investigations. This training covers the following topics:

- MUI Rule Definitions
- Reporting Requirements
- Patterns and Trends
- Access to Records
- Training Responsibilities

What is O.A.C. 5123:2-17-02?

The MUI Rule establishes the requirements for addressing major unusual incidents and unusual incidents and implements a continuous quality improvement process in order to prevent or reduce the risk of harm to individuals.



Importance of reporting

- What is the purpose of Ohio's Health and Welfare system?
- Are MUIs bad?
- What does it mean if I or the agency I work for report MUIs?

What can we do to encourage reporting?

1. Follow a system that everyone understands and knows what to do. Start by believing.

2. Build into the system and test for times/areas of weakness – Weekends, prior to vacations, certain key people not available to report to.

3. Take all reports seriously – including “historical” reports and reports from all witnesses.

What can we do to encourage reporting?

4. Know resources and relationship with law enforcement/children's services prior to crisis. Safety planning.

5. Maintain, as much as possible, confidentiality and anonymity. Support witness.

6. Red Flags of Non-Reporting – investigate.

7. Take Immediate Action.

What can we do to encourage reporting?

8. Prevention measures for failure to report. Criminal charges, Removal, Registry, Provider Certification, Training.

9. Individual First – Think about the worst case scenario.

10. Leadership.

Major Unusual Incidents

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 to this rule.

Major Unusual Incidents

Key points:

- Alleged, suspected or actual occurrence
- Reason to believe a person is at risk of harm based on facts present not opinion
- Receiving services or will be as a result of incident

There are 19 categories of MUIs

Physical Abuse

Elements: Physical force and reasonably be expected to result in harm

Examples: Hitting, slapping, pushing, dragging or throwing an object when the allegation indicates that it could reasonably result in harm.

Cause/Contributing Factors:

- Control
- Unrealistic expectations, retaliation, intimidation for covering up theft
- Care giver burn out and exhaustion
- Scheduled excessive hours
- Lack of coping skills
- Ineffective training to deal with aggression

Physical Abuse Trends 2015

1,465 physical abuse were reported and 421 (29%) were substantiated.

Break down by PPI Type is as follows:

Family- 96 (23%)

Employees -138 (33%)

Others*- 122 (29%)

Guardian- 5 (1%)

Payee-1 (less than 1%)

Unknown- 59 (14%)

* Other includes friends, neighbors and acquaintances.

Verbal Abuse

Verbal abuse means the use of words, gestures, or other communicative means to threaten, coerce, intimidate, harass or humiliate an individual.

Examples: Using social media to post humiliating pictures of someone you serve, threatening to harm a person if they tell on you for sleeping, telling the individual that you will have their roommate beat them up if they don't stop screaming.

Cause/Contributing Factors:

- Control; unrealistic expectations
- Staff are in challenging situation with little support
- Staff don't recognize their own trauma history

Verbal Abuse Trends 2015

773 Verbal Abuse MUIs were reported and 324 (42%) were substantiated.

Break down by PPI Type is as follows:

Employees-192 (59%)

Others-72 (22%)

Family-44 (14%)

Unknown-16 (5%)

Sexual Abuse

- Unlawful sexual contact
- Unlawful sexual conduct
- Public indecency, voyeurism, importuning, etc.

Examples:
Contact involves touching of an erogenous zone of another, including without limitation the thigh, genitals, buttock, pubic region, or, if the person is a female, a breast, for the purpose of sexually arousing or gratifying either person. Conduct includes oral sex or penetration including digital or with objects.

Causes and Contributing Factors:
Power
PPI was a victim of sexual abuse

Sexual Abuse Trends 2015

294 Sexual Abuse reports were made and 69 were substantiated (23%).

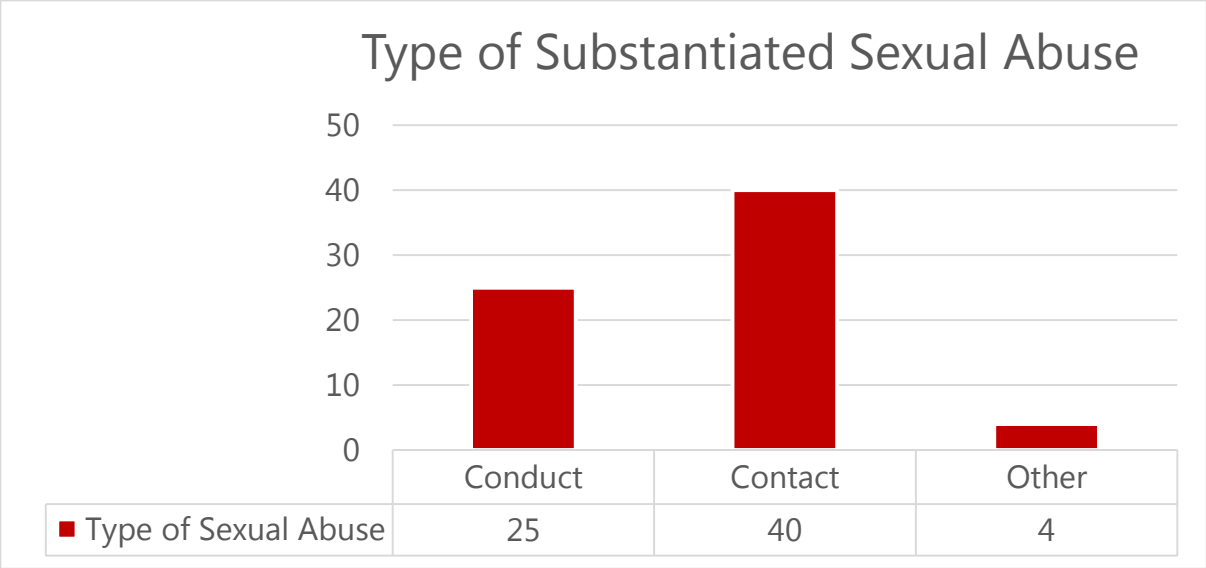
Break down by PPI:

Others-40 (58%)

Family-19 (28%)

Unknown-7 (10%)

Employees-3 (4%)



Important to remember:

Some reasons people don't report:

- Manipulation, threats or fears of retaliation
- Fear of not being believed, especially if they have tried to report before
- Family dynamics/keeping the family together
- They may believe they are at fault
- The individual may not realize that he or she has been victimized

Learn more about the impact of trauma

http://mha.ohio.gov/Portals/0/assets/Initiatives/TIC/Disabilities/Health%20challenges%20facing%20Ohioans%20with%20disabilities.pdf

Know the Signs of Abuse

- Ongoing unexplained health problems like stomach aches, headaches
- Display of new fears
- Withdrawal from previously enjoyable activities, places, or persons, suddenly avoiding places or people
- Changes in sleep patterns such as nightmares,
  trouble sleeping, sudden bedwetting, and other sleep problems
- Dressing in layers of clothing
- Changes in appetite, loss of appetite, weight gain or loss
- Bruising
- Bleeding, soreness, redness, irritation, itching, and unusual discharges
- Torn or stained underwear or linens
- Sexually transmitted diseases
- New sexual knowledge or sexual behavior
- Sudden difficulty walking or sitting
- Suddenly frightened of certain people or situations

Know what to do

- Help the person feel safe, set judgements aside
- Remember to NOT imply blame on the victim.
- Ask questions like "Were you able to?" instead of "Why didn't you?" when talking to the individual.
- Emotionally support the victim.

Know what to do

- Remember to refer the individual for counseling and victim's assistance as appropriate. Ask open-ended questions
- Make a point to talk with the person one on one, repeatedly over multiple visits
- Make unscheduled visits
- Have a plan of response
- Every one deals with trauma differently

You have the power to make people feel safe and supported.

Prohibited Sexual Relations

- Developmental Disabilities employee
- Consensual sexual conduct or contact
- With an individual who is not their spouse
- Employed or under contract to provide care to the individual at the time of the incident
- Anyone in the Developmental Disabilities employee's supervisory chain of command

20 Allegations and 6 Substantiated Cases (30%) in 2015

Misappropriation

- With intent
- Deprive, defraud, or otherwise obtain real or personal property
- As prohibited in Ohio Revised Code 2911 and 2913

Examples: Using someone's credit card, taking a person's Ipad, "borrowing" someone's money and paying it back on Friday, withdrawing cash from their personal funds without their knowledge/permission.

Cause and Contributing Factors:

PPI has a gambling or drug problem

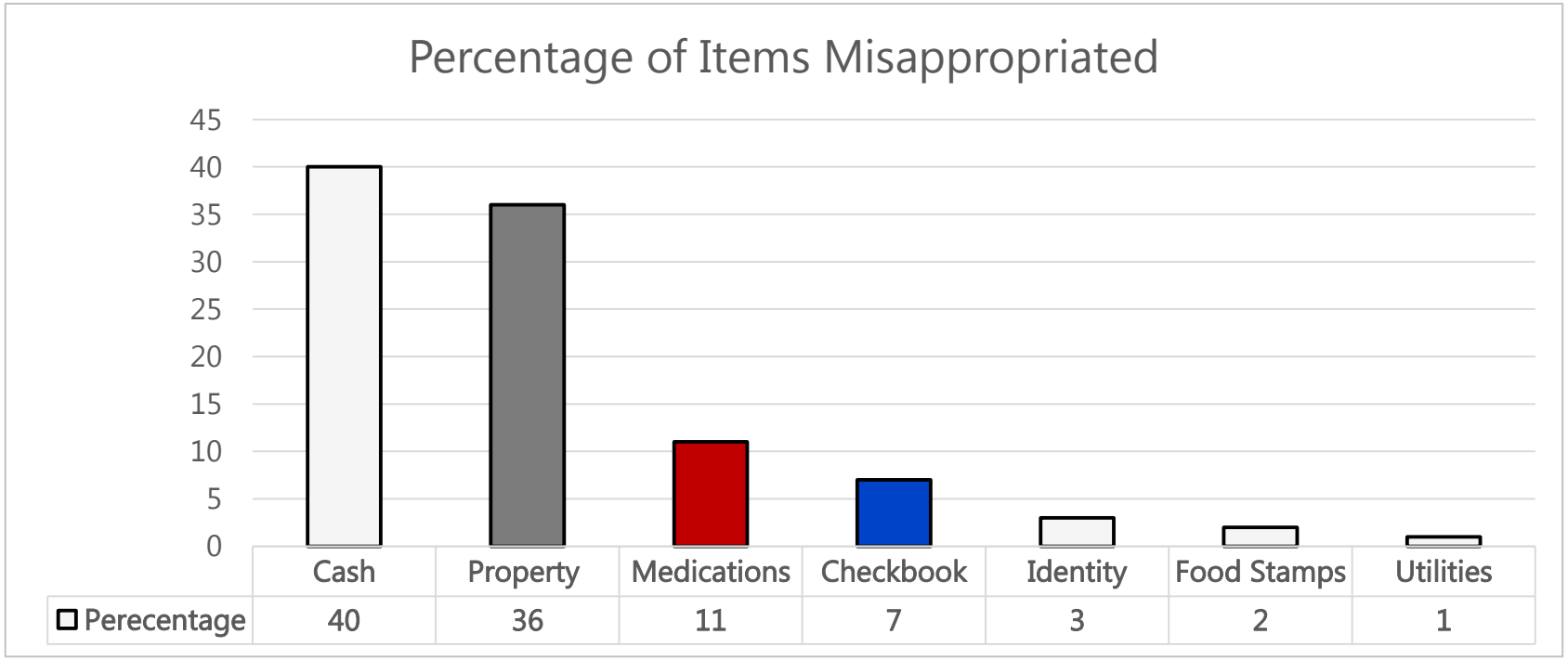
Multiple people have access to property or funds

Easy access to individual's financial information

Misappropriation Trends 2015

1,246 Allegations were reported and 813 were substantiated (65%).

Break down by PPI:
Unknown-482 (59%)
Employees-168 (21%)
Guardian-12 (1%)
Others-72 (9%)
Family-65 (8%)
Payee-14 (2%)



Exploitation

- Unlawful or improper or
- Using Individual's resources for personal benefit, profit, or gain

Examples: Selling raffle tickets to individuals for your daughter's sports team, having the individual buy home party items so you can get free stuff, having an individual clean your house, having the individual buy a fax machine for you to use at their home for your business.

In 2015, there were 117 allegations of Exploitation reported. 70 (60%) of those reports were substantiated.

Neglect

- A duty
- Failing to provide treatment, care, goods, supervision or services
- Necessary to maintain the health or welfare of the individual

What is Reasonable Risk? Harm more likely than not could occur

Examples: Not ensuring that someone was there to receive person when you dropped off from school/work, not securing the tie downs on van, giving someone the wrong diet.

Neglect Trends 2015

1,811 Allegations and 1,208 Substantiated Cases (67%).

Break down by PPI:

Employees-976 (81%)

Others-92 (8%)

Family-114 (9%)

Guardian-15 (1%)

Unknown-11(1%)

Neglect

- Failing to provide supervision made up **63%** of all substantiated neglect cases.
- Failing to provide treatment was **37%** of all substantiated 2015 cases.

What is Systems Neglect?

When a individual is neglected and the neglect is not the result of a particular person/people, a system neglect is identified. A systems issues is a process that involves multiple components playing a role in the neglect.

Causes & Contributing Factors Supervision Neglects

Supervision Levels are not met by:

- Scheduling Problems; Impaired Staff
- Employee-No Shows, Planned sleeping and/or leaving
- Not following supervision levels (i.e., community, mealtimes).
- No training or lack of training on supervision levels (1:1, 24-7 eyes on, etc.) Risk of Harm?

Be extra alert during transition times to make sure people's needs are met.

Causes & Contributing Factors Treatment Neglects

- Criminal activity – not feeding or providing medication to a person
- Medical attention – will not call 911
- Dietary Texture and pacing while eating
- Failure to follow ISP
- Failure to follow Doctor's orders
- Lack of training on treatments (i.e., turning schedule, monitoring treatments)

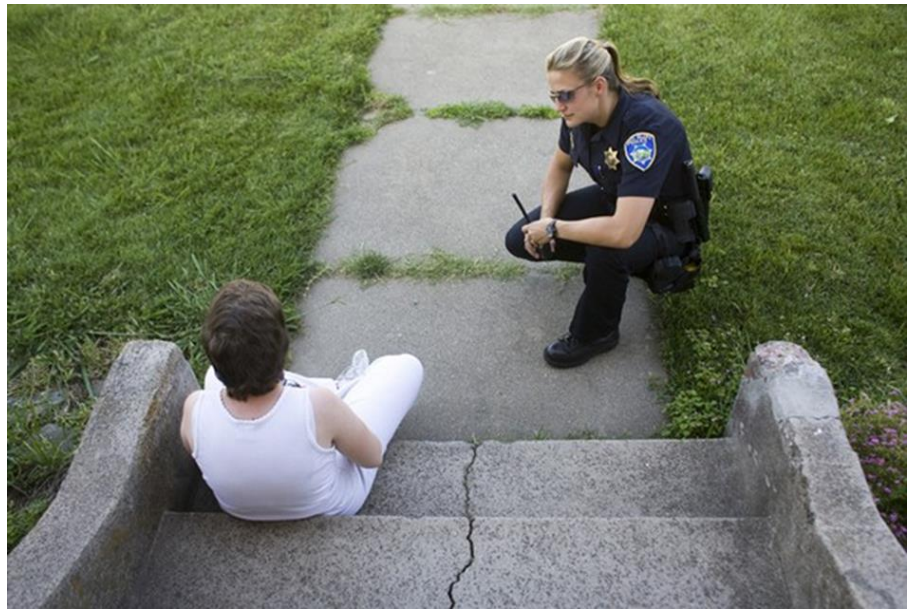
Failure to Report (Registry)-2015

- Developmental Disabilities employee unreasonably failed to report Abuse or Neglect
- Knew or should have known
- Failure would result in a substantial risk of harm

In 2015, there were 182 allegations of Failure to Report reported. 137 (75%) of those reports were substantiated.

Due to the definition, staff was the PPI 100% of all substantiated cases.

Law Enforcement



Individual is:

Charged (C)

Incarcerated (I)

Arrested (A)

*added tased even if individual is not arrested

In 2015, there were 860 MUIs filed for Law Enforcement events with individuals served.

Attempted Suicide

Physical attempt that:

- Results in ER treatment **or**
- Inpatient observation **or**
- Hospital admission

There were 123 attempted suicides reported resulting in 2 deaths.

Take any suicidal talk very seriously. It's not just a warning sign that the person is thinking about suicide — it's a cry for help.

Missing Individual

An incident that is not considered neglect and an individual's whereabouts, after immediate measures taken, are unknown and the individual is believed to be at or pose an **imminent risk of harm to self or others.** An incident when an individual's whereabouts are unknown for longer than the period of time specified in the individuals service plan that does not result in imminent risk of harm to self or others shall be investigated as an unusual incident.

In 2015, there were 331 MUIs filed for Missing Individuals which was a 13% decrease from 2014.

Peer to Peer Acts

Peer-to-peer act. "Peer-to-peer act" means one of the following incidents involving two individuals served:

- Exploitation
- Theft
- Physical Act
- Sexual Act
- Verbal Act

In 2015, there were 1,452 MUIs filed for Peer to Peer Acts.

Peer to Peer Act Definitions

Exploitation which means the unlawful or improper act of using an individual or an individual's resources for monetary or personal benefit, profit, or gain.

Theft which means intentionally depriving another individual of real or personal property valued at *twenty dollars or more or property of significant personal* value to the individual.

Sexual Act which means sexual conduct and/or contact for the purposes of sexual gratification without the consent of the other individual.

Verbal Act which means the use of words, gestures, or other communicative means to purposefully threaten, coerce, or intimidate the other individual when there is the opportunity and ability to carry out the threat.

Peer to Peer Act Definitions

Physical Act that occurs when an individual is targeting, or firmly fixed on another individual such that the act is not accidental or random and the act results in an injury that is treated by a physician, physician assistant, or nurse practitioner. Allegations of one individual choking another or any head or neck injuries such as a bloody nose, a bloody lip, a black eye, or other injury to the eye, shall be considered major unusual incidents.

Minor injuries such as scratches or reddened areas not involving the head or neck shall be considered unusual incidents and shall require immediate action, a review to uncover possible cause/contributing factors, and prevention measures.

Examples: Black eye (firmly fixed), choking peer, bloody nose (firmly fixed), or any injury from P2P physical act that results in treatment by a physician, physician's assistant, nurse practitioner or dentist.

Rights Code Violation

"Rights code violation" means any violation of the rights enumerated in section 5123.62 of the Revised Code that creates a likely risk of harm to the health or welfare of an Individual.

Examples:

Staff takes the individual to a movie, he does not want to go, and he becomes upset and bangs his head against the wall.

Staff padlocks the refrigerator and the individual sustains a laceration trying to break the lock.

Staff refuses to take the individual on a scheduled activity for their own convenience or preference. The scheduled activity is a reinforce for positive behavior. Individual is upset due to this rights violation and becomes aggressive. LE is contacted the individual is arrested.

There were 71 reported Rights Code Violations and 38 (54%) were substantiated.

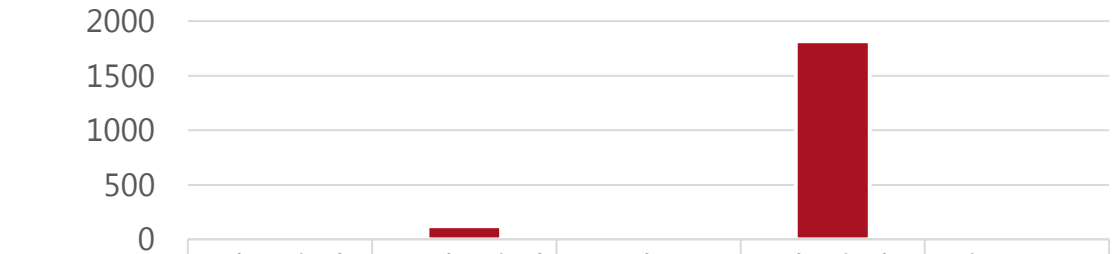
Unapproved Behavior Support

Unapproved behavior support. "Unapproved behavior support" means the use of an aversive strategy or intervention prohibited by of rule 5123:2-2-06 of the Administrative Code or an aversive strategy implemented without approval by the human rights committee or behavior support committee or without informed consent, that results in a likely risk to the individual's health and welfare.

An aversive strategy or intervention prohibited by 5123:2-2-06 of the Administrative Code that does not pose a likely risk to health and welfare shall be investigated as an unusual Incident.

Reporting of Unapproved Behavior Supports

- There were 2,015 reported UBS in 2015.
- In 87% of all cases there was no injury.
- 13% minor injuries were sustained.
- Anytime, you place your hands on someone that is not approved, there is a risk of harm.



	Chemical	Mechanical	Other	Physical	Time Out
UBS Type	35	121	25	1,816	18

-Use of restrictive measure without HRC approve must be reported as an "unapproved behavior support"

-UI or MUI
Was health/welfare adversely affected or was there a risk of harm?

-You should still intervene in a crisis to ensure health/safety.

Significant Injury

Significant injury means an injury of known or unknown cause that is not considered abuse or neglect and that results in concussion, broken bone, dislocation, second or third degree burns or that requires immobilization, casting, or five or more sutures. Significant injuries shall be designated in the incident tracking system as either known or unknown cause.

Examples: falls, broken finger of unknown origin, scalding burn to hands from faucet.

There were 1,619 reported Significant Injuries.

734 of those were falls.

Significant Injuries-Falls

Year	Falls Reported as Significant Injuries	Total Significant Injuries Reported	% Falls Related Injuries
2010	752	1763	45%
2011	733	1638	45%
2012	761	1635	47%
2013	764	1755	44%
2014	771	1691	46%
2015	734	1619	45%

Medical Emergency

Medical emergency means an incident where emergency medical intervention is required to save an individual's life.

Examples include: choking relief techniques such as back blows or cardiopulmonary resuscitation, epinephrine auto injector usage, or intravenous for dehydration.

There were 703 medical emergencies filed in 2015.

- Abdominal Thrusts were used on 262 occasions and back blows were used 85 times, accounting for 49% of all medical emergencies.
- Dehydration was 2nd highest category with 99 reports.

Choking Prevention- You are the key

- Right Diet
- Proper Positions- 90 degree angle during all intake
- Supervision
- Take precaution with foods that are common choking hazards
- Document all choking incidents
- Notify the doctor or nurse of any swallowing concerns

High Risk Medical Conditions

A special emphasis should be placed on those with high risk conditions as these conditions can change rapidly and consistent monitoring is key to maintain stable health.

Those who provide care to people with high-risk medical conditions should frequently talk with the person about any changes or symptoms that might be developing, in order to identify any potential issues at their earliest stages.

If a person is in charge of their health care for themselves, (i.e. scheduling their own appointments, administering their own medications) then those who provide care can still offer assistance and support in complying with medical direction.

High Risk Medical Conditions

- Individuals on blood thinners, whose blood tests are monitored closely
- Brittle diabetics
- Cardiac pacemakers/implanted cardio-defibrillators/severe cardiomyopathy
- Refractory or hard to control seizures
- End stage kidney failure/dialysis patients
- Individuals with high risk of falls
- Advanced COPD/asthma/patients requiring O2
- Unstable mental illness: schizophrenia/bipolar/depression
- Hormone deficiency: Thyroid, adrenal, pituitary, insulin
- Dysphagia/high risk aspiration-G tubes, or specialized diets
- Cancer

Unscheduled Hospitalizations

Unscheduled hospitalization. "Unscheduled hospitalization" means any hospital admission that is not scheduled unless the hospital admission is due to a pre-existing condition that is specified in the individual service plan indicating the specific symptoms and criteria that require hospitalization.

Unscheduled Hospital-2015

- In 2015, there were 5,016 reports of unscheduled hospitalizations (leading reported MUI).
- Unscheduled Hospitalizations make up 25% of all MUIs.

Some Examples:

- The individual has labored breathing and rapid heartbeat and is admitted to the hospital with a diagnosis of pneumonia.
- The individual is lethargic and unsteady, goes to the ER and is hospitalized for a possible medication error.
- Individual goes to ER and is sent home after 25 hours.

Death Definitions

- Accidental or suspicious death. "Accidental or suspicious death" means the death of an individual resulting from an accident or suspicious circumstances (Category A)

- Death other than accidental or suspicious death. "Death other than accidental or suspicious death" means the death of an individual by natural cause without suspicious circumstances (Category B)

Deaths Trends-2015

- There were 750 reported deaths in 2015 which is a slight decrease from 2014.
- Of the 2015 deaths, 35 were considered Accidental or Suspicious while 715 were Non-Accidental/Non-Suspicious Deaths.
- Heart disease continues to be the leading cause of death for Ohioans with disabilities as well as the general population.
- Pneumonia and aspiration pneumonia continue to make up the next largest causes of death.

Positive Trend: Accidental deaths decreased 39% from the last year.

Heart Health

While the numbers for Heart Disease are similar for people without developmental disabilities, **people with developmental disabilities face some additional challenges** when it comes to being heart healthy. According to the American Heart Association, people with disabilities are at an increased risk for cardiovascular disease because they are more likely to:

- **Have high blood pressure**
- **Have abnormal cholesterol and high triglycerides**
- **Be overweight**
- **Not get enough exercise or movement**

The good news is, its never too late to lower the risk for heart disease, and changing habits can help to begin reducing risks right away.

- **Eat a heart healthy diet:** Eat a balanced diet with plenty of fruits and vegetables. Avoid fried foods, and foods with a lot of salt.
- **Get plenty of exercise:** The American Heart Association recommends at least 30 minutes of moderate-intensity aerobic activity at least 5 days per week, or at least 25 minutes of vigorous aerobic activity at least 3 days per week – or a combination of moderate-and vigorous-intensity aerobic activity. You don't even need to go to the gym – walking is great exercise.
- **Don't smoke:** Smoking is one of the most dangerous and unhealthy habits you can have. It offers no health benefits, and greatly increases your risk of lung cancer and autoimmune diseases as well as heart disease. Smoking is one of the most difficult habits to break, but it is worth it. Talk with your doctor about ways to quit.

Check out this learning tools for individuals and their caregivers about Heart Health
http://www.ddssafety.net/health/heart-problems

2015 MUI Review by Percentage

Decided MUIs and Percentage of Total MUIs-2015			
Decided Incident Category	MUI Count	Total MUIs	%
Unscheduled Hospitalization	5,016	19,875	25.24
Unapproved Behavior Support	2,015	19,875	10.14
Alleged Neglect	1,811	19,875	9.11
Significant Injury	1,619	19,875	8.15
Alleged Abuse - PHYSICAL	1,465	19,875	7.37
Peer-to-Peer Acts	1,452	19,875	7.31
Misappropriation	1,246	19,875	6.27
Law Enforcement	860	19,875	4.33
Alleged Abuse - VERBAL	773	19,875	3.89
Non Accidental/Suspicious Death	715	19,875	3.60
Medical Emergency	703	19,875	3.54
Missing Individual	331	19,875	1.67
Alleged Abuse - SEXUAL	294	19,875	1.48
Failure To Report	182	19,875	0.92
Attempted Suicide	123	19,875	0.62
Exploitation	117	19,875	0.59
Rights Code Violation	71	19,875	0.36
Accidental/Suspicious Death	35	19,875	0.18
Prohibited Sexual Relations	20	19,875	0.10
Undecided MUIs as of 2.1.16	1,027	19,875	5.17
Total MUIs Decided 2015	19,875	19,875	100.00

(D) Reporting Requirements

(D)(1)-All MUIs should be reported for those living in ICFs or receiving around the clock services

(1) All major usual incidents involving an individual who resides in an intermediate vices shall be filed and the requirements of this rule followed regardless of where the incident occurred.

(D)(2)-These MUI Reports shall be filed regardless where the incident occurs:

(2) Reports regarding the following major unusual incidents shall be filed and the requirements of this rule followed regardless of where the incident occurred:

(a) Accidental or suspicious death;

(b) Attempted suicide;

(c) Death other than accidental or suspicious death;

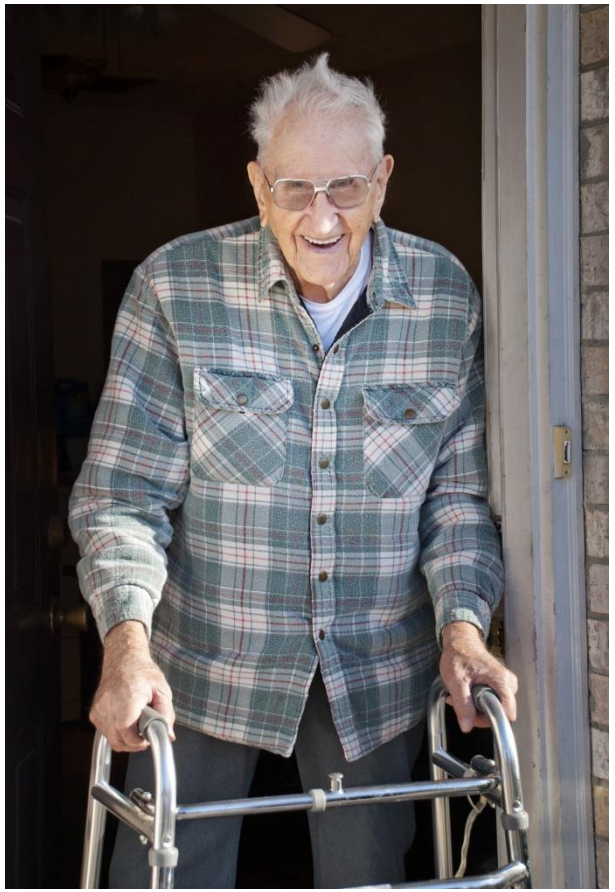
(d) Exploitation;

(e) Failure to report;

(f) Law enforcement;

(D)(2)-These MUI Reports shall be filed regardless where the incident occurs

(g) Misappropriation;
(h) Missing individuals
(i) Neglect;
(j) Peer-to-peer act;
(k) Physical abuse;
(l) Prohibited sexual relations;
(m) Sexual abuse; and
(n) Verbal abuse.



(D)(3) Reports regarding the following MUIs shall be filed when with provider:

Shall be filed and the requirements of this rule followed only when the incident occurs in a program operated by a county board or when the individual is being served by a licensed or certified provider:

(a) Medical emergency;

(b) Rights code violation;

(c) Significant injury;

(d) Unapproved behavior support; and

(e) Unscheduled hospitalization.

(D)(4) Upon Identification or Notification of MUI, Provider or County Board Shall:

Take immediate actions to protect all at risk individuals which shall include:

a. Immediate or ongoing medical attention as appropriate
b. 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;
c. Other measures as necessary

The Department shall resolve any disagreements

(D)(5) County Board Upon Notification shall:

- Ensure reasonable measures to protect **all** at risk individuals, as appropriate
- Determine if additional measures are needed
- Notify the Department if circumstances in Paragraph (I)(1)of this rule are present requiring a Department directed investigation

(D)(6) Immediate to 4 Hour Reporting

Provider or county board as a provider, using county board identified system for MUIs, should report incidents or allegations of:

(a)Accidental or suspicious death;

(b) Exploitation;

(c) Misappropriation;

(d) Neglect;

(e) Peer-to-peer act;

(f) Physical abuse;

(g) Sexual abuse;

(h) Verbal abuse; and when the provider has received an inquiry from the media regarding a major unusual incident.

(D)(7) Submit Written Incident Report by 3:00 p.m. the Next Working Day

- Agency providers and county boards as providers
- Department prescribed format
- Individual providers notify county board contact person
- Potential or determined MUI

(D)(8) County Board enter reports into Incident Tracking System by 3 p.m.

The county board shall enter preliminary information regarding the incident in the incident tracking system and in the manner prescribed by the department by three p.m. on the working day following notification by the provider or of becoming aware of the major unusual incident.

(D)(9) CB/Provider keep appraised of investigation and protective actions

When a provider has placed an employee on leave or otherwise taken protective action pending the outcome of the administrative investigation, the county board or department, as applicable, shall keep the provider apprised of the status of the administrative investigation so that the provider can resume normal operations as soon as possible consistent with the health and welfare of at-risk individuals.

The provider shall notify the county board or department, as applicable, of <u>any</u> changes regarding the protective action.

(D)(10) DC notifies the Department

If the provider is a developmental center, all reports required by this rule shall be made directly to the department.

(D)(11) CB shall have a system 24- hours for reporting

The county board shall have a system that is available twenty-four hours a day, seven days a week, to receive and respond to all reports required by this rule. The county board shall communicate this system in writing to all providers in the county and to the department.

24 Hour County Contact numbers are available on the Department's website at www.dodd.gov

(E) Alleged Criminal Acts

The provider shall immediately report to the law enforcement entity having jurisdiction of the location where the incident occurred, any allegation of exploitation, failure to report, misappropriation, neglect, peer-to-peer act, physical abuse, sexual abuse, or verbal abuse which may constitute a criminal act. The provider shall document the time, date, and name of person notified of the alleged criminal act. The county board shall ensure that the notification has been made.

(F) Abused or Neglected Children

- Allegations of Abuse or Neglect per Ohio Revised Code 2151.03 and 2151.031
- Under the age of 21
- Report to local public children's agency
- The county board shall ensure reports have been made

(G)(1) Notifications

The provider shall make the following notifications, as applicable, when the major unusual incident or discovery of the major unusual incident occurs when such provider has responsibility for the individual. The notification shall be made on the same day the major unusual incident or discovery of the major unusual incident occurs and include immediate actions taken.

(a) Guardian or other person whom the individual has identified.

(b) Service and support administrator serving the individual.

(c) Licensed or certified residential provider.

(d) Staff or family living at the individual's residence who have responsibility

for the individual's care.

(e) Support broker for an individual enrolled in the self-empowered life

funding waiver.

(G)(2) All notifications shall be documented

All notifications or efforts to notify shall be documented. The county board shall ensure that all required notifications have been made.

(G)(3) Notification shall not be made to the PPI

Notification shall not be made if the person to be notified is the primary person involved, the spouse of the primary person involved, or the significant other of the primary person involved.

(G)(4)Notifications to Guardian

Notification shall be made to the individuals, individuals' guardians, and other persons whom the individuals have identified in a peer-to-peer act unless such notification could jeopardize the health and welfare of an individual involved.

(G)(5)Notifications are not required in deaths when family already aware

Notification to a person is not required when the report comes from such person or in the case of a death when the family is already aware of the death.

(G)(6)Secondary Notifications

In any case where law enforcement has been notified of an alleged crime, the department may provide notification of the incident to:

- Any other provider;
- Developmental center;
- County board for whom the primary person involved works, for the purpose of ensuring the health and welfare of any at-risk individual.

The notified provider or county board shall take such steps necessary to address the health and welfare needs of any at-risk individual and may consult the department in this regard. The department shall inform any notified entity as to whether the incident is substantiated. Providers, Developmental centers, or county boards employing a primary person involved shall notify the department when they are aware that the primary person involved works for another provider.

(H)(1)General Investigations

Each county board shall employ at least one investigative agent or contract with a person or governmental entity for the services of an investigative agent. An investigative agent shall be certified by the department in accordance with rule 5123:2-5-07 of the Administrative Code. Developmental center investigators are considered certified investigative agents for the purpose of this rule.

(H)(2)Appendix A, B and C

All major unusual incidents require an administrative investigation meeting that applicable administrative investigation procedure in appendix A, appendix B or appendix C to this rule unless it is not possible or relevant to the administrative investigation to meet a requirement under this rule, in which case the reason shall be documented. Administrative investigations shall be conducted and reviewed by investigative agents.

Appendix A

- Cases in which the police, CSB or IA may be involved in the investigation.
- Good communication and cooperation among investigative entities will be required for these investigations.
- Accidental or Suspicious Death, Exploitation, Failure To Report, Misappropriation, Neglect, Peer to Peer Act, Physical Abuse, Prohibited Sexual Activity, Rights Code, Sexual Abuse and Verbal Abuse

Appendix B

- Cases investigated by IA
- Attempted Suicide, Medical Emergency, Missing Individual, Death other than an accidental or suspicious, and Significant Injury

Appendix C

- Cases investigated by IA- Format Requirements
- Law Enforcement, Unapproved Behavior Supports and Unscheduled Hospitalizations.

(H)(2)(a)Elect to complete Category A

(a) The department or county board may elect to follow the administrative investigation procedure for category A major unusual incidents for any major unusual incident.

(H)(2)(b) Category could change

(b) Based on the facts discovered during administrative investigation of the major unusual incident, the category may change. If a major unusual incident changes category, the reason for the change shall be documented and the new applicable category administrative investigation procedure shall be followed to investigate the major unusual incident.

(H)(2)(c)-Closing of Criminal Cases

Major unusual incidents that involve an active criminal investigation may be closed as soon as the county board ensures that the major unusual incident is properly coded, the history of the primary person involved has been reviewed, cause and contributing factors are determined, a finding is made, and prevention measures implemented. Information needed for closure of the major unusual incident may be obtained from the criminal investigation.

(H)(3) Gathering Docs for Category C

County board staff may assist the investigative agent by gathering documents, entering information into the incident tracking system, fulfilling category C administrative investigation requirements, or performing other administrative or clerical duties that are not specific to the investigative agent role.

(H)(4)IA conducts interviews

Except when law enforcement or the public children's services agency is conducting the investigation, the investigative agent shall conduct all interviews for major unusual incidents unless the investigative agent determines the need for assistance with interviewing an individual.

(H)(5)County Board shall commence Category A within 24 hours; days for B,C

Except when law enforcement or the public children's services agency has been notified and is considering conducting an investigation, the county board shall commence an administrative investigation. If law enforcement or the public children's services agency notifies the county board that it has declined to investigate, the county board shall commence the administrative investigation within a reasonable amount of time based on the initial information received or obtained and consistent with the health and welfare of all at-risk individuals, but no later than twenty-four hours for a major unusual incident in category A or no later than three working days for a major unusual incident in category B or category C.

(H)(6)ICF shall conduct investigations in accordance with 42 C.F.R. 483.420

An intermediate care facility shall conduct an investigation that complies with applicable federal regulations, including 42 C.F.R. 483.420 (October 1, 2012), for any unusual incident or major unusual incident involving a resident of the intermediate care facility, regardless of where the unusual incident or major unusual incident occurs. The intermediate care facility shall provide a copy of its full report of an administrative investigation of a major unusual incident to the county board. The investigative agent may utilize information from the intermediate care facility's administrative investigation to meet the requirements of this rule or conduct a separate administrative investigation. The county board shall provide a copy of its full report of the administrative investigation to the intermediate care facility. The department shall resolve any conflicts that arise.

(H)(7)ICF's findings due to CB within 14 calendar days

When an agency provider, excluding an intermediate care facility, conducts an internal review of an incident for which a major unusual incident has been filed, the agency provider shall submit the results of its internal review of the incident, including statements and documents, to the county board within fourteen calendar days of the agency provider becoming aware of the incident.

(H)(8)All DD employees required to cooperate with investigation

All developmental disabilities employees shall cooperate with administrative investigations conducted by entities authorized to conduct investigations. Providers and county boards shall respond to requests for information within the time frame requested. The time frames identified shall be reasonable.

(H)(9)IA submits report into ITS within 30 working days

The investigative agent shall complete a report of the administrative investigation and submit it for closure in the incident tracking system within thirty working days unless the county board requests and the department grants an extension for good cause. If an extension is granted, the department may require submission of interim reports and may identify alternative actions to assist with the timely conclusion of the report.

(H)(10)Report Requirements

The report shall follow the format prescribed by the department. The investigative agent shall include the initial allegation, a list of persons interviewed and documents reviewed, a summary of each interview and document reviewed, and a findings and conclusions section which shall include the cause and contributing factors to the incident and the facts that support the findings and conclusions.

(I)(1)Department Directed Investigations

(1) The department shall conduct the administrative investigation when the major unusual incident includes an allegation against:

(a) The superintendent of a county board or developmental center;

(b) The executive director or equivalent of a regional council of governments;

(c) A management employee who reports directly to the superintendent of the county board, the superintendent of a developmental center, or executive director or equivalent of a regional council of governments;

(d) An investigative agent;

(e) A service and support administrator;

(I)(1)Department Directed Investigations

(f) A major unusual incident contact or designee employed by a county board;

(g) A current member of a county board;

(h) A person having any known relationship with any of the persons specified in paragraphs (I)(1)(a) to (I)(1)(g) of this rule when such relationship may present a conflict of interest or the appearance of a conflict of interest; or

(i) An employee of a county board when it is alleged that the employee is

responsible for an individual's death, has committed sexual abuse,

engaged in prohibited sexual activity, or committed physical abuse or neglect resulting in emergency room treatment or hospitalization.

(I)(2)-(3)Department Directed Investigations

(2) A department-directed administrative investigation or administrative investigation review may be conducted following the receipt of a request from a county board, developmental center, provider, individual, or guardian if the department determines that there is a reasonable basis for the request.

(3) The department may conduct a review or administrative investigation of any major unusual incident or may request that a review or administrative investigation be conducted by another county board, a regional council of governments, or any other governmental entity authorized to conduct an investigation.

(J)(1) Written Summaries for A, B due within 5 days of recommended closure

No later than five working days following the county board's, developmental center's, or department's recommendation via the incident tracking system that the report be closed, the county board, developmental center, or department shall provide a written summary of the administrative investigation of each category A or category B major unusual incident, including the allegations, the facts and findings, including as applicable, whether the case was substantiated or unsubstantiated, and preventive measures implemented in response to the major unusual incident to the following unless the information in the written summary has already been

communicated:

(J)(1) (a) Written Summaries to:

(a) The individual, individual's guardian, or other person whom the individual has identified, as applicable; in the case of a peer-to-peer act, both individuals, individuals' guardians, or other persons whom the individuals have identified, as applicable, shall receive the written summary;

(b) The licensed or certified provider and provider at the time of the major unusual incident; and

(c) The individual's service and support administrator and support broker, as applicable.

(J)(2)-(4) Written Summaries

(2) In the case of an individual's death, the written summary shall be provided to the individual's family only upon request by the individual's family.

(3) The written summary shall not be provided to the primary person involved, the spouse of the primary person involved, or the significant other of the primary person involved. No later than five working days following the closure of a case, the county board shall make a reasonable attempt to notify the primary person involved as to whether the major unusual incident has been substantiated, unsubstantiated/insufficient evidence, or unsubstantiated/unfounded.

(4) If a service and support administrator is not assigned, a county board designee shall be responsible for ensuring the preventive measures are implemented based upon the written summary.

(J)(5) Disputing the Findings

An individual, individual's guardian, other person whom the individual has identified, or provider may dispute the findings by submitting a letter of dispute and supporting documentation to the county board superintendent, or to the director of the department if the department conducted the administrative investigation, within fifteen calendar days following receipt of the findings. An individual may receive assistance from any person selected by the individual to prepare a letter of dispute and provide supporting documentation.

(J)(6) CB reviews dispute within 30 calendar days

The county board superintendent or his or her designee or the director or his or her designee, as applicable, shall consider the letter of dispute, the supporting documentation, and any other relevant information and issue a determination within thirty calendar days of such submission and take action consistent with such determination, including confirming or modifying the findings or directing that more information be gathered and the findings be reconsidered.

(J)(7) Dispute to the Department

In cases where the letter of dispute has been filed with the county board, the disputant may dispute the final findings made by the county board by filing those findings and any documentation contesting such findings as are disputed with the director of the department within fifteen calendar days of the county board determination. The director shall issue a decision within thirty calendar days.

(K)(1) Review, Prevention, and Closure of MUIs

County boards and agency providers shall implement a written procedure for the internal review of all major unusual incidents and shall be responsible for taking all reasonable steps necessary to prevent the recurrence of major unusual incidents.

(K)(2) Preventative Measures

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

(K)(3)Department Review

The department may review reports submitted by a county board or developmental center. The department may obtain additional information

necessary to consider the report, including copies of all administrative investigation reports that have been prepared. Such additional information shall be provided within the time period specified by the department

(K)(4) Dept. Closes the following MUIs

(a) Accidental or suspicious death;

(b) Exploitation;

(c) Failure to report;

(d) Misappropriation;

(e) Missing individual;

(f) Neglect;

(g) Peer-to-peer act;

(h) Physical abuse;

(i) Prohibited sexual relations;

(j) Rights code violation;

(k) Sexual abuse;

(l) Significant injury when cause is unknown;

(m) Unapproved behavior support;

(n) Verbal abuse;

(o) Any major unusual incident that is the subject of a director's alert; and

(p) Any major unusual incident investigated by the department.

(K)(5)The CB closes these MUIs

The county board shall review and close reports regarding the following major unusual incidents:

(a) Attempted suicide;

(b) Death other than accidental or suspicious death;

(c) Law enforcement;

(d) Medical emergency;

(e) Significant injury when cause is known; and

(f) Unscheduled hospitalization.

(K)(6) Dept. Review of CB Closures

The department may review any case to ensure it has been properly closed and shall conduct sample reviews to ensure proper closure by the county board. The department may reopen any administrative investigation that does not meet the requirements of this rule. The county board shall provide any information deemed necessary by the department to close the case.

(K)(7) Case Closures

The department and the county board shall consider the following criteria when determining whether to close a case:

(a) Whether sufficient reasonable measures have been taken to ensure the health and welfare of any at-risk individual;

(b) Whether a thorough administrative investigation has been conducted consistent with the standards set forth in this rule (based on review in ITS);

(c) Whether the team, including the county board and provider, collaborated on developing preventive measures to address the causes and contributing factors;

(d) Whether the county board has ensured that preventive measures have been implemented to prevent recurrence;

(e) Whether the incident is part of a pattern or trend as flagged through the incident tracking system requiring some additional action; and

(f) Whether all requirements set forth in statute or rule have been satisfied.

(L)(1)Analysis of MUIs

Providers shall produce a semi-annual and annual report regarding major unusual incident trends and patterns which shall be sent to the county board.

The county board shall semi-annually review providers' reports. The semi-annual review shall be cumulative for January first through June thirtieth of each year and include an in-depth analysis. The annual review shall be cumulative for January first through December thirty-first of each year and include an in-depth analysis.

(L)(2)Analysis Requirements

(2) All reviews and analyses shall be completed within thirty calendar days following the end of the review period. The semi-annual and annual reports shall contain the following elements:

(a) Date of review;

(b) Name of person completing review;

(c) Time period of review;

(d) Comparison of data for previous three years;

(e) Explanation of data;

(L)(2)Analysis Requirements

(f) Data for review by major unusual incident category type;

(g) Specific individuals involved in established trends and patterns (i.e., five major unusual incidents of any kind within six months, ten major unusual incidents of any kind within a year, or other pattern identified by the individual's team);

(h) Specific trends by residence, region, or program;

(i) Previously identified trends and patterns; and

(j) Action plans and preventive measures to address noted trends and patterns.

(L)(3)Analysis of MUIs

County boards shall conduct the analysis and implement follow-up actions for all programs operated by county boards such as workshops, schools, and transportation. The county board shall send its analysis and follow-up actions to the department by August thirty-first of each year for the semi-annual review and by February twenty-eighth of each year for the annual review. The department shall review the analysis to ensure that all issues have been reasonably addressed to prevent recurrence.

(L)(4)Analysis of MUIs

Providers shall conduct the analysis, implement follow-up actions, and send the analysis and follow-up actions to the county board for all programs operated in the county by August thirty-first of each year for the semi-annual review and by February twenty-eighth of each year for the annual review. The county board shall review the analysis to ensure that all issues have been reasonably addressed to prevent recurrence. The county board shall keep the analyses and follow-up actions on file and make them available to the department upon request.

(L)(5)Trends and Patterns

The county board shall ensure that trends and patterns of major unusual incidents are included and addressed in the individual service plan of each individual affected.

(L)(6)CB and COGs required to review for Trends and Patterns

Each county board or as applicable, each council of governments to which county boards belong, shall have a committee that reviews trends and patterns of major unusual incidents. The committee shall be made up of a reasonable representation of the county board(s), providers, individuals who receive services and their families, and other stakeholders deemed appropriate by the committee.

(L)(6)(a)Committee's Role

The role of the committee shall be to review and share the county or council of governments aggregate data prepared by the county board or council of governments to identify trends, patterns, or areas for improving the quality of life for individuals served in the county or counties.

(L)(6)(b)Committee meets each Sept

The committee shall meet each September to review and analyze data for the first six months of the calendar year and each March to review and analyze data for the preceding calendar year. The county board or council of governments shall send the aggregate data prepared for the meeting to all participants at least ten calendar days in advance of the meeting.

(L)(6)(c)-(d)Record of Meetings

(c) The county board or council of governments shall record and maintain minutes of each meeting, distribute the minutes to members of the committee, and make the minutes available to any person upon request.

(d) The county board shall ensure follow-up actions identified by the committee have been implemented.

(L)(7) Dept. shall prepare a report on patterns and trends of MUIs

The department shall prepare a report on trends and patterns identified through the process of reviewing major unusual incidents. The department shall:

- Periodically, but at least semi-annually, review this report with a committee
- Appointed by the director of the department which shall consist of at least six members who represent various stakeholder groups, including disability rights Ohio and the Ohio department of Medicaid.
- The committee shall make recommendations to the department regarding whether appropriate actions to
- Ensure the health and welfare of individuals served have been taken.
- The Committee may request that the department obtain additional information as may be necessary to make recommendations.

Unusual Incident Definition

"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 service plan,* but is not a major unusual incident.

Unusual Incident Definition

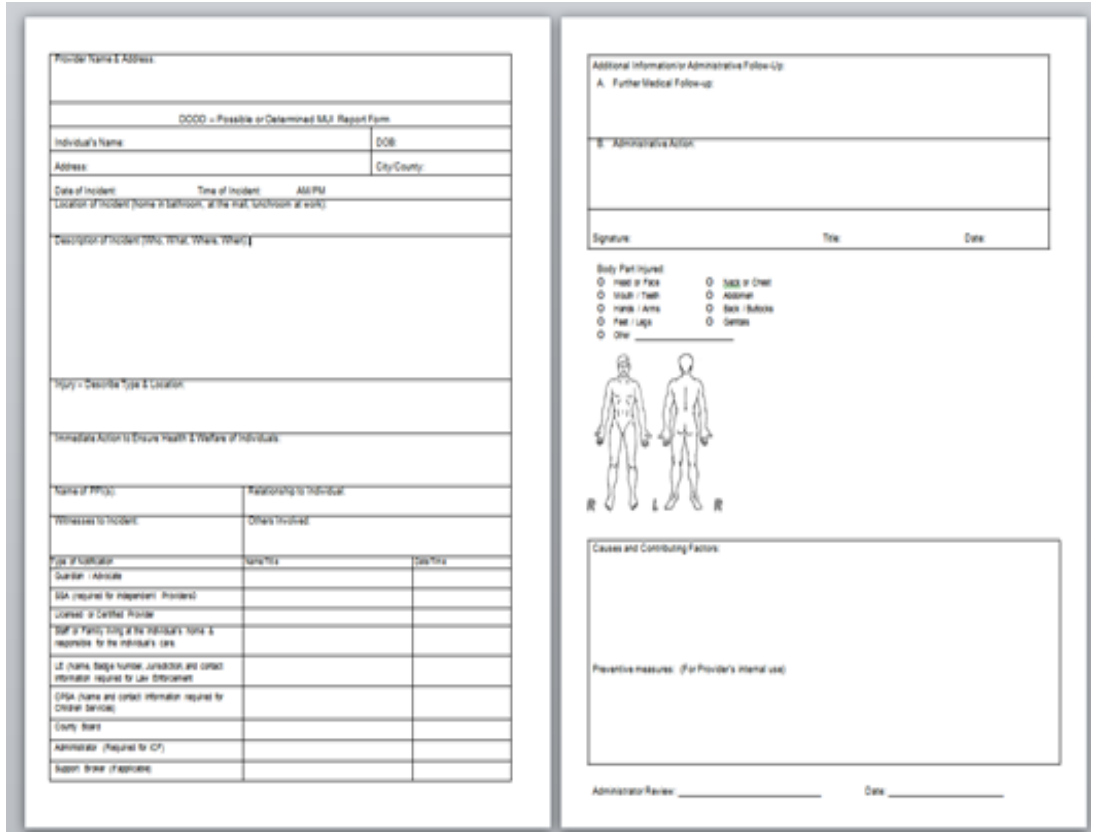
Unusual incident includes, but is not limited to: dental injuries; falls; an injury that is not a significant injury; medication errors without a likely risk to health and welfare; overnight relocation of an individual due to a fire, natural disaster, or mechanical failure; an incident involving two 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.

Responsibility for reporting incident and completing the incident report

Any person who provides any type of service to an individual with developmental disabilities includes, but is not limited to:

- Direct Care Staff (residential & workshop)
- SSAs
- Bus Drivers/Bus Monitors
- Job Coaches
- Work Supervisors
- Nurses
- Volunteers

Requirements of an Incident Report



- 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; and

Requirements of an Incident Report continued

- Name of Primary Person Involved-PPI (Alleged Perpetrator) 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
- Signature and name of person completing the incident report.

A complete, well written and easily understood incident report is the key to a good investigation. It all starts with you!

Unusual Incidents

Requires the provider to investigate unusual incidents, identify the cause and contributing factors when applicable, and develop preventive measures to protect the health and welfare of any at-risk individuals.

Immediate Actions

Always document what actions were taken following the incident:

Checked for Injuries	Called 911	Initiated First Aid	Contacted the Doctor	Secured the money
Made sure individual had food	Picked up needed meds	Notified Law Enforcement for criminal acts	Contacted County Board/IA	Separated the individuals
Removed the PPI when appropriate	Nursing Assessment	Taken to E.R.	Called Poison Control	Provided additional staffing

Causes, Contributing Factors and Prevention Plans

- All UI's require causes and contributing factors
- All UI's require a prevention plan
- All UI logs need prevention plans
- A good prevention plan may prevent an MUI
- Determine if it is a UI trend

(M)(1)-(2) Reqs for Unusual Incidents

(1) Unusual incidents shall be reported and investigated by the provider.

(2) Each agency provider shall develop and implement a written unusual incident policy and procedure that:

(a) Identifies what is to be reported as an unusual incident which shall include unusual incidents as defined in this rule;

(b) Requires an employee who becomes aware of an unusual incident to report it to the person designated by the agency provider who can initiate proper action;

(M)(2)(c) Requires report be made no more than 24 hours after the UI

(c) Requires the report to be made no later than twenty-four hours after the occurrence of the unusual incident; and

(d) Requires the agency provider to investigate unusual incidents, identify the cause and contributing factors when applicable, and develop preventive measures to protect the health and welfare of any at-risk individuals.

(M)(3) Staff shall be knowledgeable

The agency provider shall ensure that all staff are trained and knowledgeable regarding the unusual incident policy and procedure.

(M)(4)UI Notifications

If the unusual incident occurs at a site operated by the county board or at a site operated by an entity with which the county board contracts, the county board or contract entity shall notify the licensed provider or staff, guardian, or other person whom the individual has identified, as applicable, at the individual's residence. The notification shall be made on the same day the unusual incident is discovered.

(M)(5) Independent Provider Requirements

Independent providers shall complete an incident report, notify the individual's guardian or other person whom the individual has identified, as applicable, and forward the incident report to the service and support administrator or county board designee on the same day the unusual incident is discovered.

(M)(6) Monthly Review

Each agency provider and independent provider shall review all unusual incidents as necessary, but no less than monthly, to ensure appropriate preventive measures have been implemented and trends and patterns identified and addressed as appropriate.

(M)(7)Document Trends and Patterns

The unusual incident reports, documentation of identified trends and patterns, and corrective action shall be made available to the county board and department upon request.

(M)(8) UI Logs

Each agency provider and independent provider shall maintain a log of all unusual incidents. The log shall include, but is not limited to:

- Name of the individual
- A brief description of the unusual incident
- Any injuries
- Time and date
- Location
- Preventive measures
- Causes and Contributing Factors (best practice)

(M)(9)Trends addressed in Plan

The agency provider and the county board shall ensure that trends and patterns of unusual incidents are included and addressed in the individual service plan of each individual affected.

(N) (1) Oversight

The county board shall review, on at least a quarterly basis, a representative sample of provider logs, including logs where the county board is a provider, to ensure that major unusual incidents have been reported, preventive measures have been implemented, and that trends and patterns have been identified and addressed in accordance with this rule. The sample shall be made available to the department for review upon request.

(N)(2) CB Programs

When the county board is a provider, the department shall review, on a monthly basis, a representative sample of county board logs to ensure that major unusual incidents have been reported, preventive measures have been implemented, and that trends and patterns have been identified and addressed in accordance with this rule. The county board shall submit the specified logs to the department upon request.

(N)(3) Department review of logs

The department shall conduct reviews of county boards and providers as necessary to ensure the health and welfare of individuals and compliance with this rule. Failure to comply with this rule may be considered by the department in any regulatory capacity, including certification, licensure, and accreditation.

(O)(1) Access to Records

Reports made under section 5123.61 of the Revised Code and this rule are not public records as defined in section 149.43 of the Revised Code. Records may be provided to parties authorized to receive them in accordance with sections 5123.613 and 5126.044 of the Revised Code, to any governmental entity

authorized to investigate the circumstances of the alleged abuse, neglect, misappropriation, or exploitation and to any party to the extent that release of a record is necessary for the health or welfare of an individual.

(O)(2) Access to Records

A county board or the department shall not review, copy, or include in any report required by this rule a provider's personnel records that are confidential under state or federal statutes or rules, including medical and insurance records, workers' compensation records, employment eligibility verification (I-9) forms, and social security numbers. The provider shall redact any confidential information contained in a record before copies are provided to the county board or the department. A provider shall make all other records available upon request by a county board or the department.

(O)(3) Waive report

Any party entitled to receive a report required by this rule may waive receipt of the report. Any waiver of receipt of a report shall be made in writing.

(P)(1) Training

Agency providers and county boards shall ensure staff employed in direct services positions are trained on the requirements of this rule prior to direct contact with any individual. Thereafter, staff employed in direct services positions shall receive annual training on the requirements of this rule including a review of health and welfare alerts issued by the department since the previous year's training.

(P)(2)Training Requirements

Agency providers and county boards shall ensure staff employed in positions other than direct services positions are trained on the requirements of this rule no later than ninety days from date of hire. Thereafter, staff employed in positions other than direct services positions shall receive annual training on the requirements of this rule including a review of health and welfare alerts issued by the department since the previous year's training.

(P)(3)Training on Alerts

Independent providers shall be trained on the requirements of this rule prior to application for initial certification in accordance with rule 5123:2-2-01 of the Administrative Code and shall receive annual training on the requirements of this rule including a review of health and welfare alerts issued by the department since the previous year's training.

Health & Safety Alerts 1/1/15-12/31/15

• 52-12-15	12/4/2015	Winter Weather
• 35-11-15	11/23/2015	Preventing Pneumonia
• 22-11-15	11/13/2015	Preventing Physical Abuse
• 56-10-15	10/16/15	Sexual Abuse Prevention and Reporting
• 59-09-15	9/2/2015	Oral Medications for those with Dysphagia
• 44-09-15	9/2/2015	Transitions
• 02-05-15	5/11/15	Summer Safety
• 18-04-15	4/8/2015	Choking
• 51-03-15	3/13/2015	Health and Welfare is Priority 1

Winter Weather Alert #52-11-11

- Avoid going outside without proper clothing including hats and gloves.
- Don’t stay outdoors too long in the extreme cold.
- Make sure individuals are well supervised so accidental exposure to extreme temperatures is avoided.
- Understand first aid for Frostbite and Hypothermia so immediate attention can be given in an emergency situation.
- Prepare in advance when conducting outdoor activities and trips. Take along extra clothing, blankets, warm liquids, etc.
- Be very careful with any heating elements. (Space heaters, fireplaces, furnaces, etc.) Assure that all are in good working order before being used for the winter.
- Avoid walking on frozen ponds or lakes unless the ice has been checked and is safe.

Pneumonia Alert #35-11-15

Ohio Department of Developmental Disabilities

Office of MR/A Registry Unit

Health and Welfare Alert # 35-11-15

Preventing Pneumonia

The purpose of this Health and Welfare Alert is to identify factors and conditions that may increase the risk, signs and symptoms that would indicate the need to contact a physician, and ways to help prevent pneumonia.

It is suggested that county boards and providers assess individuals that have a high risk and develop a plan to help mitigate the risk. All persons that support the individual should be aware of the signs and symptoms as well as the plan.

All DD Employees are required to be trained, annually, on identification and reporting of Major

Did you know?

Pneumonia/Influenza-related hospitalizations accounted for 858 (17%) of all unscheduled hospitalization for Ohioans with developmental disabilities in 2014. Pneumonia is the leading cause of unscheduled hospitalizations. Deaths attributed to pneumonia and influenza comprised 14% of all non-accidental deaths in 2014 (794).

Pneumonia is an infection of the lungs that can cause mild to severe illness in people of all ages. Common signs of pneumonia can include cough, fever, and trouble breathing.

Factors/conditions that may increase risk of pneumonia:

Risk factors continued:

- *Recent hospitalization;*
- *Sedentary lifestyle;*
- *Intravenous drug use;*
- *Immune system altered or weakened;*
- *Alcoholism Cirrhosis;*
- *Spleen removed or not functioning;*
- *Certain cancers and cancer treatments;*
- *HIV infection;*
- *Malnourished and*
- *Certain medications (e.g., steroids).*

Symptoms of Pneumonia that indicate the need to see a Physician

- Sudden onset of cough productive of discolored phlegm (bloody or containing pus colored yellow, green or

Steps to preventing Pneumonia

- Talk to your Doctor about the Influenza and pneumococcal vaccine. Individuals should discuss with their physician if the influenza and pneumococcal vaccine is appropriate for them.
- *Exercise:* active, passive exercise for those with limited mobility.
- *Positioning* -elevation of head and trunk, during and for at least 30 minutes after eating.
- *Obtain a swallow evaluation* if signs of possible swallowing problems.
- *Stop smoking and limit contact with cigarette smoke*
- Eat a healthy diet
- *Always use universal precautions* to avoid carrying bacteria and viruses from sick to healthy individuals.
- *Try to stay away from sick people*. If you are sick, stay away from others as much as possible to keep from getting them sick.

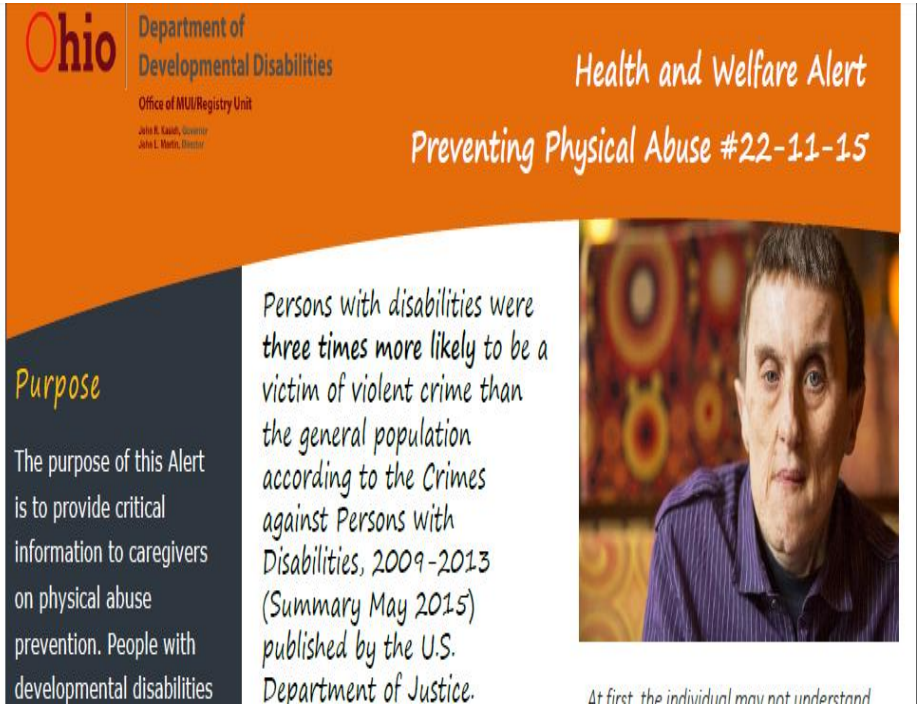
You can also help prevent respiratory infections by:

- Wash your hands regularly
- Clean surfaces that are touched a lot
- Cough or sneeze into a tissue or into your elbow or sleeve
- Treat and prevent conditions like diabetes

Preventing Physical Abuse Alert #22-11-15

Steps to take for suspected/alleged abuse

- Get the individual appropriate medical attention;
- Take immediate action to protect the person from further assault
- Report immediately to law enforcement or CSB
- Report to the County Board immediately but within 4 hours;
- Remember NOT to infer blame on the victim;
- Emotionally support the alleged victim
- Remember to refer the individual for counseling and victim's assistance as appropriate;
- Notify DODD MUI Unit if the alleged PPI is a County Board Employee;
- The law says certain people MUST make a report if they have good reason to believe that abuse or neglect has happened; this is called mandated reporting. They include: DD personnel, doctors, nurses and other healthcare providers, mental health professionals,
- counselors, social workers, teachers and others



Sexual Abuse Alert #56-10-15

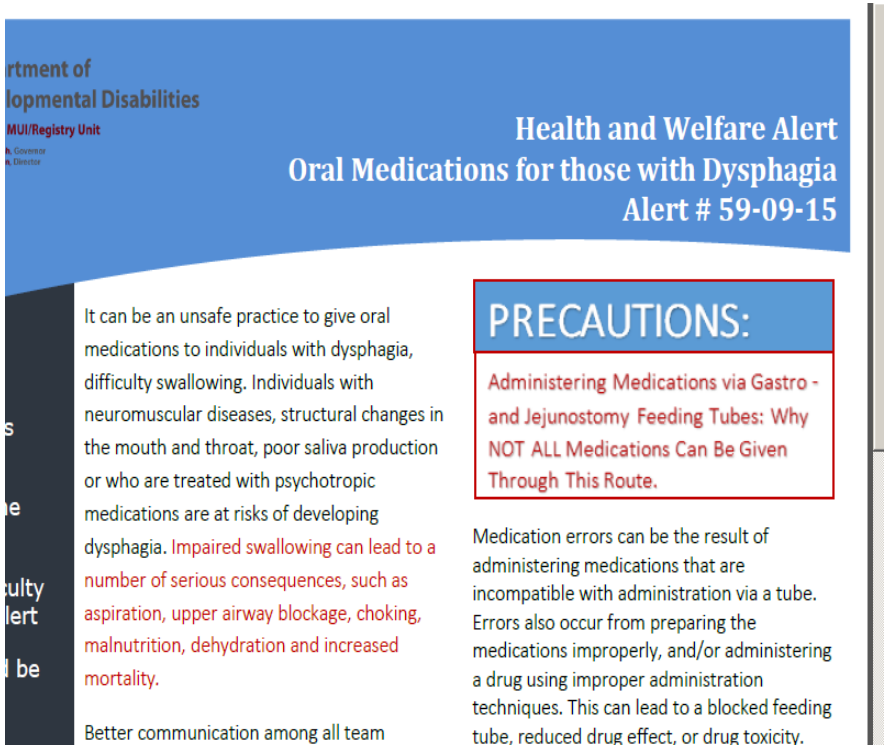
- Take action if an individual communicates that he or she has been abused. Do not ignore or dismiss any such reports regardless of whether or not they appear plausible. The proper authorities will determine what occurred.
- Get the individual appropriate medical attention.
- Report according to O.A.C.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

Sexual Abuse Alert #56-10-15

Know the possible signs:

- Ongoing unexplained health problems like stomach aches, headaches
- Display of new fears
- Withdrawal from previously enjoyable activities, places, or persons, suddenly avoiding places or people
- Changes in sleep patterns such as nightmares, trouble sleeping, sudden bedwetting, and other sleep problems
- Dressing in layers of clothing
- Changes in appetite, loss of appetite, weight gain or loss
- Bruising, bleeding, soreness, redness, irritation, itching, and unusual discharges
- Torn or stained underwear or linens
- Sexually transmitted diseases
- New sexual knowledge or sexual behavior
- Sudden difficulty walking or sitting
- Suddenly frightened of certain people or situations

Oral Medications Alert #59-09-15



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MUI/Registry Unit

Health and Welfare Alert
Oral Medications for those with Dysphagia
Alert # 59-09-15

It can be an unsafe practice to give oral medications to individuals with dysphagia, difficulty swallowing. Individuals with neuromuscular diseases, structural changes in the mouth and throat, poor saliva production or who are treated with psychotropic medications are at risks of developing dysphagia. Impaired swallowing can lead to a number of serious consequences, such as aspiration, upper airway blockage, choking, malnutrition, dehydration and increased mortality.

Better communication among all team

PRECAUTIONS:

Administering Medications via Gastro - and Jejunostomy Feeding Tubes: Why NOT ALL Medications Can Be Given Through This Route.

Medication errors can be the result of administering medications that are incompatible with administration via a tube. Errors also occur from preparing the medications improperly, and/or administering a drug using improper administration techniques. This can lead to a blocked feeding tube, reduced drug effect, or drug toxicity.

It can be an unsafe practice to give oral medications to individuals with dysphagia, difficulty swallowing. Individuals with neuromuscular diseases, structural changes in the mouth and throat, poor saliva production or who are treated with psychotropic medications are at risks of developing dysphagia. Impaired swallowing can lead to a number of serious consequences, such as aspiration, upper airway blockage, choking, malnutrition, dehydration and increased mortality.

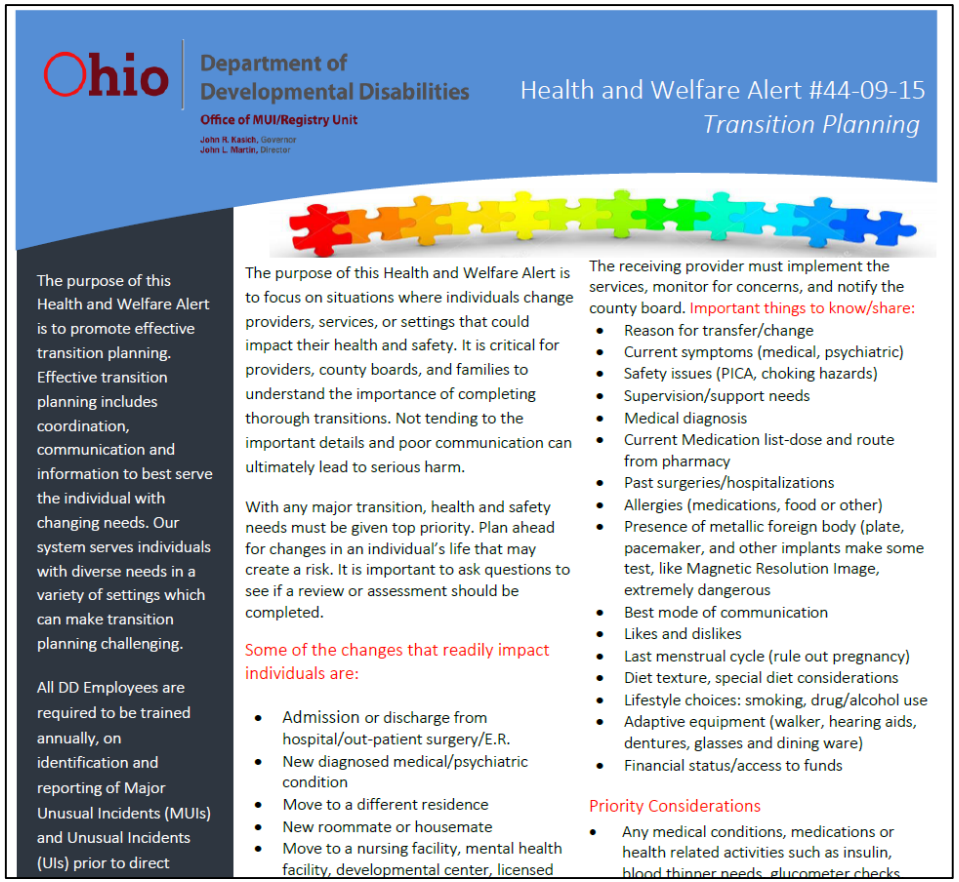
Oral Medications Alert #59-09-15

What steps can be performed to decrease risk of inappropriate medication administration via feeding tube?

1. Establish route suitability - Providers administering medications via the feeding tube should consult with a pharmacist to ensure the medication(s) will be properly dissolved and absorbed.
2. Establish drug and dosage form suitability - Providers should ensure that the form of the drug is appropriate for enteral (feeding tube) administration. Use only immediate-release solid dosage forms or liquid dosage forms. If in doubt, contact ordering physician.
3. Don’t mix medications with feeding formulas - Medication(s) should not be added directly to the feeding formula. Mixing drugs with the formula could cause drug-formula interactions, leading to tube blockages, absorption issues, and changes in bowel function.
4. Flush - Any tube feeding should be stopped and the tube flushed with at least 15 mL of water before and after administering each medication.
5. Administer separately - Each medication should be administered separately through the feeding tube.
6. Flush again - The tube should be flushed again with at least 15 mL of water to ensure drug delivery and clear the tube.

Transition Issues Alert #44-09-15

- Change in provider
- Move to a different home
- New medication, dose or system of receiving it
- Death or illness of the family member, caregiver or a loved one
- Placement of a feeding tube
- New roommate or housemate
- Change in supervision needs
- Change in diet/texture
- Move to a nursing facility, Mental health facility, developmental center, licensed facility or rehabilitation center
- Change in services provided to the individual
- Job change
- Change in Service and Support Administrator (SSA) or QIID
- Hospitalization
- New pharmacy provider
- Retirement



Ohio | Department of Developmental Disabilities
Office of MUI/Registry Unit
John R. Kasich, Governor
John L. Martin, Director

Health and Welfare Alert #44-09-15
Transition Planning

The purpose of this Health and Welfare Alert is to promote effective transition planning. Effective transition planning includes coordination, communication and information to best serve the individual with changing needs. Our system serves individuals with diverse needs in a variety of settings which can make transition planning challenging.

All DD Employees are required to be trained annually, on identification and reporting of Major Unusual Incidents (MUIs) and Unusual Incidents (UIs) prior to direct

The purpose of this Health and Welfare Alert is to focus on situations where individuals change providers, services, or settings that could impact their health and safety. It is critical for providers, county boards, and families to understand the importance of completing thorough transitions. Not tending to the important details and poor communication can ultimately lead to serious harm.

With any major transition, health and safety needs must be given top priority. Plan ahead for changes in an individual's life that may create a risk. It is important to ask questions to see if a review or assessment should be completed.

Some of the changes that readily impact individuals are:

- Admission or discharge from hospital/out-patient surgery/E.R.
- New diagnosed medical/psychiatric condition
- Move to a different residence
- New roommate or housemate
- Move to a nursing facility, mental health facility, developmental center, licensed

The receiving provider must implement the services, monitor for concerns, and notify the county board. Important things to know/share:

- Reason for transfer/change
- Current symptoms (medical, psychiatric)
- Safety issues (PICA, choking hazards)
- Supervision/support needs
- Medical diagnosis
- Current Medication list-dose and route from pharmacy
- Past surgeries/hospitalizations
- Allergies (medications, food or other)
- Presence of metallic foreign body (plate, pacemaker, and other implants make some test, like Magnetic Resolution Image, extremely dangerous
- Best mode of communication
- Likes and dislikes
- Last menstrual cycle (rule out pregnancy)
- Diet texture, special diet considerations
- Lifestyle choices: smoking, drug/alcohol use
- Adaptive equipment (walker, hearing aids, dentures, glasses and dining ware)
- Financial status/access to funds

Priority Considerations

- Any medical conditions, medications or health related activities such as insulin, blood thinner needs, glucometer checks

Transition Issues Alert #44-09-15

Four important steps in transition process:
1. Ensuring that the receiving provider, including the direct support professionals, is clearly apprised of and ready to meet the individual's needs.

2. The transferring provider must emphasize how they have managed potential health and safety risks; this should also include important historical information about the individual.

3. The assigned SSA/QIPD must actively facilitate the transition to the receiving provider or setting. This includes a review of the plan to assess any new circumstances and determine potential risks. It is important for the SSA/QIPD to ensure the receiving provider has the current plan in sufficient time to train the direct support professionals.

4. The receiving provider must implement the services, monitor for concerns, and notify the county board/medical professionals/team/other supports when there are

Keeping Safe in the Summer Alert #02-05-15

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Health and Welfare Alert #02-05-15
Keeping Safe in the Summer

Did you know?
-Last year over 70 people served were hospitalized for dehydration.
-Some have life-threatening allergies to bee stings.
-Certain medications make you more prone to sun burn.

Summer is an enjoyable time to be outside and visit with family and friends. However, with the warm weather comes some risks. We hope that you will have a fun and safe summer by taking a few simple precautions to protect yourself and those you serve.

FOOD POISONING

INSECTS
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. If a tick becomes attached, get medical help immediately! Usually, a Lyme disease-carrying tick has to be

Help avoid heat related illnesses by taking these steps:

- 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

Keeping Safe in the Summer Alert #02-05-15

- *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 regularly*

WATER SAFETY

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. It is not recommended.
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, or TOO much strenuous activity.

Keeping Safe in the Summer Alert #02-05-15

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

- Heat exhaustion
- Headaches
- Nausea and/or vomiting
- Fainting
- Blurred vision
- 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
- Confusion

If dehydration is suspected, *rehydration* is the key to preventing further complications. Remember to drink lots of fluids!

Choking Alert #18-04-03

Ohio Department of Developmental Disabilities
Office of MUI/Registry Unit
John R. Kasich, Governor
John L. Martin, Director

Health and Welfare Alert
Choking #18-04-13

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 (MUIs)

In 2013, seven Ohioans with developmental disabilities passed away due to choking related accidents. Unfortunately, there have been more choking related deaths in 2014. We believe prevention is the key to saving lives. While seven people lost their lives, many more were saved by the fast action of others. In over 370 of the cases in 2013, 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

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 or
- Has Gastroesphogeal Reflux

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 or communicating;
- Slumped over in chair where they were eating; and
- Wide-eyed look on face

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 , follow provided instructions.

Choking Prevention Alert #18-04-15

Basic safe swallow strategies for ALL people to follow

- Sit upright 90 degree angle during all intake (sitting upright in a chair at a table is typically 90 degrees) and up to 30 minutes after
- Follow supervision levels and needed supports
- Provide proper diet texture
- Take slow, teaspoon size bites
- Swallow all food prior to new a new bite
- Drink more often to help flush the food out of the mouth and down the throat
- Don’t encourage someone to eat if they are not alert to task of eating
- Add extra moisture to dry meat (i.e. gravies, condiments)

Health and Welfare is Priority One #51-03-15

When to call 911 for Emergency Assistance

This listing may not be all-inclusive and should be updated to **meet the needs of the individuals you serve.**

- The person appears very ill; sweating, skin looks blue or gray
- Severe, constant abdominal pain
- Bleeding heavily, despite direct pressure
- Blood pressure of 220 or above for upper number and/or 120 or above for lower number
- Blood pressure below 90 for upper number, when normally above 90
- Pulse (heart rate) is less than 40 or greater than 140

Health and Welfare is Priority One #51-03-15

When to call 911 for Emergency Assistance

This listing may not be all-inclusive and should be updated to **meet the needs of the individuals you serve.**

- Difficulty breathing and/or severe wheezing
- Chest pain
- Fainting or loss of consciousness
- Change in responsiveness
- Fall with severe head injury (fall on face, bleeding, change in level of consciousness). Do not move; keep warm
- Fall, unable to get up on own and normally would be able to do so, or in a lot of pain when lying still or trying to get up. Do not move; keep warm
- Fall, limb deformity noted (bone sticking out, swelling, unusual position of arm, leg). Do not move; keep warm
- First time seizure; roll to side, protect head, and move obstacles that may pose a threat

Abuser Registry

Prevents persons who were DD employees from working in this field.

95 People were placed on the Registry in 2015.

As of February 17, 2016 there are 685 people placed on the Abuser Registry and 1 Removal

Abuser Registry

The Ohio Department of Developmental Disabilities ("Department") maintains an Abuser Registry which is a list of employees who the Department has determined have committed one of the Registry offenses listed below. If your name is placed on the Registry you are barred from employment as a Developmental Disabilities employee in the state of Ohio. Because other state agencies require employers to check the Abuser Registry, placement on the Registry also prohibits you from being employed (1) by a Medicaid agency, being an owner (5 percent or more) of an agency or having a Medicaid Provider Agreement as a non-agency provider; (2) in a position to provide Ombudsman services or direct care services to anyone enrolled in a program administered by the Ohio Department of Aging; and (3) by a home health agency in a direct care position and may prevent you from being hired in a nursing home or residential care facility in a direct care position.

Registry Offenses

- Physical Abuse
- Sexual Abuse
- Verbal Abuse
- Prohibited Sexual Relations
- Neglect
- **Misappropriation (Theft)** - obtaining the property of an individual or individuals, without consent, with a combined value of at least $100. Theft of the individual's prescribed medication, check, credit card, ATM card and the like are also Registry offenses.
- Failure to Report Abuse, Neglect or Misappropriation
- **Conviction or plea of guilty to:** Offense of Violence - R. C. 2901.01, including convictions for the offense of Assault, Menacing, Domestic Violence or Attempting to commit any offense of violence; Sexual Offenses - R. C. Chapter 2907; Theft Offenses - R. C. Chapter 2913; Failing to provide for a functionally impaired person – R.C. 2903.16; Patient Abuse or Neglect - R.C. 2903.34; Patient Endangerment - 2903.341; and/or Endangering Children - 2919.22.

Is It All Cases of Abuse/Neglect, etc?

Registry Definitions:

- Knowingly – Aware that conduct will probably cause a certain result
- Recklessly – Heedless indifference to the consequences.
- Negligently – Substantial lapse in care, failure to perceive or avoid risk

Abuser Registry

Proof Levels

- Criminal offenses must be proven beyond a reasonable doubt.
- The Abuser Registry definition is found in R.C. 5123.50. It requires clear and convincing evidence and also considers extenuating factors in certain cases.
- The major unusual incident (MUI) definition in Ohio Administrative Code 5123:2-17-02(C)(15)(a)(iii) is the broadest of the three definitions and requires a preponderance to substantiate.

Abuser Registry Process

- All Substantiated cases are screened after being closed on ITS
- Registry Investigators review the entire file
- If it meets criteria goes to External Committee
- Notified by Certified Mail
- Opportunity for a Hearing/Affidavit
- Finial decision made by Director
- If decision is for placement, name goes on the list

Abuse and Neglect Hotline and Contacts

Hotline (866)313-6733

DODD MUI Office
614-995-3810

County Board Emergency Contacts

http://dodd.ohio.gov/reportabuse/Pages/default.aspx

WWW.dodd.ohio.gov

Assessing the Tool Kit

Select Tool Kit and Resources on Drop Down

The Tool Kit can be located under the Health and Welfare banner on our website. If you do not see the Health and Welfare Banner, you can also access through Individuals, Families or Providers below.

Assessing the Tool Kit

Home → Health & Welfare → Tool Kits

Tool Kit and Resources

Click Here to access the Toolkit

Other Resources

- Person Centered Approaches to Health Welfare Risks

Falls Prevention

- Steady U Website
- Head Injury Health and Safety Alert
- Falls Risk Self-Assessment
- Falls Prevention Health and Safety Alert

Choking Prevention

- Choking Prevention Video
- Choking Prevention Health and Safety Alert

Click here for all the forms and resources

Assessing the Tool Kit

Tool Kit and Resources

Click Here to access the Toolkit

Informational Links

After Hours Contacts
Could This Happen In Your Program...
County Board After Hours Numbers
County Board Contacts
New York Times Article
DODD Work Space
Abuse/Neglect Reporting
Access the Abuser Registry List
Could this Happen in Your Program...
UI Training
Family Chat
Health & Welfare Alerts
Related Rules
List of County Responsibilities
Regional Manager Map
Online Complaint Form

Training Presentations

Domestic Violence and Sexual Assault with Persons with DD Training
Fire and Burn Prevention Healthcare Providers
Incident Tracking System Intake Training
Preventing and Investigating Misappropriation
Seizures and Developmental Disabilities Training
UI Training
2015 MUI RULE Training for Direct Support Professionals
2015 MUI Rule Training for Administrators
Analysis Webinar 2015
Appendix C Form Webinar Presentation
Appendix C Webinar Presentation
CCF and Prevention Plan Training Handouts
Domestic Violence and Sexual Assault
Falls Prevention Training
MUI Rule Revision Presentation
Patterns and Trends Training
Provider Analysis 2/2014
Rule Revision Training Video
Stakeholders Presentation 2015
UI Log Presentation 2015
UI Training
Stakeholders Webinar
MUI Intake Webinar
Falls Prevention Webinar
Choking Prevention Webinar
Mental Health and Supports

New MUI Rule Revisions

5123-2-17-02 Appendix A
5123-2-17-02 Appendix B
5123-2-17-02 Appendix C
Revised FAQ
Revised Rule 5123-2-17-02 (effective 9-3-13)

Forms, Templates and Examples

Unusual Incident Report Log
Unusual Incident Report Form
SEMI OR ANNUAL ANALYSIS REVIEW FORM-AGENCY EXAMPLE
SEMI OR ANNUAL ANALYSIS REVIEW FORM-INDEPENDENT
MOU Sample
PPI Letter
Unapproved Behavior Support Form
Unscheduled Hospitalization Form
Law Enforcement Form

Other Reference Materials

Actions to take following a death
Analysis Schedule
MUI/UI Fact Sheet
Self-Waiver Guide
UI Random Sample CB Check-Sheet
Analysis Tips - Agency
Analysis Tips - Independent
Annual Abuser Registry Notice
AT A GLANCE - CB
AT A GLANCE - CB as PROVIDER
AT A GLANCE - AGENCY
AT A GLANCE-INDEPENDENT
Family Guide

Investigative Tools

IA Vacation and Time Off Rotation Example
Ohio Revised and Administrative Code
Referral Phone Listing
Abuser Registry Definition of Terms
Annual Abuser Registry Notice
Investigation Report Example A
Investigation Report Example B
Annual Abuser Registry NoticeMedical Information Authorization and Release
Ohio Clerk of Courts Association
Websites that may be useful

Available Resources

Do you have ideas on what we can do to improve training or resources, please let us know.

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