



Office of Ombudsman for Mental Health and Developmental Disabilities



Client Residence Information for Health Care Providers



This Medical Alert is based on the work of the Medical Review Subcommittee and should be posted prominently. The Office of Ombudsman for Mental Health and Developmental Disabilities works to improve the services provided to people with disabilities by communicating important information found in the Medical Review Subcommittee's reviews of deaths and serious injuries. Thank you for promptly reporting deaths and serious injuries. You are helping us to meet our mission.

The Medical Review Subcommittee (MRS) continues to review a large number of cases in which the client had appeared ill to residential staff shortly before his or her unexpected death. Residential staff brought the client to the clinic, to Urgent Care, or to the Emergency Department for assessment, and the client was returned home to the residential facility only to die unexpectedly at the residence.

The MRS has concluded that the treating health care provider frequently is unaware of the client's living situation before sending the client home.

The MRS recommends that the staff of residential facilities or other staff, who accompany clients who live independently to health care appointments, give the health care provider information about the client's living situation. A sample form is provided with this Alert, but providers are encouraged to develop their own preferred forms.

This Alert was prompted by the following tragic case:

Could This Happen to Your Client?

Case Study: A 46-year-old woman, with schizoaffective disorder, hypertension, and other medical conditions, was found dead in the morning in the shared housing residence in which she had lived. Her death was reported to the medical examiner, and an autopsy was performed. Her manner of death was an accident, and her immediate cause of death was attributed to an opiate overdose. Two days before her unexpected death while she waited to be picked up by the van for work, the client had fallen outside her home during a snowstorm. She was accompanied by a mental health services staff person to the doctor, who diagnosed a fractured right shoulder and prescribed Tylenol #3. She also was referred for a follow up appointment with an orthopedic specialist the next day. On the next day she was evaluated by the orthopedic specialist, who was concerned about her level of sedation, which was reported to be more than usual. He sent her to the emergency room for evaluation. A CT scan was done and did not show any conditions that might contribute to her sedation. The emergency room physician discharged her back to her residence believing that the sedation was secondary to the Tylenol #3 in combination with the client's psychiatric medications. The client had been accompanied to the emergency room by a mental health services staff person, who dropped the client off at home at approximately 10:30 PM on the day before her death. The shared housing residence had no overnight staff. Because the client had stated she was too tired to get to her room, a shared housing resident assisted the client to bed on the couch. She was found dead on the couch on the next morning by another resident. After the client's death, a pill count was done, and, between the date of her injury and the date of her death, the client had used only six of the Tylenol #3 tablets prescribed for her.

The MRS makes the following recommendations:

- 1) When a client goes to an emergency room, to urgent care, or to her primary health care provider, residential staff should be prepared to provide the following information: type of program (e.g. board and lodge, nursing home, independent living), type of supervision (e.g. no staff in residence, overnight sleep staff, overnight awake staff), and types of services provided (e.g. medication supervision, medication administered by trained medication aides, staff supervision of self-administration of medication, independent medication administration).
- 2) The MRS recommends that all clients take with them to the ER, urgent care, or primary health care provider a copy of their current medication administration record, which should include at minimum: the name of patient, the name of facility with an emergency contact number, and the name and phone number of client's pharmacy.

(Sample Form)
Client Residence Information for Health Care Providers

Name of Client/Patient:

Address:

Living Situation (circle one):

Adult Foster Care Group home Independent living Shared housing
Intermediate Care Facility (ICF-DD or ICF-ID) Board and Lodge

Total number of residents/roommates: _____

Telephone:

Fax:

24 hour contact (residential supervisor/case manager):

In Home Staffing (Circle as appropriate):

None.

Day: _____ Eve: _____ Night (circle one): Awake Asleep

Health Care Resources

Residential RN (or circle None):

Name:

Phone Number:

On-site availability (circle one): Yes No

Total number of sites _____ & residents _____ supervised.

Residential LPN (or circle None):

Name:

Phone Number:

On-site availability (circle one): Yes No

Total number of sites _____ & residents _____ supervised.

Primary Physician

Name:

Phone Number:

Fax Number:

Pharmacy

Name:

Phone Number:

Fax Number:

Delivery mode &/or time allowed to fill prescription:

Med Administration (circle one): Trained staff Licensed staff Self-administration

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