

PROTECTING PEOPLE WITH SPECIAL NEEDS FROM THE DANGERS OF CAREGIVER FATIGUE

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The NYS Justice Center for the Protection of People with Special Needs (Justice Center) is committed to supporting and protecting the health, safety and dignity of people with special needs and disabilities. The Justice Center has launched a series of toolkits which provide facts, best practices and resources that can be used by everyone who has a vested interest in preserving the safety and well-being of individuals who receive services or supports.



Falling asleep on the job puts caregivers at risk of making mistakes that could endanger adults and children who may require consistent and responsive attention to ensure their health and safety. Over the past year, the Justice Center's 24-hour abuse and neglect hotline has received numerous reports of incidents involving staff inattention to their duties and poor decision-making resulting from sleep deprivation, workplace fatigue or sleeping during a shift.

Whether you are an individual, self-advocate, direct care provider, agency administrator, friend or family member-- you have an important role to play in preventing a needless tragedy from happening. The information provided in this

toolkit will help raise awareness of the serious consequences of caregiver fatigue and falling asleep on duty. It also includes simple safety practices to reduce the risks linked to this serious safety hazard.

The Risks

Caregiver inattention may result in an incident that jeopardizes the safety and well-being of people receiving services. This could include:

- An individual's personal care and health needs not being met;
- Failure to prevent or de-escalate an individual's high risk behaviors, such as choking or elopement;
- Inability to respond to an individual's acute medical needs; and/or
- Failure to respond to an emergency, such as a fire.

FROM OUR CASE FILES¹



Resident choking risks and fire evacuation hazards

A case of staff complicity, willful sleeping + environmental barricades + setting an alarm to avoid detection by incoming day shift staff.

James, an administrator made an unannounced visit to the Miller Road residence at 5 a.m. The facility, which provides services for individuals with mental illness, is routinely staffed with two full-time awake care staff between the hours of 10 p.m. and 8 a.m. When James arrived, he found both staff members asleep in the living room. An alarm clock next to a couch was found to be set for 5:45 a.m. Dining room chairs had been placed outside of the bedroom doors and in front of the kitchen entrance in what appeared to be barricades. When James approached the kitchen, he discovered a chair had been pushed slightly aside and resident Jay eating peanut butter from a jar with a spoon. Because Jay has a history of unsafely consuming food, which puts him at risk of choking, he is never to be left alone in the kitchen.

¹ The case studies in this toolkit involve fictitious victims and represent a collection of facts identified from multiple investigations and are used for illustrative purposes only.



Inattention to a resident's acute medical need and a seizure in progress

A case of staff complicity and failure to communicate with administration on-duty, willful sleeping due to illness + co-worker sympathy or detachment.

Joseph works the day shift at a community residence for individuals with developmental disabilities. He observed co-worker Jessica lying on the living room couch, facing away from view of resident Sierra who was sitting in her wheelchair quietly watching television. Joseph proceeded to the kitchen to start making breakfast without advising Jessica because he knew that she did not feel well. While in the kitchen, Joseph heard a loud noise coming from the living room and rushed to see what was going on. He found Jessica fast asleep as Sierra was having a grand-mal seizure. Jessica failed to adhere to Sierra's safety plan for her seizure disorder, which includes continuous one-to-one monitoring. Staff must also notify 9-1-1 if a seizure lasts more than four minutes or if Sierra turns blue.

Joseph quickly responded by observing Sierra's airway and coloring and timed the length of her seizure. He stayed with Sierra until after the seizure was over and she appeared to be okay. He then documented the incident and notified the nurse before heading back to the kitchen. About mid-morning, Jessica told Joseph that she was very sick and went home early. Joseph worked alone until another staff member arrived a half-hour later. Neither Joseph, nor Jessica reported to the administrator-on-duty that Jessica was unfit for duty all morning due to illness or that she needed to leave early.



Inappropriate resident access to medications stored in the residence

A case of a non-traditional/long shift + use of prescribed medications affecting alertness + no emergency staffing plan to relieve staff who are unfit for duty.

One Fall Saturday afternoon, individuals receiving services at a community residence for drug and alcohol treatment noticed that Michelle, the only staff person on duty appeared to be “groggy” and possibly under the influence of drugs. They became concerned when she failed to administer their scheduled medications. They tried, but were unable to rouse Michelle when they found her slumped over and asleep in the medication room. One resident opened the unlocked medication cabinet and helped three others retrieve their medication from labeled drawers before Michelle woke up. Michelle’s work schedule includes an “on-call” shift on Thursdays. She is the only staff person on duty from Friday at 5 p.m. until Monday at 3:00 p.m. Michelle is permitted to sleep during the overnight shift, barring any need that may arise to provide assistance to individuals during those hours.

On the afternoon of the incident, Michelle called the program administrator and asked to be relieved of her duties after taking a prescribed medication. The administrator, who was either unable or unwilling to grant Michelle’s request failed to send anyone to relieve her. Michelle recalled feeling dizzy around 7 p.m. and sat down in a chair. She said she was later awakened by a resident who told her that while she had been sleeping the residents had gained access to their medications.



A motor vehicle accident

A case of a non-traditional/long work shift (17-hour shift followed by a 12-hour shift) + a new medication affecting alertness + a staffing assignment to transport residents.

It was a beautiful summer afternoon when Zoraya, who works the day shift at a residence for individuals with developmental disabilities, offered to take six residents to the local county fair. The group arrived at the fair around 4 p.m. and spent a few hours walking around, eating food and playing games. During the drive back to the residence, Mary fell asleep at the wheel, drove off the road, and crashed into a utility pole. The impact of the collision woke Zoraya, at which time she immediately checked on the status of all of her passengers who all reported being okay. Zoraya reported the accident to her supervisors as she was required to do.

Zoraya’s work schedule often varied throughout the week. Her shifts ran 8 to 17 hours, averaging a 42-hour work week. The day prior to the accident, Zoraya had worked a 17-hour shift and then reported back to work approximately eight hours later for a 2-hour shift. When interviewed about the accident, Zoraya confirmed that she had lacked sleep and was exhausted. She admitted that she caught herself dozing off during the drive back to the residence. Zoraya also revealed she had been taking a new medication with a side effect that could affect alertness and included a caution against driving. Zoraya neglected to inform her supervisor of her medication regimen as it might affect her driving responsibilities as was required in the agency’s “Vehicle Use” policy.



An elopement

A case of willful sleeping + staff complicity + failure to follow facility protocol for bed checks.

Jeremy has worked the night shift at the same youth residential facility for almost seven years. During this time, he has become close friends with the other night shift staff. His co-workers know that Jeremy works two jobs. At around 11 p.m. each night, Jeremy routinely dozes off for a few hours. After taking his “power nap,” he gets up and completes the rest of his nightly duties. One night at around 2 a.m., Jeremy awoke and resumed his scheduled bed check responsibility, when he noted resident Caleb was missing from his bedroom. Staff members found a bed sheet had been tied around a fixed object that led out through the window. Police ultimately located Caleb at a family member’s residence. Caleb later reported he stayed up late several nights to prepare for his escape, after he discovered scheduled bed checks were not performed until around 2 a.m. On the night he eloped, Caleb waited until 11:30 p.m. and then quickly fled the residence, expecting this would give him about two hours before anyone would notice he was gone. When questioned, the other night staff acknowledged they were aware of Jeremy’s habits. And though unaware of his exact responsibilities—they believed he did a good job overall, and didn’t see any harm in him taking a few hours to rest. His supervisor had suspected Jeremy may be sleeping, but when asked previously, other staff had denied it and the supervisor had not been able to perform surprise “spot checks” as planned to confirm for himself.

LESSONS LEARNED

- **Unexamined Risk Factors**--Many incidents involved staff working extended or otherwise non-traditional work shifts. Identifiable risk factors included reporting to work when their ability to work was questionable; or they were unfit for duty, due to an illness, exhaustion or the side-effects of prescribed medications. These risk factors often do not appear to have been considered within agency remediation plans.
- **Indiscriminate Policies for Addressing *Willful* and *Accidental* Acts of Sleeping on the Job**—Agencies often addressed both *willful* acts of sleeping and *accidental* nodding-off with the same approaches. Most incident investigation and review activities failed to adequately consider the unique risk profiles and the circumstances of individual staff and events when determining staff penalties or other plans for corrective action.
- **Ineffective Deterrents**--Agencies where staff were found sleeping routinely had strong policies in place that are meant to deter workplace sleeping. Most agencies imposed random administrative spot checks and rigorously addressed all acts of confirmed staff sleeping with penalties associated with neglect, misconduct or other dereliction of duty. Yet, incidents of staff sleeping on duty continue to occur, even at agencies with strategies in place.
- **Disempowered Individuals Receiving Services**—Individuals receiving in-patient or residential care who discovered that their solitary caregiver (or in some cases, all of their caregivers on duty) was sleeping or was otherwise incapacitated, did not regularly take any action. It appeared that these service-recipients had not been taught or empowered to take action to bring attention to unsafe conditions or emergencies. Further, when they were questioned about specific incidents of alleged staff sleeping--they often disclosed previous unreported complaints of staff sleeping.

➤ **New Prevention Strategies Are Needed--** Strategies to detect and deter caregiver fatigue and sleeping on the job must:

- plan for identifiable staff risk factors;
- discriminate between risks of willful and accidental sleeping on the job;
- utilize effective deterrents for each type of hazard; and
- empower service recipient to recognize unsafe conditions and seek out help in emergencies and other unsafe situations.

This prevention tool kit contains a sample *Staff Personal Action Plan* as an example of a strategy that could be used to help a caregiver and his or her supervisor in the assessment of, and in planning for mitigating risks, associated with accidental caregiver sleeping on the job. Completing a plan like this one could also serve as an opportunity to reinforce with a caregiver the agency’s expectations of caregiver alertness and attention to safety, and that there are strict penalties for unauthorized sleeping on the job. *(See additional resources for link/download.)*

This tool kit also provides a sample *Personal Safety Plan for an Individual Receiving Services* as an example of a potential strategy that could be used to help in the development of a plan to teach and reinforce resident/patient safety skills. *(See additional resources for link/download.)*





SAMPLE PERSONAL SAFETY PLAN

My Personal Safety Plan Date: 9/30/2014

Person who helped me with my plan: House Manager Bill Davies.

My Name: James Michaels (James can readily give his full name when asked)

My Address is: 501 Cardinal Drive, Buffalo, NY, 14201 (James cannot read or write his address, nor is he able to repeat his entire address at this time. He has been practicing and he can respond that he lives on "Cardinal Drive, in a group home" when asked.)

My Home Phone Number is: 518-555-1111. (James can understand numbers and can dial a phone with a written number in front of him. He has not memorized any numbers yet. He is practicing learning his home number. He carries emergency and other important phone numbers in his wallet, including numbers for his house and the administrator on duty.)

Emergency Safety Plan: James and I discussed these scenarios and he readily came up with some good plans to address each issue and together we added a few additional strategies. We will review this plan at least monthly to review and reinforce the following strategies.

If I need staff help, I can:

- Ask staff at the house to help me;
- If my staff was not here, or was sleeping or sick, or could not help me, I can call Bill Davies,
- the House Manager or the Administrator on Duty to get help. Their numbers are next to the phone on the kitchen wall; or
- I can also call my case manager week days between 9:00 a.m. - 5:00 p.m.

If I am scared, sad, worried, anxious or mad, I can:

- Call my sister Susie;
- Talk to my friend Mary. I can call her in the evening, before 9:00 p.m.;
- Have a cup of tea, take a hot bath or listen to music on my headphones; or
- Tell staff. Staff can help me by listening to me and telling me it's going to be OK.

(continued on page 2)

PARTNERS IN PREVENTION: WHAT YOU CAN DO

Remember: Everyone has a role in preventing and responding to dangerous caregiver fatigue.

Provider Agencies	Staff	Individuals, Self-Advocates, Families & Friends
<p>Deter and detect willful acts of sleeping on the job. Implement and regularly review the effectiveness of policies meant to deter and detect unauthorized <i>willful</i> sleeping on the job through practices such as conducting frequent unannounced spot checks.</p> <p>Establish emergency contingency plans to address the occasional need to relieve staff found to be unfit for duty.</p> <p>Identify and plan for addressing risk of staff accidentally sleeping on the job. Implement policies that assess and plan for identifiable risks of staff accidentally falling asleep on the job; establish procedures that direct staff to develop <i>Personal Action Plans</i> with their supervisors, especially for staff working, non-traditional shifts or who work alone.</p> <p>Encourage, teach and support persons receiving services to respond appropriately to emergencies and other unsafe conditions. Implement policies to direct treatment teams or other circles of support to assist each resident to develop <i>Personal Safety Plans</i>, which include instruction on how to call for help if a caregiver is unresponsive to immediate needs.</p>	<p>Report to work fit for duty. Communicate with your supervisor and utilize appropriate strategies (including approved time-off) anytime you are unfit for duty or you are concerned about your ability to fulfil work-related expectations, especially due to exhaustion, illness or medication.</p> <p>Identify and plan for addressing your individual risks of accidental sleeping on the job. Whenever possible, complete and comply with a formal set of personalized strategies with your supervisor, such as a <i>Personal Action Plan</i> to prevent accidental sleeping on the job.</p> <p>Don't commit willful acts of sleeping on the job and don't be complicit in a co-worker's authorized sleeping on the job. Be aware that sleeping on the job is routinely addressed as misconduct and may also constitute neglect. Have a strategy in place and be prepared to address any co-workers unauthorized sleeping on the job. It is your responsibility to address and report unsafe conditions.</p> <p>Report Abuse or Neglect to the Justice Center's 24/7 Statewide Toll-Free Hotline: Call: 1-855-373-2122 TTY 1-855-373-2123</p>	<p>Speak Up. Tell trusted staff and others anytime you find a caregiver sleeping on the job or otherwise unable to attend to your, your housemates or your loved one's needs.</p> <p>Know emergency phone numbers and/or program them into a phone for ease of use. Ask provider residences to post emergency phone numbers, make an Administrator-on-Duty's phone number available and make sure a working phone is available for your use in an emergency.</p> <p>Make A Personal Safety Plan for yourself or your loved one. Practice strategies including how to alert others if a caregiver is unavailable or incapacitated.</p> <p>Get involved. Ask provider agencies to provide you with copies of policies and procedures that are in place to deter and detect both willful and accidental sleeping on the job.</p> <p>Report Abuse or Neglect to the Justice Center's 24/7 Statewide Toll-Free Hotline: Call: 1-855-373-2122 TTY 1-855-373-2123</p>



Spotlight on Prevention

Partnering to Protect People with Special Needs



ADDITIONAL RESOURCES:

Spotlight on Prevention Toolkit: Protecting People with Special Needs from the Dangers of Caregiver Fatigue

- Article
- Fact Sheets
- How to Make a Staff Action Plan to Identify and Address Risks of Dangerous Caregiver Fatigue
- How to Make a Resident Personal Safety Plan

New York State Agencies

New York State's "SafeNY" www.safeny.ny.gov, SafeNY's Drowsy Driving and Fatigue Resources at www.safeny.ny.gov/drow-ndx.htm#warning

- Fact Sheet: Sleep Hygiene 101 www.safeny.ny.gov/media/Sleep-Hygiene101.pdf
- How Sleepy Are You? Take the Quiz www.safeny.ny.gov/media/Sleepiness-Quiz.pdf

New York State Department of Health (OMH) www.health.ny.gov

- Working at Night? Not Getting Enough Sleep
<http://www.health.ny.gov/publications/3042.pdf>

New York State Office for People With Developmental Disabilities (OPWDD)

www.opwdd.ny.gov

- Supporting Individuals to Achieve Personal Safety and Wellbeing
http://www.opwdd.ny.gov/opwdd_resources/incident_management/documents/supporting_individuals_personal_safety_wellbeing

New York State Office of Child and Family Services (OCFS) www.ocfs.ny.gov

New York State Office of Mental Health (OMH) www.omh.ny.gov

New York State Office of Alcoholism and Substance Abuse Services (OASAS) www.oasas.ny.gov

New York State Education Department (NYSED) www.nysed.gov

Other Fatigue Related Resources

- National Sleep Foundation <http://www.sleepfoundation.org>
- AAA Foundation for Traffic Safety <http://aaafoundation.org>
- National Heart, Lung and Blood Institute
<http://www.nhlbi.nih.gov/health/public/sleep/index.htm>
- Federal Motor Carrier Highway Safety Administration <http://www.fmcsa.dot.gov/>
- Sleep Quest <http://www.SleepQuest.com>
- American Sleep Apnea Association <http://www.sleepapnea.org>
- National Institutes of Health, National Medical Library PUBMED (Sleep Research)
<http://www.ncbi.nlm.nih.gov/pubmed>
- American Academy of Sleep Medicine <http://www.aasmnet.org/>
- Everyday Safety at Work: 9 Tips to Avoid Falling Asleep on the Job
<http://www.safetyservicescompany.com/topic/uncategorized/everyday-safety-at-work-9-tips-to-avoid-falling-asleep-on-the-job>
- Half-asleep at your desk? Easy fixes to fight fatigue
<http://www.today.com/health/half-asleep-your-desk-easy-fixes-fight-fatigue-804856>
- Article: Help Me Make it Through the Night (Shift)
<http://uselessdesires.blogspot.com/2012/02/article-help-me-make-it-through-night.html>



About the NYS Justice Center for the Protection of People with Special Needs

Established by Governor Andrew M. Cuomo and the Legislature, the NYS Justice Center for the Protection of People with Special Needs is dedicated to supporting and protecting people with special needs and disabilities. The Justice Center serves as a law enforcement agency which seeks to ensure that individuals who receive services from a facility or provider that is operated, licensed or certified by six state agencies, are protected from abuse, neglect and mistreatment. Assessing risks to the health and safety of individuals receiving services, and supporting commensurate action to prevent potential abuse and neglect, are critical components of the agency's independent oversight role. Through its advocacy-related services, the Justice Center also provides information, technical assistance and training to support and empower individuals with disabilities of all ages, in all settings.

For more information, please contact the Justice Center's Information and Referral staff at:

Toll-Free: 1-800-624-4143 (8:30 a.m. to 4:30 p.m.)

Relay users, please dial 7-1-1 and give the operator 1-800-624-4143.

Email: infoassistance@justicecenter.ny.gov

Website: www.justicecenter.ny.gov