MINNESOTA
OFFICE OF OMBUDSMAN
FOR MENTAL HEALTH AND
DEVELOPMENTAL DISABILITIES

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As we are in the midst of another hot Minnesota summer, we want to draw attention to the possible impacts that hot temperatures, increased time spent outdoors, and increased sun exposure can have on people with mental illness, substance use disorder, and/or developmental disabilities. Common risk associated with summer include heat stroke, dehydration, extra strain put on the cardiovascular system, and breathing issues. Over the past 4 years, there were 23 serious injury reports involving a sunburn, 5 serious injury reports involving heat exhaustion, 4 accidental drowning deaths in open water, and 1 death report involving heat exhaustion. These risks are addressed in our summer alerts, which are updated each year by the Medical Review Unit.

The main focus of the Medical Review Unit is to review the circumstances of death affecting OMHDD's clients. The purpose of these death reviews is not to duplicate work done by regulatory agencies, but to seek opportunities for both targeted and systemic improvements of the care delivery system for persons receiving services for mental illness, developmental disabilities, and substance use. Additionally, death reviews allow us to identify trends within and across populations, which can help inform policy.

Our team consists of four registered nurse and one administrative support staff. You may have noticed an increase in the frequency of record requests, which is a direct result of our increased capacity. Many of our records requests are sent out due to facilities and staff submitting death reports that contain only minimal information, which do not allow us to form a good understanding of the circumstances of death. Reporting a death in as much detail as possible will help reduce the number of record requests you receive. If you do not have all of the information within the reporting timeframe of 24 hours, you should still report the death via webform or fax, and provide additional details later, through email (annelies.stevens@state.mn.us), phone (1-800-657-3506), or fax. Submitting complete reports and/or providing additional information at a later time helps us get a better idea of the circumstances of a person's death right away, and if necessary, identify any immediate safety concerns. In particular, it is helpful for us to have a full list of medications and diagnoses, as much as is known about how or why the death happened, and the date of birth as well as the date of death.

Certain deaths require a more in-depth review, especially those concerning unusual circumstances, those involving certain psychotropic medications, those occurring in certain settings, and those potentially caused by a delay in care. These cases are brought forward to the Medical Review Subcommittee (MRS), which currently consists of an interdisciplinary team of three physicians, a pharmacist, and a registered nurse. The subcommittee members have a combined 66 years of service!

Trends

During the past two calendar years there were 3,313 deaths reported to us. The vast majority of these were the result of natural causes. The most common causes of death involved in unexpected deaths were related to fentanyl and/or another illicit substance (340, or 10.3%), sepsis (156, or 4.7%), a fall (69, or 2.1%), a bowel obstruction (30, or 0.9%), and choking on food (26, or 0.8%). There are numerous interventions that can help prevent these types of deaths, including fall risk plans, early intervention when signs of sickness are noticed, following established plans regarding eating protocols, and making naloxone and fentanyl test strips available. Focusing on efforts to have all staff trained in emergency procedures like CPR and choking interventions is another great step to take. We often receive reports that staff reached out to managers or nurses before calling 911, and we want to encourage each of you that you are empowered to call 911 when you believe there is a life-threatening situation. Several medical alerts we have issued in the past go more in-depth on prevention strategies, and we look forward to issuing additional Medical Alerts in 2025, in addition to our updated alert on Choking and Aspiration.

Person-centeredness is an important concept related to enhancing the wellbeing of people served, as it allows each person to be considered as they are, yet OMHDD continues to see care plans that either omit key elements or lack specificity. If someone is prone to urinary tract infections, for example, it is important to include that information in the person's care plan, and to ensure all staff who work with that person are trained to understand what to look for. Or if someone has a history of suicide attempts, this should be noted in their treatment plan, and it should be considered when suicide risk assessments are completed. Someone who has difficulty swallowing should have a specific plan in place to help them stay safe while eating, which often includes an altered texture as well as staff supervision.

Substance use & fentanyl

Fentanyl is high on our radar, just like it is for many other agencies and organizations in Minnesota. It is a very powerful synthetic opioid that is often added to drugs like heroin and methamphetamine, and the person using the drug may not even know that they are using it. This creates a very real risk of death or serious injury, because the effects of fentanyl are much more severe than those of other opioids. In calendar years 2023 and 2024, 341 deaths were reported to us that involved fentanyl, making it our most common cause of unexpected death.

It is not uncommon for people to (intentionally or unintentionally) use fentanyl while they are in treatment for substance use or mental health, and knowing what to look for can help prevent death.

Common signs of a fentanyl overdose include:

- Pinpoint pupils
- Loss of consciousness
- Slow, weak, or no breathing
- Choking or gurgling sounds (which may include loud snoring sounds)
- Limp body

- Cold and/or clammy skin
- Discolored skin, especially in lips and nails

If you notice any of these signs, call 911 immediately, and administer naloxone. A second dose should be given if you do not see a response after 2-3 minutes. It is best practice to have at least 2 doses of naloxone readily available at each facility, and to make sure all staff are trained on how to administer it.

Opioids and Fentanyl - MN Dept. of Health
(https://www.health.state.mn.us/communities/opioids/basics/fentanyl.html)

Fentanyl Facts | Stop Overdose | CDC
(https://www.cdc.gov/stop-overdose/caring/fentanyl-facts.html?CDC_AAref_Val=https://www.cdc.gov/stopoverdose/fentanyl/index.html)

Lifesaving Naloxone | Stop Overdose | CDC
(https://www.cdc.gov/stop-overdose/caring/naloxone.html?CDC_AAref_Val=https://www.cdc.gov/stopoverdose/naloxone/index.html)

What to Do if You Think Someone is Overdosing | Stop Overdose | CDC
(https://www.cdc.gov/stop-overdose/response/index.html)

Falls & osteoporosis

Each year we receive a significant number of serious injury reports (and even some death reports) related to fractures. These fractures may be spontaneous in nature, which means there is not a specific incident, like a fall, that caused the fracture. Many times, osteoporosis is discovered when a client is evaluated in the emergency room after a fracture happens.

Osteoporosis is a condition commonly associated with old age. It is diagnosed when bones weaken and become more susceptible to fractures. People with intellectual and developmental disabilities are often at a higher risk than the general population for developing more severe osteoporosis at a much younger age. This can be due to certain medications that might be prescribed (such as antiepileptic medications to help prevent seizures), underlying diseases that affect bone density, lack of proper bone growth in childhood, and decreased mobility. Unfortunately, fractures can lead to worsening disability and even death.

There are strategies that can be implemented to help maintain bone strength and prevent fractures. One simple strategy is to support the person to talk with their health care provider about their specific osteoporosis risk in the context of their health and medication history. It may be helpful to discuss the possibility of adding calcium and vitamin D with the client's health care provider, as these supplements can help promote bone health. Another option is to encourage increasing weight-bearing activities, like walking, to a level that is safe and manageable for the person. Fall risk prevention strategies can also help reduce the number of life-changing fractures and should include a careful evaluation of the person's risk factors and their immediate environment.

We wish you the very best for the coming year and thank you for all that you do. If you have questions, concerns, or feedback, feel free to connect with me at annelies.stevens@state.mn.us. I look forward to hearing from you!

Sincerely,

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Medical Review Coordinator