January 2021

Dear Colleague:

Extending best wishes to you and the clients with whom you work. The past months have been challenging and likely will remain so. This office recommends the following sources of up to date information about COVID-19:

- Minnesota’s COVID-19 Response - Stay Safe MN (https://mn.gov/covid19/)

The OMDHH wishes to remind providers that even when Minnesotans are recommended to Stay Safe MN and limit interactions with others, it is still important for all of us to go outside - weather permitting, take walks, and go for drives while practicing social (actually physical) distancing.

The Medical Review Subcommittee (MRS) continues to review reports of individual deaths and reviews accumulated data on all deaths and serious injuries reported to the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD). Periodically, the MRS develops Medical Alerts based upon those reviews.

Announcing the Winter Alerts for 2021 (https://mn.gov/omhdd/documents/medical-alerts.jsp)

| Winter Alert | Frostbite Alert | Hypothermia Alert | NWS Wind Chill Chart |

For continued updates from the (OMHDD), you can Subscribe to the OMHDD Medical Alerts E-Mail List Service. When you subscribe to this service, you will be notified by e-mail when new Medical Alerts are posted to the OMHDD website.
New Method for Reporting Deaths and Serious Injuries

In early 2020 the OMHDD made webform reporting available for the routine reporting of deaths and serious injuries. Webform reporting is the preferred method of reporting deaths and serious injuries, but the paper forms remain available on the OMHDD website for use when preferred by reporters.

Death Review webform (https://omhddcms.i-sight.com/portal/death-review)

Serious Injury webform (https://omhddcms.i-sight.com/portal/serious-injury)


While webform reporting has been going well so far, the office has received Serious Injury reports on the Death Report webform and Death Reports on the Serious Injury webform. If, for example, you report a death on the Serious Injury webform, the data you reported must be manually transferred to a death report form, and the number assigned to the report you have made will no longer apply.

In addition, while the office recognizes that you may not have all the information requested on the forms, please provide the information to which you do have access, for example: the client’s first and last names, the client’s date of birth, the date of death (when applicable/known), the contact information for the reporter including the reporter title (case manager, social worker, program director, mental health practitioner, etc.) and the Reporter Facility/Agency Name.

Please Note: Both the death report and serious injury report forms will timeout after 15 minutes of inactivity. Although the form can be printed after submission, it cannot be “saved” for later completion.

New – Both online Death Reports and online Serious Injury Reports now permit the secure upload of up to ten attachments.

Reports of deaths and serious injuries can still be faxed to the OMHDD at the following number:

Fax: 651-797-1950 Please note the fax number. (The old back-up fax number is no longer available.)

Thank you for continuing to report Serious Injuries and Deaths to the OMHDD and for your continuing cooperation with the review process. Please call Voice: 651-757-1800 or Toll Free: 1-800-657-3506 with any questions.
MedWatch Safety Alerts are now called Drug Safety Communications by the FDA

Since the 2020 Summer Alert, the FDA has released Drug Safety Communications for many medications, some of which are prescribed for clients of the OMHDD. These medications include the following:


To reduce the risk of death from opioid overdose, the U.S. Food and Drug Administration (FDA) is making the following recommendations about the opioid reversal medicine, naloxone:

For all patients who are prescribed opioid pain relievers, health care professionals should discuss the availability of naloxone, and consider prescribing it to patients who are at increased risk of opioid overdose, such as patients who are also using benzodiazepines or other medicines that depress the central nervous system, who have a history of opioid use disorder (OUD), or who have experienced a previous opioid overdose. Health care professionals should also consider prescribing naloxone if the patient has household members, including children, or other close contacts at risk for accidental ingestion or opioid overdose.

For all patients who are prescribed medicines to treat OUD, health care professionals should discuss the availability of naloxone and strongly consider prescribing it. For methadone and buprenorphine-containing products, health care professionals should also consider prescribing naloxone if the patient has household members, including children, or other close contacts at risk for accidental ingestion or opioid overdose....


To address the serious risks of abuse, addiction, physical dependence, and withdrawal reactions, the U.S. Food and Drug Administration (FDA) is requiring the Boxed Warning be updated for all benzodiazepine medicines. Benzodiazepines are widely used to treat many conditions, including anxiety, insomnia, and seizures. The current prescribing information for benzodiazepines does not provide adequate warnings about these serious risks and harms associated with these medicines so they may be prescribed and used inappropriately. This increases these serious risks, especially when benzodiazepines are used with some other medicines and substances.

Benzodiazepines can be an important treatment option for treating disorders for which these drugs are indicated. However, even when taken at recommended dosages, their use can lead to misuse, abuse, and addiction. Abuse and misuse can result in overdose...
or death, especially when benzodiazepines are combined with other medicines, such as opioid pain relievers, alcohol, or illicit drugs. Physical dependence can occur when benzodiazepines are taken steadily for several days to weeks, even as prescribed. Stopping them abruptly or reducing the dosage too quickly can result in withdrawal reactions, including seizures, which can be life-threatening.


The U.S. Food and Drug Administration (FDA) is warning that taking higher than recommended doses of the common over-the-counter (OTC) allergy medicine diphenhydramine (Benadryl) can lead to serious heart problems, seizures, coma, or even death. We are aware of news reports of teenagers ending up in emergency rooms or dying after participating in the “Benadryl Challenge” encouraged in videos posted on the social media application TikTok.

We are investigating these reports and conducting a review to determine if additional cases have been reported. We will update the public once we have completed our review or have more information to share. We also contacted TikTok and strongly urged them to remove the videos from their platform and to be vigilant to remove additional videos that may be posted.

**Consumers, parents, and caregivers** should store diphenhydramine and all other OTC and prescription medicines up and away and out of children’s reach and sight. FDA recommends you lock up medicines to prevent accidental poisonings by children and misuse by teens, especially when they are home more often due to the COVID-19 pandemic and may be more likely to experiment....


**Medication Administration**

When administering prescription and over-the-counter medications to your clients, please be aware of the potential side effects of the medications. Document any changes in the client’s condition that the medications are intended to treat, as well as any side effects observed and/or reported by your clients, so the health care provider/prescriber can be informed.

Thank you for your interest in the Medical Alerts.

Please call me at 651-431-5202 or 1-800-657-3506 with any questions or concerns.

Sincerely,

Jo Zillhardt, RN-BC, PHN
Medical Review Coordinator