

MUI Prevention Plan

MUI # _____ **Individual's Name:** _____ **MUI Type:** _____

Date of Incident: _____ **Location of Incident:** _____

This Prevention Plan is the result of an MUI that was reported. The Ohio Department of Developmental Disabilities requires that a plan be developed and implemented BEFORE the case is closed. Please identify clear, reasonable "action steps" that will prevent the incident from happening again OR at least "reduce the likelihood". DO NOT use the term "will monitor". The primary aim is to reduce the risk of the individual being hurt or in jeopardy again. It is understood that there are situations where you cannot guarantee the steps will work, however it must be clear that the team is serious about reducing the risk and is making "active" efforts towards success. Please indicate (in addition to the new "action steps" the team is taking) any services the individual is receiving (counseling, psychiatric visits, etc.) if relevant in reducing the risk of re-occurrence. Please attach all relevant/ supporting documentation to this prevention plan.

PLEASE INCLUDE THE FOLLOWING INFORMATION:

1. What is the plan to prevent future/ additional incidents from occurring?
2. Have other significant factors that played a part in the incident been addressed?
3. Who is responsible for follow up and when will it be completed?
4. How will this plan be carried out?
5. Staff training (if applicable, attach training verification)?
6. Who will verify the outcome of the action steps?

PREVENTION PLAN

Please complete and submit supporting documentation (meeting notes, Plan/ EMP revision, referrals, etc.) **Return to:** _____ **Due Date:** _____

What is the plan? Make the steps "action oriented" whenever possible and time specific	Who is responsible for ensuring the plan/ action steps are implemented	When will plan/ action steps be initiated/ completed (Date)	Who is responsible for follow up?

A check mark here indicates the person completing this form collaborated (spoke to/ corresponded with/ held meeting) with the appropriate team members (individual, guardian, SSA, Provider, Day Program, etc.) to identify and implement the preventative steps above.

List Team Members: _____

 Name of person completing form Title Date