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# Case #1

Barry started to pace back and forth in the living room of his group home after dinner one night. Staff member Janice noticed this and asked Barry if he was ok. Barry was mostly non-verbal but he could typically indicate when he was in pain. Barry pointed to his stomach while he continued to pace. Janice chuckled and said, "Yep, my stomach hurts a little bit too after that big dinner we had! Your body probably just needs some time to digest and then you'll feel better." Janice and the other staff continued with the evening routine, gave everyone their medications and got them ready for bed. Barry stopped pacing and went to lie down in his room earlier than was normal for him. When Janice checked on him at 9:00 p.m. he was lying quietly on his bed, facing away from Janice.

At 11:00 p.m., Gregor, the overnight staff, arrived and started to do room checks while Janice gathered her belongings and got ready to leave for the evening. When Gregor checked on Barry, he noticed that Barry was sleeping in an unusual position. He went further into Barry's room to check on him. He saw that that Barry had vomited and that Barry's eyes were open and fixed. He called Barry's name a few times and tried to find his pulse but Barry did not respond and did not appear to have a pulse. He called out to Janice, "I think something may be wrong with Barry! Can you come check?" Janice came into Barry's room and also observed that Barry was not responsive and did not have a pulse. Janice called the house supervisor, Carol, to let her know that something was wrong with Barry. Carol told Janice to start CPR and call 911. Janice called 911 while Gregor began CPR on Barry while Barry was still lying in his bed.

- Janice did not identify changes in Barry's behavior that indicated he was unwell and needed medical attention. She did not take his vital signs when he indicated his stomach hurt and did not notify a nurse that Barry was complaining of stomach pain.
- Although Janice checked on Barry at 9pm she did not check him for signs of life, even though he had indicated that he did not feel well.
- ♦ Gregor did not immediately contact 911 when he realized that Barry did not have a pulse.
- ♦ Janice called the house supervisor instead of contacting 911 when she realized Barry did not have a pulse.
- Janice and Gregor began CPR on Barry while he was lying in his bed rather than moving him to a hard, flat surface.



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# Case #2

James was complaining of stomach pain and pointing to his stomach. James' blood pressure was regularly monitored. Laureen, a direct care staff, took his blood pressure and noted that it was high. Laureen called the RN about James' blood pressure but did not tell the RN that James was also complaining of stomach pain. The RN directed Laureen to bring James to the emergency department. Instead of immediately taking James there, Laureen waited for her co-worker to return from an outing. She gave James a shower and a shave and changed him into clean clothing while they waited.

When the other staff returned, Laureen took James outside to hail a taxi. While doing so, James collapsed on the sidewalk. Laureen called her supervisor to tell him that James had collapsed. Some bystanders administered CPR to James while Laureen was on the phone.

- ♦ Laureen did not tell the RN that James was complaining of stomach pain.
- Laureen did not tell the RN that she was waiting for another staff to return from an outing before bringing James to the emergency department.
- ♦ The RN did not provide a timeframe for when to bring James to the ER or direct Laureen to contact 911.
- ♦ Laureen did not immediately bring James to the ER and instead gave him a shower and changed his clothing.
- ♦ Laureen did not contact 911 or begin CPR when James collapsed on the sidewalk.
- ♦ The agency policy did not provide explicit instructions for transporting people receiving services to the ER.

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# Case #3

Amelia was admitted to an inpatient substance abuse unit at a hospital for inpatient treatment after finishing four days in the hospital's detox unit. She had a diagnosis of bipolar disorder and opiate use disorder. Amelia used the bathroom in the hallway while walking with staff from the detox unit to the inpatient unit. There she found a medication bottle with a week's supply of hydrocodone. Amelia took the pills out of the bottle and put them in her pocket. Inpatient staff did not conduct a search of her person when she arrived since she came from another area in the hospital.

Amelia settled into her room and then crushed the pills and snorted them. Staff found her unconscious on the floor between the wall and her bed a few minutes later. Staff yelled for help and asked that someone bring a Narcan kit. The Narcan was not easily accessible. It was kept in a locked cabinet and only the shift supervisor had a key. When they got the cabinet open, they rushed it to Amelia's room. They had a hard time reaching her because several staff members were crowded around her bed. Staff also discovered the Narcan was expired and they were unsure if they should use it.

- Staff did not check the hallway bathroom for contraband prior to Amelia entering the room.
- Staff did not complete a search of Amelia and her belongings when she was admitted to the inpatient unit.
- The Narcan kit was behind a locked cabinet and was expired.
- Staff did not administer the expired Narcan, causing a delay in a potentially life saving intervention.
- Staff did not call for a code for a medical response.
- ♦ Too many staff members attempting to help delayed treatment. No one coordinated response efforts to ensure only essential staff responded.

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# Case #4

Georgiana was admitted to an inpatient psychiatric unit for depression, stating that she did not want to live anymore. Georgiana had a specific plan for ending her life and was placed on 15 minute checks for safety. While on the inpatient unit, Georgiana's doctor made changes to her medication regimen. Georgiana appeared to be less depressed and began to talk about plans for the future. LPN Nancy was assigned to provide supervision and 15 minutes safety checks to Georgiana. However, Nancy had been having trouble at home and argued with her husband just before her shift started. Her husband called her while she was working and Nancy stepped into an empty stairwell to speak to him. Nancy was on the phone for approximately 20 minutes.

When she came back onto the unit, she spent time at the nurse's station reviewing shift reports and chart updates. When Nancy went to check on Georgiana, it had been 35 minutes since her last check. As Nancy walked down the hall to Georgiana's room she saw that Georgiana's door was closed. As she opened the door she found that Georgiana had used the blanket from her bed to hang herself from the door. Nancy yelled out for someone to call 911 and then ran out of the room to try and find help. Another nurse contacted 911 and the dispatcher directed them to remove the blanket from Georgiana's neck and lower her to the floor and begin CPR. When first responders arrived, they took over CPR but could not revive Georgiana.

- ♦ There was a delay in staff lowering Georgiana to the floor and beginning CPR. Nancy did not call a code blue, or try to immediately help Georgiana.
- Nancy did not provide the 15 minutes safety checks for Georgiana as required or transfer the responsibility to conduct the checks to another staff when she left the unit.
- Nancy did not let anyone know that she was experiencing difficulty at home that might impact her ability to provide supervision to people receiving services.
- ♦ The hospital did not have a policy or practice in place to monitor the completion of safety checks.

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# Case #5

Allana took Ian and Steve out for a ride in the agency vehicle one night in December to look at holiday lights. They spent an hour driving around looking at lights and decorations and had a great time. On the way back home, Allana decided to go to the drive-thru window of a fast food restaurant to get everyone a hot chocolate and a snack. As soon as she got them, she passed the hot chocolate and cookies to Ian and Steve in the back seat. She warned them that the drinks were hot and they needed to wait for them to cool down. Ian decided to wait until they got home to eat his cookie. Steve started eating his right away. Allana turned the radio up loud to listen to a song she liked and laughed as Ian and Steve started to sing along.

Steve stopped singing just long enough to take a bite of his cookie and started singing again. Suddenly he started coughing and sputtering and Ian patted him on the back and said, "Slow down Stevie!" Steve stopped coughing and went silent while Alanna continued singing along to the radio. When she glanced in the rear view mirror, she saw that Steve was slumped over in his seat with his hand on his throat. She yelled to Ian, "Is Steve okay?" while she continued to drive. Ian looked at Steve and shrugged his shoulders. Since they were close to their house, Alanna drove home as quickly as she could. When she pulled into the driveway, she hopped out of the van and ran around to open the passenger door where Steve was sitting. Steve had stopped breathing and was turning blue. Alanna ran into the house and called for someone to help her then ran back to the car and began pounding on Steve's back. Vaughan, another staff who was working that night, called 911 then ran outside to help Alanna with Steve. When the ambulance arrived, they took over resuscitation efforts and transported Steve to the hospital.

- Alanna gave food to lan and Steve while they were still in the vehicle which was against agency policy.
- Alanna could not supervise Steve while he was eating since she was driving.
- Alanna did not immediately pull over as soon as she saw that Steve was in distress.
- Neither Alanna or Vaughan administered abdominal thrusts on Steve.