MINNESOTA
OFFICE OF OMBUDSMAN
FOR MENTAL HEALTH AND
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Happy holidays!

As we move into another (hopefully) beautiful winter season, I would like to introduce myself as the new Medical Review Coordinator. In this role I lead the Medical Review Unit with the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD). My background is in nursing with a focus on people with developmental and/or intellectual disabilities as well as people who have experienced sexual violence. I feel honored to be able to shift my focus towards an even broader group of people deserving of advocacy. At OMHDD, we strive to provide the highest attainable standards of treatment, competence, efficiency, and justice for persons receiving services for mental illness, developmental disabilities, chemical dependency, or emotional disturbance. I look forward to working alongside each of you who support our mutual clients.

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

Deaths must be reported within 24 hours of learning of the death. When completing the **OMHDD Death Report Form**, please include as much information as possible, so that we have what we need to complete our initial review. If you don't have everything yet, report the death anyway, and provide additional information once you get it. This will help reduce the number of record requests you may get from us, thereby saving you time in the future. It also 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's 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 and a pharmacist.

The MRS meets every two months to review these more complex cases, and to look for opportunities for systemic improvement. We have one open position in the Subcommittee, and we encourage you to consider joining if you have experience working with our clients!

Scan to submit an application to join the MRS

Trends in deaths

Some of the more common causes of unexpected deaths reported to us include those related to sepsis, choking, bowel obstructions, falls, and fentanyl. In the most recent biennium, 135 deaths involved sepsis, 16 deaths involved choking, 151 deaths involved aspiration pneumonia, 23 deaths involved a bowel obstruction, 42 deaths involved falls, and 351 deaths involved fentanyl. 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. Ensuring all staff are trained in emergency procedures like CPR and choking intervention is another great step to take. 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 2024.

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's important to include that information in their 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.

Respiratory illness

The COVID health emergency officially ended on May 11, 2023, but we continue to see cases in community and congregate care settings. Influenza and RSV (Respiratory Syncytial Virus) are also present in the community, as is typical this time of year. For up-to-date guidance on how to help people be safe and healthy, we recommend checking out the following links:

Coronavirus Disease 2019 (COVID-19) – MN Dept. of Health
(https://www.health.mn.gov/diseases/coronavirus/index.html)

Influenza (Flu) – MN Dept. of Health
(https://www.health.mn.gov/diseases/flu/index.html)

Respiratory Syncytial Virus (RSV) – MN Dept. of Health
(https://www.health.mn.gov/diseases/rsv/index.html)

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're 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 fiscal years 2022 and 2023, 351 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 don't 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.

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

Fentanyl Facts | cdc.gov
(https://www.cdc.gov/stopoverdose/fentanyl/index.html)

Lifesaving Naloxone | cdc.gov
(https://www.cdc.gov/stopoverdose/naloxone/index.html)

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 isn't a specific

incident, like a fall, that caused the fracture. Many times, osteoporosis is discovered when the 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, which 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,

Annelies Stevens-de Jong, BSN, RN, PHN, CDDN, SANE-A
Medical Review Coordinator