MUI Prevention Plan

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

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

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

This **PREVENTION PLAN** is the result of an MUI that was reported. The Ohio Department of Developmental Disabilities requires that **CAUSE AND CONTRIBUTING FACTORS** be identified and a prevention plan be developed and implemented BEFORE the case is closed. Please identify possible cause and contributing factors. To do this, the Team should consider things like procedures/ policies, people/ human factors, environments, materials, equipment, etc. Identifying the Cause and Contributing Factors will help the Team 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.

CAUSE AND CONTRIBUTING FACTORS: (Please list and explain)

PREVENTION PLAN

What is the plan to prevent future/ additional incidents? Make the steps "action oriented" whenever possible and time specific Have other significant factors that played a part in the incident been addressed?	**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? Staff training? Who will verify the outcome of the action steps?

☐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 _____