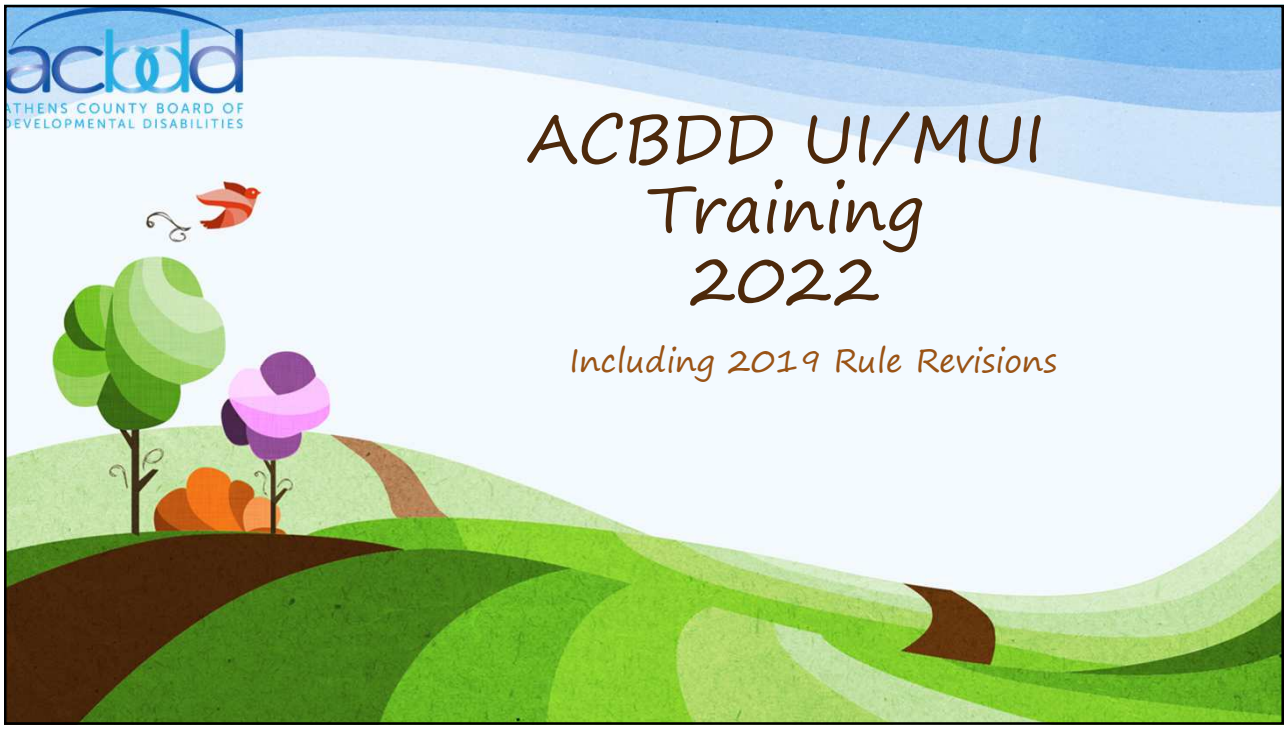
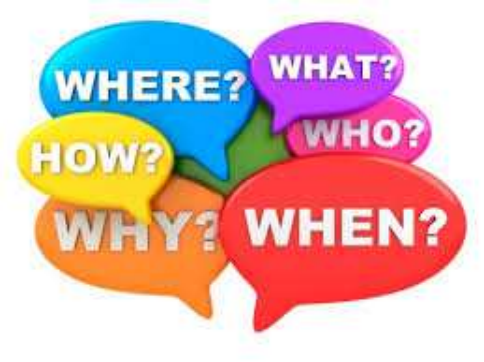


What is an unusual incident?

- An "unusual incident" is an event or occurrence involving an Individual that is not consistent with normal or routine actions or procedures for that person.
- Unusual incidents include, but are not limited to:
- dental injuries, falls, an injury is not a "significant" injury, medication errors without a likely risk to health and welfare, an incident involving two peers that is not a peer-to peer act MUI, rights code violations or unapproved behavioral supports without a likely risk to health and welfare, emergency room or urgent care treatment center visits, and program implementation incidents.

Elements of an effective Incident Report

- **Who**—Staff and Individuals involved in the incident
- **What**—What happened before (antecedent), during (detailed account), and after (immediate action)
- **When**—Date and time of incident was witnessed or reported
- **Where**—Location of the incident
- **Why**—Why did the incident happen

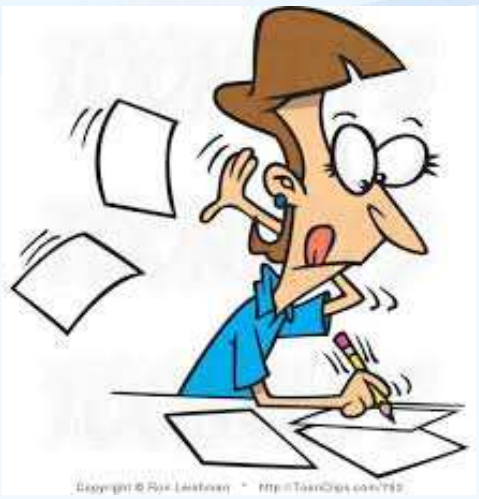


What comes first following a witnessed or reported incident?

The health and welfare of an Individual will always come first.

- Always document what actions were taken following the incident:
  - Assessed for injuries
  - Initiated first aid
  - Called 911 if necessary
  - Separated Individuals during an altercation
  - Notified law enforcement
  - Contacted providers/team/guardian

Etc…



It sometimes feels like all you do is fill out incident reports, right?

Why are they so necessary??

DETERMINING CAUSE AND CONTRIBUTING FACTORS

and

PREVENTION!

What is a UI Investigation?

- It 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

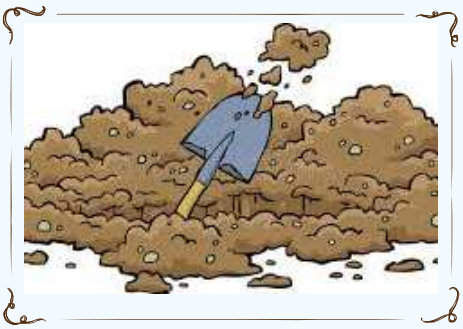
How do you investigate a UI?

- Start with the incident report:
  - Description: Does the information given by staff explain what happened? Did the witness tell us the WHO, WHAT, WHERE, and WHEN?
  - What immediate actions were taken?
  - What was happening prior to the incident? What were staff and Individuals doing?
- Was there an injury? Does the injury match the story given as to how it occurred? Was medical treatment provided?
- Unknown Injury? Does staff document on the IR how this may have occurred?
- Where did the incident occur? Bathroom? Bedroom? Community? Workshop?
- Were there witnesses? Staff and Individuals, anyone else?
- Were all necessary people notified of the incident?

How do you investigate a UI? cont'd

- Gather additional information if needed/interview as soon as possible after the incident as it is difficult to recall specifics as more time passes
- What do we know about the Individual? ISP, BSP, IHP, IEP, and relevant medical information
- What do we know about others involved? This would include peers, staff, family, etc.
- What is the cause?
- What are some of the contributing factors?
- How can we prevent this from occurring again?

Cause/Contributing Factors



Dig down into the incident to identify the root cause as well as contributing factors

Why did it happen?

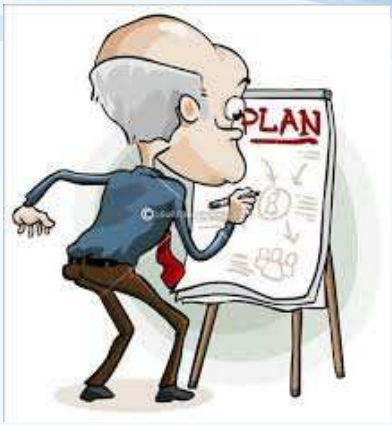
Prevention!

Once you determine why something happened, you need to find ways to ***prevent*** it from re-occurring

If you identify the Cause and Contributing Factors, you can develop an effective prevention plan.

Prevention Plans

- Does the action to be taken address the cause of the incident?
- Is the action to be taken within the control of the responsible person?
- Are the necessary resources available to implement the plan?
- If the preventive action is effectively implemented, can it minimize recurrence of the incident?



Elements of a good prevention plan:

- A quality prevention planning process includes the steps that have been taken for a specific case, as well as any steps that will be systemic in nature, regarding future prevention for that Individual and/or others
- Both specific preventions for the individual case and far reaching system changing preventions should be included in a good prevention plan

What's a good prevention plan for this picture?

Consider...
- *Will this make a difference in the life of this Individual and/or other Individuals?*
- *How will you make sure that the prevention plan can and will be implemented?*

Prevention plans should:

- Attempt to address each cause identified, not just "the obvious"
- Not be just a "plan to plan," but is specific in identifying WHO is going to do WHAT, WHEN, WHERE, and HOW to reduce the risk of future incidents
- Include involvement of the person and their guardian, as applicable, in the planning process
- Be shared across a variety of settings

What is a UI Trend or Pattern?

- Three of the same or similar incidents in a week or five in a month
- This can be found with the same Individual, same location, or same provider agency

Scenario:

- Johnny has been started on new medication, but family is inconsistent with providing it to him. On days that staff believe he has missed his dose, he runs through the hallways and hits anyone in his way. Other days, he is calm and focused. You are looking for a trend in the UIs.

UI Trends

Examples of trends include:

- Falls, peer/peer acts, medication errors (including missed meds), unknown injuries, rights code violations, unapproved behavior supports, etc

What needs to be considered when a trend is found?

- Ensure health and welfare
- Initiate a prevention plan
- Address the trend in the ISP
- Dig down to find root cause and contributing factors

Example of UI Investigations

Peer to Peer Investigation
Incident Description:

- Mike was at his day site when he grabbed another peer, Bill, because he wanted to touch Bill's leather coat. Staff were moving to separate the two men as Mike would not let go of the coat. Before staff could separate them, Bill fell to the ground.

Immediate Action:

- Did Bill have an injury? Was he assessed and did he receive treatment?
- Was Mike firmly fixed and does the injury make this an MUI?
- Were notifications made to the necessary people?
- Were supervision levels followed for both Mike and Bill?

Cause/Contributing Factors:

- History? Does Mike have a history of grabbing people or only people with certain clothing?
- Does Bill have an unsteady gait or a history of falls?
- Have there been any recent medication changes?
- What other contributing factors are there?

Prevention Plan: Does it address the cause/contributing factors?

Example of UI Investigations

Falls Investigation
Incident Description:

Individuals were eating breakfast when Jane stood up from the table and fell to the ground. Jane must have bumped her head on the table, as she has a red mark on her forehead. She seemed fine so we helped her up to her chair and she finished drinking her juice. Incident was called in to the supervisor on call.

Immediate Action:

- Was Jane assessed for injury to her head? Did she require treatment?
- Was she monitored for any signs of a head injury?
- Were notifications made to the necessary people?

Cause/Contributing Factors:

- History? Does Jane have a history of falls? Does she need assistance with transfers?
- Were the staff distracted when she was standing up? The staff indicated she "must have" hit her head. Does Jane require visual supervision?
- Have there been any recent medication changes?
- What other factors are there?

Prevention Plan: Does it address the cause/contributing factors?

Example of UI Investigations

Medication Error Investigation
Incident Description:

On Tuesday June 4, Tony was accidently given 10mg of Niacin. I was passing out medications to the guys in the home. We were rushing around to get on the bus and I gave him the Niacin. The Niacin belongs to his housemate Chuck. I contacted the supervisor who will contact the nurse on duty.

Immediate Action:

- Immediate actions are very important when a med error occurs. Always review the risk on medication errors and contact the pharmacy to be aware of signs of risks
- Ensure all necessary people have been notified of the error
- Review Medication Administration and your policies and procedures in regards to passing medications
- Look for trends!

Cause/Contributing Factors:

- Is there a trend with this particular staff?
- Was the staff properly trained on med admin?
- Why was the staff rushed on that day? Certain day of the week? New staff?
- What other factors are there?

Prevention Plan: Does it address the cause/contributing factors?

DODD MUI Hotline
1-866-313-6733
www.dodd.ohio.gov

ACBDD
Stephanie Kendrick, MUI Coordinator
740-541-9590 (office)
skendrick@athenscbdd.org

THANK YOU!