



SPOTLIGHT PREVENTION

Partnering to protect
people with special needs

DANGERS OF CAREGIVER FATIGUE

The Justice Center created this toolkit in 2014 to provide information and resources for people receiving services, service provider agencies, staff, and family members on the risks associated with caregiver fatigue. Updated in 2020 amidst the COVID-19 pandemic, this revised toolkit contains new information and resources with a focus on self-care for staff working with people with special needs.

The Issue:

Falling asleep or being less than alert on the job puts caregivers at risk of making mistakes that could endanger anyone who may require consistent and responsive attention to ensure their health and safety. Over the past seven years, 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 a person receiving services, self-advocate, direct care provider, agency administrator, friend or family member, you have an important role to play in preventing incidents of abuse and neglect resulting from caregiver fatigue. The information provided in this toolkit is intended to raise awareness of the serious consequences of caregiver fatigue and falling asleep on duty. It also includes simple safety practices to reduce the risks associated with caregiver fatigue.

The Risks

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

- The personal care and health needs of people receiving services not being met;
- Failure to prevent or de-escalate high-risk behaviors, such as choking or elopement;
- Inability to respond to acute medical needs; and/or
- Failure to respond to an emergency, such as a fire.

Could This Happen in Your Program?

These case studies are offered for use in staff training and are loosely based on real Justice Center cases. The names of the people, settings, and other information have been changed.

Case #1

Brandon works the overnight shift as a direct support professional at an individualized residential alternative (IRA). He injured his shoulder on the job during a physical intervention and received a prescription for Lortab, a medication that is known to cause drowsiness. There was no de-briefing after the intervention so management was unaware of Brandon's injury. Brandon's doctor offered to write him a note to take a few days off from work but Brandon turned him down. He knew that the IRA he worked at was short staffed and was relying on him to work extra shifts. Brandon believed that there were not many staff who had the necessary training to work at the IRA or who could deal with "his guys" so he decided to power through and return to work without taking any time off.

During his next shift, Brandon had some pain in his shoulder, so he took one Lortab. Brandon drank extra coffee so he didn't think he would fall asleep, even though the medication made him drowsy.

Brandon dozed off for an hour and missed the 2 a.m. check of the people living in the IRA. When Brandon did the 3 a.m. check, he noticed Jeffrey, one of the people receiving services, was missing from his bed. Brandon searched the house and found Jeffrey outside on the front porch.

Case Concerns:

- ✓ **There was no debriefing following the physical intervention**
- ✓ **Brandon did not report his injury to the agency**
- ✓ **Brandon did not practice self-care by taking the recommended time off**
- ✓ **Brandon took prescription medication that could cause drowsiness**
- ✓ **Brandon's decision to "power through" and keep working despite his injury and medication put people receiving services at risk.**

Case #2

Ally was recently hired as a therapy aide at a hospital for people diagnosed with a mental illness. She was training with Donna, a veteran staff who usually helped orient new employees to the unit. They were working the 3 p.m. – 11 p.m. shift which included overseeing dinner for the people receiving services, helping with medications, and doing rounds. Donna had worked a double shift the night before while also orienting another new employee. Donna knew she was tired, but figured since Ally was working with her, she would pick up the slack. Around 10:45 p.m., Donna asked Ally to complete the last quarterly round of the unit so she could get caught on some paperwork that she had

not completed because she had been busy orienting Ally. Ally knocked on the door to each patient room. All but one person responded and Ally figured the person who did not respond must have been sleeping. Ally did not want to be rude and wake the person up so she went back to Donna and reported that the patient was sleeping. They did not have any further conversation about it and because Donna was feeling tired and overwhelmed with her paperwork, she did not get up and check on the patient herself. When the overnight staff came on shift a few minutes later and completed her first rounds, she found the patient unresponsive in the bathroom from an apparent self-inflicted injury.

Case Concerns:

- ✓ **Donna may have been given too much responsibility to work her shifts while also orienting new employees**
- ✓ **Donna was fatigued but did not let anyone know that or ask for help**
- ✓ **Donna's fatigue led her to ask a new employee to complete rounds before her orientation and training were completed**
- ✓ **Instead of telling Donna that there was no response from one person, Ally told Donna the person was sleeping and Donna did not confirm that the person was sleeping**

Case #3

Trevor was hired as a driver for a group home. He usually worked from 7 a.m. to 3 p.m. and brought people residing in the home to their doctor's appointments and day program. After his last drop off at 3 p.m., the new program manager asked Trevor if he would be able to come back later in the evening and help with a recreation event the agency was hosting at an off-site location. Trevor wanted to be helpful so he agreed to come back in the evening to drive the people residing in the home to an 8 p.m. movie, even though he usually goes to bed by 9 p.m. so he can be ready for work in the mornings. The movie ended around 10 p.m. and Trevor headed back to the residence

with four people in the vehicle, all of whom required to be transported in wheelchairs. Trevor was tired and wanted to get back to the home as soon as possible, so he quickly secured everyone in their wheelchairs. Trevor began to fall asleep behind the wheel and veered into a guardrail on the side of the highway. Three of the people in the van were uninjured but the fourth person tipped over in their wheelchair and hit their head on the door of the van, and required stitches to close the wound. Trevor realized he forgot to lock the brakes on the wheelchair before he began driving.

Case Concerns:

- ✓ **Trevor did not feel comfortable saying no to the manager's request to work even though he knew it would mean needing to stay awake later than usual**
- ✓ **Because Trevor was tired, he rushed through the wheelchair securement process and forgot to lock the brakes on the wheelchair**
- ✓ **Trevor did not let anyone know he was tired or ask for any help**

Case #4

Victor worked full time at Agency A as a residential supervisor for an IRA. He had worked at Agency A for several years and enjoyed his job and the people he worked with. Victor enjoyed working extra shifts and earning overtime but the agency policy limited the overtime he could work to 20 hours a week. One of Victor's friends, Calvin, told him about some openings at Agency B, an agency very similar to Agency A that had openings for residential supervisors. Victor was able to work a full time schedule at Agency B that did not conflict with his schedule at Agency A. Victor typically worked seven days a week and had every other

Sunday off. He was tired from working both jobs but felt good about the money he was making and was saving for a new car. One Saturday, after working for seven days straight, Victor was assigned to administer medications at the IRA. He was tired from a busy week and looking forward to his day off. One of the people receiving services had just been discharged from the hospital with a new prescription but Victor forgot about the new prescription and did not add it to the person's medication administration record. The person did not get his medication until the nurse came in on Monday and saw the discharge paperwork from the hospital.

Case Concerns

- ✓ **Victor was working too many hours between the two jobs**
- ✓ **Victor was tired and distracted and forgot to give a person their medication and failed to document the new medication in the agency's medication record**
- ✓ **Neither agency knew that Victor was working full time at both agencies**

Case #5

Amanda had been the awake overnight staff at an IRA for several years. She was supposed to do hourly bed checks for the people receiving services at the IRA. One night, after a busy weekend, Amanda was so tired that she was struggling to stay awake. In all the years she had worked for the agency she had never had a "surprise" visit from management so she figured it would be okay to catch up on some sleep. She did a quick check on the people receiving services then set her phone alarm,

grabbed a blanket and took a nap on the couch. For some reason, Amanda's alarm did not go off to wake her and she woke with a start at 6 a.m. when the morning staff arrived. After rushing around trying to get people up and ready for their day, she went into Bobby's room and discovered he was unresponsive. 911 was called but they were unable to resuscitate Bobby and emergency personnel noted that he had likely been dead for several hours.

Case Concerns

- ✓ **Amanda knowingly went to sleep when she was supposed to be the awake overnight staff**
- ✓ **The agency did not have a management presence on the overnights, or do spot checks to ensure overnight staff remained awake and vigilant**
- ✓ **Amanda did not let anyone know that she was tired or reach out for help to stay awake**

Case #6

The ICF Jason worked at had been quarantined because several of the people receiving services who lived there tested positive for the flu. Additionally, one of the people, Marisol, was terminally ill and receiving support from the local Hospice. Jason and the other staff were working extra hours to provide support and activities to everyone during the day as none of the people could attend their

typical day programs because of the flu. The staff were also working their usual evening and weekend shifts and were earning a lot of overtime. Jason had worked with Marisol for 3 years and it was very difficult for him to see her health decline. Though Jason and the staff tried to stay positive, they were tired, stressed, and sad trying to take care of everyone while also knowing that Marisol

would soon die. As the days went on, the hospice staff said staff that Marisol would die very soon. Marisol died the next day, in her home, surrounded by staff who had known her and cared for her. Jason had never even been to a funeral before, and watching Marisol die was heart-wrenching for him. After Marisol died he was very sad

and had a hard time talking about how he was feeling. He became irritable with the other people in the home and told one person to “Go ask someone else, leave me alone” when the person asked for help tying his tie to go to Marisol’s funeral.

Case Concerns

- ✓ **Jason and the other staff were overwhelmed trying to care for everyone’s needs**
- ✓ **No resources and supports were provided to staff to prepare and support them through the death and grieving process**
- ✓ **Agency administration did not do a “check in” with the staff after Marisol’s death to see if anyone needed time off or additional support such as contacting the employee assistance program (EAP)**

Factors that Contribute to Caregiver Fatigue

- **Unexamined Risk Factors**—Many incidents involved staff working extended or otherwise non-traditional work shifts. Identifiable risk factors included reporting to work when 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 in agency corrective action 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 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 Monitoring**—Agencies where staff were found sleeping did not have strong policies or practices in place that were meant to deter workplace sleeping. Agencies did not conduct random administrative spot checks or rigorously address all acts of confirmed staff sleeping with penalties associated with neglect, misconduct or other dereliction of duty. Agencies also did not monitor excessive staff overtime or cap the amount of overtime that staff could work.
- **People Receiving Services Not Reporting Unsafe Conditions**—People 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 otherwise incapacitated, often did not have any way to bring attention to the unsafe conditions or emergencies and/or were not aware that they could report these incidents. Further, when they were questioned about specific incidents of alleged staff sleeping, they often disclosed previous unreported complaints of staff sleeping.
- **Overwhelmed Staff** - Incidents occurred from staff burnout and fatigue. Staff who held multiple jobs, who were given too many responsibilities, including training new staff, or who were not supported to take time off and practice self-care suffered from fatigue.

Prevention Strategies


➤ **Strategies to detect and deter caregiver fatigue** – Agencies may need new strategies to detect and deter caregiver fatigue and sleeping on the job. Strategies must:

- plan for identifiable staff risk factors;
- discriminate between risks of willful and accidental sleeping on the job when developing corrective action plans;
- identify resources to recognize and support staff who are experiencing compassion fatigue
- utilize effective deterrents for staff sleeping on shift; and
- help people receiving services 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.

This tool kit also provides a sample *Personal Safety Plan for a Person 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.



Spotlight on Prevention
Partnering to Protect People with Special Needs

**SAMPLE STAFF PERSONAL ACTION PLAN TO
PREVENT AND RESPOND TO DANGEROUS CAREGIVER FATIGUE**

Personal Action Plan for: Mary Smith; Alone Awake Overnight Staff at Waldorf IRA Sunday through Wednesday 10 pm-8 am (2 additional staff report at 6:00 AM)

Risks/Warning Signs:

- If I didn't sleep before the shift, this is rare, but sometimes it happens
- If I don't feel well but have to work because no one will cover for me, also rare, but sometimes it happens

I feel most tired:

- Between 4:00 and 6:00 a.m., when chores are done, it is dark and quiet, a.m. staff haven't arrived yet, and none of the residents are up yet
- On my Wednesday shift, my last shift of the week, it catches up to me at the end of the week
- If I have to work a double shift.

Making the Environment Safe: Internal Coping Strategies, Peer Strategies and Others I can call for help

To stay energized:

- Try to always get a good night's sleep, take care of my health, and use sick and personal time appropriately if I am not fit for duty
- Have a coffee and light breakfast break at 4:00 a.m.
- Open a window or step outside for a few minutes
- Turn on a light
- Sit in a hard chair or use the elliptical bike while watching TV instead of sitting in the recliner
- Save laundry or another cleaning task for between 4 and 6 a.m., or do some cooking/baking for the week's menu and freeze it with instructions to thaw/re-heat
- Bring in word puzzles or knitting for down time
- Set a timer for 10-15 minutes anytime I sit down to rest and I am at risk of falling asleep
- Have a phone-free plan with a sister house; make/receive a couple of scheduled calls per night to keep each other alert
- Have my husband call me at 5 a.m. when he gets up

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Partners in Prevention: What You Can Do

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

Provider Agencies	Staff	People Receiving Services, Self-Advocates, Families and Friends
<p>Monitor staff assignments, overtime and staff fatigue. Implement policies that limit the amount of overtime staff are permitted to work. Ensure staff assignments are manageable and monitor employees for fatigue and burnout.</p> <p>Provide support to staff through an Employee Assistance Program (EAP). Employees may need support to address personal problems or work-related issues that are adversely affecting their work and contributing to caregiver fatigue.</p> <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 visits.</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. 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>Teach and support people receiving services to respond to emergencies and other unsafe conditions. Implement policies to direct treatment teams or other circles of support to assist each person receiving services 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>Consider using a “buddy” or mentor system to provide staff with peer support. Implement a system for co-workers to monitor each other for fatigue.</p> <p>Use creative strategies: Consider identifying administrative staff who may be willing to assist with non-direct care responsibilities such as grocery shopping or cleaning in order to give breaks to front line staff.</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 fulfill 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 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>Contact EAP programs for assistance when experiencing compassion fatigue, burn out, or frustration. Ask for help when you are stressed, frustrated, irritable or overwhelmed.</p> <p>Practice Self-Care. Get a good night’s sleep before reporting to work. Use your days off to rest, recover and recuperate.</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 providers 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 support staff and to deter and detect both willful and accidental sleeping on the job.</p>

ADDITIONAL RESOURCES:

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

- Article
- Fact Sheets for People Receiving Services, Provider Agencies and staff
- Checklist
- How to Make a Staff Action Plan to Identify and Address Risks of Dangerous Caregiver Fatigue
- Sample Staff Action Plan
- How to Make a Resident Personal Safety Plan
- Sample Personal Safety Plan

Fatigue Related Resources

National Sleep Foundation <http://www.sleepfoundation.org>

AAA Foundation for Traffic Safety <http://aaafoundation.org>

National Highway Traffic Safety Administration information on Drowsy Driving:
<https://www.nhtsa.gov/risky-driving/drowsy-driving>

National Safety Council Safety Topics: <https://www.nsc.org/work-safety/safety-topics/fatigue>

National Association of Direct Support Professionals: <https://nadsp.org/covid-19resources/>

National Heart, Lung and Blood Institute <https://www.nhlbi.nih.gov/files/docs/public/sleep/healthysleepfs.pdf>

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/>

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>

NADSP: <https://publications.ici.umn.edu/frontline-initiative/15-2/when-caring-too-much-can-hurt>