Spotlight on Prevention

COULD THIS HAPPEN IN YOUR PROGRAM?

This toolkit provides a compilation of case studies that may be used for staff training and professional development.

NEW YORK STATE
Justice Center for the Protection of People with Special Needs

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SPOTLIGHT OVERVIEW

CONTENTS & BACKGROUND

ABOUT THE TOOLKIT

The Justice Center for the Protection of People with Special Needs was established in 2013 to restore public trust in the institutions and individuals charged with caring for vulnerable populations by protecting the health, safety, and dignity of all people with special needs. One way the Justice Center fulfills its mission is by developing prevention materials for agencies and their staff to use in their efforts to prevent incidents of abuse and neglect and to enhance the quality of care afforded to people receiving services. The Justice Center's library of prevention materials, the *Spotlight on Prevention* toolkits, contains information and resources on various topics and a section of case studies based on real scenarios that have been reported to the Justice Center. This manual is a compilation of case studies and is intended to be used as a training tool for agencies to use with their staff.

We could not capture every situation that may arise in a program – please feel free to modify these scenarios to make them applicable to your agency. Additionally, because the Justice Center oversees programs under six other state agencies, the terminology used throughout this manual was kept general; "residential program" and "person/people receiving services," for instance, can be changed to terms used by your program.

We hope that you find the information in this manual helpful.

For a complete list of prevention toolkits, please visit: justicecenter.ny.gov/prevent-abuse.

Have ideas for other scenarios or suggestions for new prevention products? Interested in receiving virtual or in-person training on any of the Justice Center's *Spotlight on Prevention* toolkits? Please contact our general Prevention mailbox for suggestions or training inquiries at prevention@justicecenter.ny.gov.

SCENARIO INDEX

TABLE OF CONTENTS

Click the title to jump to the desired scenario

To view the Justice Center's responses to Case Concerns click on ***Answer Key***.

ADMISSIONS BEST PRACTICES

COULD THIS HAPPEN IN YOUR PROGRAM?

After Taylor fell and required care in a rehabilitation facility, their discharge plan called for them to move into a different residence. A transition meeting was held with the treatment teams from the residence where Taylor had been living and the residence Taylor was moving into to discuss Taylor's needs. Both teams identified that Taylor required a chest harness any time they were in their wheelchair and required physical assistance from staff when exiting the residence.

At the time of the transition meeting, Taylor was expected to move into the new residence at the beginning of May. As a result, staff training on Taylor's needs was planned for late April. However, in mid-April, Taylor was discharged from the rehabilitation facility and admitted to the new residence at 3:00 p.m. on a Wednesday afternoon. The staff moved Taylor and their belongings into the residence and helped them get settled. The staff were unaware that Taylor required a chest harness when they were in their wheelchair or that Taylor needed physical assistance when exiting the residence, and there wasn't a chest harness in the residence.

During dinner, the fire alarm was triggered, and staff began to assist the other residents out of the home while Taylor attempted to wheel themselves to the front door. However, Taylor did not have a chest harness on, and staff did not provide the assistance Taylor required whenever they exited their residence. Taylor fell out of the wheelchair while exiting the residence.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

ALLERGIC REACTIONS

COULD THIS HAPPEN IN YOUR PROGRAM?

Sydney, a 23-year-old person who has schizoaffective disorder and a severe allergy to peanuts, lives in a residential program with three other people. Sydney had been experiencing a mixed mood episode for about three weeks, which included hallucinations and suicidal ideation. Sydney's housemates have agreed not to have peanuts in their home for Sydney's safety.

Due to a staff call-out, Cullen, a relief staff member, was sent to work in Sydney's home for an overnight shift. Cullen was told that they'd be working with four people in the home, and that Sydney was going through a hard time. Cullen brought a peanut butter and jelly sandwich and yogurt to eat while on shift. At 1:00 AM, Cullen went to clean one of the bathrooms. While they were cleaning, Sydney went to the kitchen and ate Cullen's sandwich. Within a minute, Sydney was unable to breathe and lost consciousness, falling to the floor. Cullen heard a crashing noise and ran out to find Sydney unconscious. Cullen called 9-1-1, EMTs arrived on the scene, administered an EpiPen, and transported Sydney to the hospital. When Sydney awoke, they stated that they had eaten the peanut butter and jelly sandwich because voices in their head told them to do it. Cullen indicated that they were not told about Sydney's peanut allergy. Cullen also said that they were not told where the plans of care for the people were located, nor were they given access to the people's files in the agency's electronic health record.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

BATHING CONCERNS

COULD THIS HAPPEN IN YOUR PROGRAM?

The plans of care for Winston reflected that they required “line of sight” supervision when at home. The plans also noted that when Winston is using the bathroom, staff should leave the door cracked open and sit outside the door to ensure Winston has privacy but be available to assist as needed. The plans of care further noted that Winston required extensive assistance with personal hygiene, however, the plans did not specify the assistance required or that staff were to continue to maintain “line of sight” supervision while Winston was bathing.

Winston was taking a bath while Sam, a direct care staff member, was assigned to provide supervision to Winston. Sam left the hallway outside the bathroom to check on another person receiving services. Sam lost track of time and forgot that Winston was in the bath. When Sam returned to the bathroom, they found that Winston had turned the hot water on, and the bathtub was overflowing onto the floor. Sam helped Winston out of the tub and saw that Winston’s skin was red from their neck down to their toes because of how hot the water was. Sam felt awful about forgetting that Winston was in the tub. Sam apologized to Winston and said, “Let’s go have some ice cream!”

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

BODY CHECKS - 1

COULD THIS HAPPEN IN YOUR PROGRAM?

Mary lives at the Main Street IRA and is mainly non-verbal. Mary recently had several falls at the IRA. Staff documented the falls, completed body checks afterward, and alerted nursing that Mary was falling a lot. Mary's nurse made an appointment for Mary to see the doctor. The nurse also wrote a note in Mary's communication log for staff to be aware that Mary had an upcoming appointment and to remind staff of Mary's increased risk for falls. That weekend, the Main Street IRA was staffed primarily with relief staff, with some staff who had never worked there before. Mary tripped and fell while walking from the living room to the kitchen. Mary immediately stood and continued to the kitchen, where they used sign language to ask for some juice. The staff poured Mary some juice, patted them on the back and said, "Glad you are okay, Mary! Did you have a nice trip?" The staff did not document the fall, did not contact nursing about the fall, and did not complete a body check to look for any injuries. When Mary saw the doctor a few days later, they noticed a large bruise on Mary's knee.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Body Checks.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

BODY CHECKS - 2

COULD THIS HAPPEN IN YOUR PROGRAM?

Henry was required to have body checks completed three times a day at each change of shift due to a history of self-injury. During a team meeting before Henry's annual review, staff reported that Henry was responding well to the new strategies in their behavior support plan and was not self-injuring as much. The behavior intervention specialist said, "Great, that's awesome to hear!" and proceeded to pull the occurrence reports that would indicate when Henry had behaviors involving self-injury, as well as body check forms from the past year to review the data so Henry's behavior support plan could be updated. However, when the behavior intervention specialist looked at the body check forms, they found that many body checks were not documented on the forms, and those checks that were documented were either incomplete or were illegible and hard to read.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Body Checks.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

BODY CHECKS - 3

COULD THIS HAPPEN IN YOUR PROGRAM?

Kareem is non-verbal and requires “line of sight” supervision with staff within an arm’s length proximity at all times and receives body checks on each shift. While staff were assisting Kareem in the shower, they noticed a large bruise on Kareem’s left side. Kareem winced and groaned when staff assisted them in washing the area around the bruise. Nursing was contacted, and Kareem was taken to the hospital and diagnosed with a fractured rib. No one knew how or when Kareem was injured. A review of the body check forms for the days prior to staff discovering the bruise revealed that body checks were not completed on each shift as required. Additionally, some completed forms did not document the bruise at all, some noted the bruise was “old,” and some noted the bruise as “other.” Staff also reported that body checks were completed while Kareem was fully clothed.

Click below to access the Justice Center’s Spotlight on Prevention Toolkit on Body Checks.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

BODY CHECKS - 4

COULD THIS HAPPEN IN YOUR PROGRAM?

Alyssa eloped from their residential treatment program. Alyssa was located and returned to the treatment program two days later. Staff informed Alyssa that they would need to see the nurse for a body check. Alyssa said, “I don’t need one, I’m fine.” Staff told Alyssa that the body check was required by policy and told Alyssa, “You need to let the nurse check you. The sooner you comply, the sooner this will be over with.” Alyssa continued to refuse to see the nurse for the body check and became more and more agitated as staff insisted that Alyssa do so. Finally, the staff offered Alyssa a PRN medication because Alyssa was so agitated.

Click below to access the Justice Center’s Spotlight on Prevention Toolkit on Body Checks.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

BODY CHECKS - 5

COULD THIS HAPPEN IN YOUR PROGRAM?

Lucas, a direct support professional, had just returned to work from a week-long vacation. Lucas immediately noticed that Sean, one of the people receiving services, had a large bruise on their arm. Sean was not verbal and could not tell Lucas where the bruise came from. Lucas looked in Sean's binder of personal information and the house communication log, but did not see any occurrence reports or body check documentation about the bruise. Lucas took a picture of Sean and their bruise with their personal cell phone and texted the photo to their friend and co-worker, Brian, who had worked with Sean while Lucas was on vacation. Lucas texted, "What happened to Sean??"

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Body Checks.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

CAREGIVER FATIGUE - 1

COULD THIS HAPPEN IN YOUR PROGRAM?

Brandon works the overnight shift as a direct support professional at a group residence. Brandon injured their 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 debriefing after the intervention, so management was unaware of Brandon's injury. Brandon's doctor offered to write them a note to take a few days off from work, but Brandon insisted on returning to work right away. Brandon knew that the group residence they worked at was short-staffed and relied on them to work extra shifts. Brandon believed there were not many staff who had the necessary training to work at the residence or could "deal with his guys," so they decided to power through and return to work without taking any time off. During their next shift, Brandon had some pain in their shoulder, so they took one Lortab. Brandon drank extra coffee as the medication was making them drowsy. While working the overnight shift, Brandon dozed off for an hour and missed the 2 a.m. check of the people living in the residence. When Brandon did the 3 a.m. check, they noticed Jeffrey, one of the people receiving services, was missing from their bed. Brandon searched the house and found Jeffrey outside on the front porch.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Caregiver Fatigue.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

CAREGIVER FATIGUE - 2

COULD THIS HAPPEN IN YOUR PROGRAM?

Ally was recently hired as a therapy aide at a psychiatric hospital. Ally was training with Donna, a veteran staff member who usually helped orient new employees to the unit. They were working the 3:00 p.m. – 11:00 p.m. shift together, which included overseeing dinner for people in the unit, helping with medication administration, and completing "rounds" where periodic checks were performed on the people in the unit. Donna had worked a double shift the night before while also orienting another new employee. Donna knew they were tired, but figured since Ally was working with them, Ally would pick up the slack. Around 10:45 p.m., Donna asked Ally to complete the last checks of people on the unit for that shift so Donna could get caught up on some paperwork. Ally knocked on the door to each person's room, and all but one person responded. 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 they returned to Donna and reported that the person was sleeping. Donna did not ask Ally any questions about the checks or the person who was sleeping, and because Donna was feeling tired and overwhelmed with their paperwork, they did not get up and check on the patient themselves. When the overnight staff came on shift a few minutes later and completed rounds, they found the person that Ally had assumed was sleeping in their room, unresponsive in the bathroom from an apparent self-inflicted injury.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Caregiver Fatigue.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

CAREGIVER FATIGUE - 3

COULD THIS HAPPEN IN YOUR PROGRAM?

Trevor was hired as a driver for a group home. Trevor usually worked from 7 a.m. to 3 p.m., bringing people residing in the home to their doctor's appointments and day programs. After Trevor's last drop-off at 3 p.m., the new program manager asked Trevor if they would be able to come back later in the evening and help with a community outing. Trevor wanted to be helpful, so they agreed to come back in the evening to drive the people to an 8 p.m. movie, even though Trevor usually went to bed by 9 p.m. to 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 were transported in wheelchairs. Trevor was tired and wanted to get back to the home as soon as possible, so they quickly secured everyone in their wheelchairs. During the drive back to the residence, Trevor dozed off 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 they forgot to lock the brakes on the wheelchair when they secured the person and their wheelchair for the drive back to the residence.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Caregiver Fatigue.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

CAREGIVER FATIGUE - 4

COULD THIS HAPPEN IN YOUR PROGRAM?

Victor worked full-time at Agency A as a residential supervisor for a group home. Victor had worked at Agency A for several years and enjoyed their job and the people they worked with. Victor enjoyed working extra shifts and earning overtime, but the agency policy limited their overtime to 20 hours a week. One of Victor's friends, Calvin, told Victor 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 their full-time schedule at Agency A. Victor typically worked seven days a week and had every other Sunday off. Victor was tired from working both jobs but felt good about the money they were making and was saving for a new car. One Saturday, after working for seven days straight, Victor was assigned to administer medications to the people at Agency A. Victor was tired from a busy week and looking forward to their day off. One of the people 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 their medication until the nurse came in on Monday and saw the discharge paperwork from the hospital.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Caregiver Fatigue.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

CAREGIVER FATIGUE - 5

COULD THIS HAPPEN IN YOUR PROGRAM?

Amanda had been the awake overnight staff at a group residence for several years. Amanda was supposed to do hourly bed checks for the people at the residence. One night, after a busy weekend, Amanda was so tired that they were struggling to stay awake. In all the years Amanda had worked for the agency, they had never had a "surprise" visit from management, so they figured it would be okay to catch up on some sleep. Amanda did a quick check on the people receiving services, then set the alarm on their cellphone, grabbed a blanket, and took a nap on the couch. For some reason, Amanda's alarm did not go off, and they woke with a start at 6 a.m. when the morning staff arrived. After rushing around to get people up and ready for their day, Amanda entered Bobby's room. Amanda discovered that Bobby had been incontinent at some point in the night, and their pajamas and sheets were soaked with urine.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Caregiver Fatigue.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

CHOKING PREVENTION - 1

COULD THIS HAPPEN IN YOUR PROGRAM?

Sean is a person with major depressive disorder. Sean was admitted to the behavioral health unit of a general hospital. While there, Sean fell and hit their head and was transferred to the medical unit for follow-up. While on the medical unit, Sean began to display swallowing difficulties and was administered a swallow evaluation. After reviewing the results, Sean's doctor wrote an order for Sean to be on a ground food diet and recommended that Sean also be supervised during mealtimes. Sean was eventually transferred back to the behavioral health unit. However, their dietary requirements were not included in their treatment plans, and staff were not aware of the changes to Sean's diet consistency or the requirement to supervise them during meals. Sean was served pork chops, French fries, and a green salad for dinner. Sean began to eat but then suddenly stopped, stood up, and started to run from the room. Sean began to cough forcefully, and some food came out of their mouth. Staff offered Sean a glass of water and encouraged them to drink it, but Sean lost consciousness and fell to the floor. Staff saw that Sean's mouth was full of food, and they were starting to turn blue. Staff administered abdominal thrusts and called a "code blue" for assistance. Staff from other areas of the hospital responded. It was very crowded and chaotic while staff were trying to resuscitate Sean. A crash cart was brought to the cafeteria, and staff attempted to suction Sean's airway, but the batteries on the portable suction machine had expired, and there was no extension cord on the crash cart. Staff administered CPR until an extension cord was located. The suction device successfully removed the food blocking Sean's airway, and they were transferred to the intensive care unit for monitoring.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Choking Prevention.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

CHOKING PREVENTION - 2

COULD THIS HAPPEN IN YOUR PROGRAM?

Allana, program staff, 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 they got them, Allana passed the hot chocolate and cookies to Ian and Steve in the back seat. Allana told Ian and Steve 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 their cookie, and Steve started eating theirs right away. Allana turned the radio up loud to listen to a song they liked and laughed as Ian and Steve began to sing along. Steve stopped singing just long enough to take another bite of the cookie and started singing again. Suddenly, Steve started coughing and sputtering. Ian patted them on the back and said, “Slow down, Stevie!” Steve stopped coughing and went silent while Alanna continued singing along to the radio. When Allana glanced in the rear-view mirror, they saw Steve slumped over in their seat with their hand on their throat. Allana yelled to Ian, “Is Steve okay?” and continued to drive. Ian looked at Steve and shrugged. Since they were close to their house, Alanna drove home quickly. When they pulled into the driveway, Allana 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, then ran back to the car and began pounding on Steve’s back. Vaughan, another staff member working that night, called 911 and ran outside to help Alanna with Steve. When the ambulance arrived, medical personnel began resuscitation efforts and transported Steve to the hospital.

Click below to access the Justice Center’s Spotlight on Prevention Toolkit on Choking Prevention.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

CHOKING PREVENTION - 3

COULD THIS HAPPEN IN YOUR PROGRAM?

Mateo had dysphagia and had a history of choking. Mateo's food was supposed to be prepared to a pureed consistency and their liquids to be thickened to avoid choking or aspirating on them. Every evening, the staff at Mateo's residence prepared lunch for Mateo to bring to day program the next day. Staff put leftovers from dinner, including meatloaf, cheesy mashed potatoes, and string beans, into the blender, ran the blender for a minute until everything looked pureed, and packed them into Mateo's lunch bag. Mateo brought their lunch to program and staff placed it in a refrigerator in the lunchroom where other people stored their lunches. At lunchtime, Mateo went to the lunchroom by themselves, took their lunch bag from the refrigerator, sat down at a table, and began to eat. Moments later, Mateo began to cough. When staff arrived to the cafeteria, they saw that Mateo had spit out a piece of a string bean that had not been pureed.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Choking Prevention.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

CHOKING PREVENTION - 4

COULD THIS HAPPEN IN YOUR PROGRAM?

Liam needed extensive dental work and was sedated during the procedure. Penny waited at the dentist's office until the work was done and Liam was ready to return to the residence. Liam was still tired and groggy as they left. On the way back, Penny stopped at a fast-food restaurant and ordered Liam's dinner. At the residence, Penny asked Liam if they were hungry, and Liam nodded their head. Penny helped Liam to the dining table, placed the food in front of them, and went into the kitchen to get some napkins and ketchup. When Penny returned, Liam was coughing and gagging, and their mouth was full of the fast food. Penny panicked and yelled out for someone to help Liam.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Choking Prevention.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

CHOKING PREVENTION - 5

COULD THIS HAPPEN IN YOUR PROGRAM?

Maya had a history of choking. Their history included taking food off counters or from the refrigerator when no one was looking and choking after they tried to eat too quickly. Maya's care plans had approved restrictions for a locked refrigerator and pantry to limit Maya's access to food. Maya also required enhanced supervision in the kitchen and dining area to prevent them from accessing and possibly choking on food. The refrigerator and pantry were each locked with a small padlock, and though the keys were supposed to be kept in the office, staff frequently left them in the lock for convenience. After dinner one night, staff threw the uneaten food, including baked chicken legs, from people's plates into the garbage. Lei was assigned to supervise Maya, but left Maya alone in the kitchen while they wiped off the dining room table. While Lei was in the dining room, Maya took a chicken leg from the trash and ran to their room with it.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Choking Prevention.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

CHOKING / RESPONDING TO MEDICAL EMERGENCIES

COULD THIS HAPPEN IN YOUR PROGRAM?

Melissa was assigned to work their first shift at a group home. When Melissa arrived, the group home manager assigned Melissa to make dinner for all the people who lived at the home and handed Melissa a binder with everyone's dining consistencies in it. Melissa made spaghetti and meatballs for dinner. Jacob required their food to be cut into ½ inch pieces. Melissa cut Jacob's meatballs into ½ inch pieces, but did not cut Jacob's spaghetti. While Jacob was eating, they started coughing, their face turned red, and they put their hands around their throat to indicate that they were choking. Melissa completed back blows on Jacob, while Sonia, another staff member on shift, contacted the nurse. The food was dislodged from Jacob's mouth while Melissa was completing back blows. Jacob thanked Melissa and then continued to eat their meal. The nurse instructed Sonia to keep an eye on Jacob but did not tell Sonia to bring Jacob to the doctor, as required by agency policy. Ten minutes later, Jacob passed out while still at the table. Melissa contacted 911, and when emergency personnel arrived, they were able to dislodge additional food that was stuck in Jacob's throat.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Responding to Medical Emergencies.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

CONTRABAND / SEARCHES - 1

COULD THIS HAPPEN IN YOUR PROGRAM?

Daniel was receiving services at a residential rehabilitation program after completing inpatient treatment for opioid and amphetamine addiction. Daniel briefly stepped out of the facility to receive what appeared to Sarah, Treatment Assistant, and Jonathan, Mental Health Counselor, to be a GrubHub food delivery. Sarah typically worked in a youth residential rehabilitation program, but Daniel's residence was short-staffed, so Sarah was assisting at the program. This was Sarah's second shift at the adult residence, and they had not yet been trained on the program-specific processes, policies, and procedures.

When Daniel re-entered the facility with the bag they collected from the delivery, Jonathan was in another area of the program running an educational group with several residents. Sarah was at the front desk. Sarah asked Daniel what was in the bag, and Daniel replied, "Just some dinner…a chicken sandwich and fries." Sarah was not familiar with the program's search procedure or whether residents were permitted food or other deliveries. Sarah believed Daniel was telling the truth, and did not search Daniel's bag prior to Daniel going to their bedroom. A short time later, during room checks, Daniel was slurring their words and appeared unsteady on their feet. Sarah suspected that Daniel was overdosing and immediately called Nicole, the program manager, to ask what to do. However, Nicole did not initially answer, and their voicemail box was full. Sarah continued to perform room checks and waited for Nicole to return their call. Approximately five minutes later, Nicole called Sarah back and instructed Sarah to obtain the Narcan kit that was in the hallway nearest Daniel's bedroom, administer the Narcan, and call 911. During a room search after the incident, drug paraphernalia was found in the delivery bag that Daniel brought into the program that evening.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

CONTRABAND / SEARCHES - 2

COULD THIS HAPPEN IN YOUR PROGRAM?

Megan receives treatment in an inpatient psychiatric setting following an attempted suicide. Megan expressed to Stacey, their preferred treatment aide, their frustration with the patient phone on the unit and how Megan rarely gets to call their family or friends because the patient phone was always in use. While Stacey knew it was against facility policy, they brought in an old cell phone that they no longer used for Megan to have and use while they were at the facility. Stacey gave Megan the cell phone and asked Megan to promise that they would not share how they got it. Megan and Stacey talked daily on the cell phone, and Megan also called family and friends regularly. Megan also accessed their Amazon account from the phone and placed Amazon orders, which were shipped to Stacey's house. Stacey would then sneak the items into the facility and give them to Megan. The items included things that were prohibited on the unit including crochet needles and yarn, a purse with a long strap, and nail polish remover.

While staff performed room searches at least once a week, they never noted their observation of these items in Megan's room or removed them. One evening while on the cell phone, Megan got into a verbal argument with their husband and threatened to self-harm. Megan's husband immediately called Courtney, the Charge Nurse on the unit, and reported their concerns. Courtney went to Megan's bedroom to assess Megan and observed the contraband items and immediately removed them and searched Megan's bedroom for any additional items.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

CONTRABAND / SEARCHES - 3

COULD THIS HAPPEN IN YOUR PROGRAM?

Stephen and Lauren, youth at a residential rehabilitation program, were diagnosed with substance use disorders and were returning to the residence from an outdoor recreational activity with other peers. As they were exiting the vehicle back at the program, Stephen and Lauren suddenly absconded and ran into the woods along the perimeter of the property. Damion, a staff person, immediately radioed for staff assistance. Staff canvassed the premises but were unable to locate the youth. Damion and Joel, another staff member, remained at the residence with the other youth while Denise, a relief staff member, drove around looking for Stephen and Lauren. Approximately a quarter of a mile from the residence, Denise found Stephen and Lauren outside a corner store talking with a police officer. The officer informed Denise that the store manager had called the police as Stephen and Lauren were observed shoplifting. The police turned the youth over to Denise, who drove them back to the program.

It was late when Denise returned to the residence with Stephen and Lauren. Denise believed that Stephen and Lauren had already turned over all of the stolen property, so she did not search them and instructed them to get ready for bed. Over the next 20 minutes, Stephen and Lauren were heard giggling, and Damion saw them going back and forth between each other's rooms. Damion went to check on them and found Lauren vomiting in the bathroom and Stephen slurring their words and staggering around the bedroom. Damion saw empty beer cans in Stephen's garbage and questioned Stephen about them. Stephen reported that they had stolen the beer from the store by stuffing it down their pant legs, and once back at the residence, they drank it with Lauren.

The Registered Nurse, Susan was called and came to the program to assess Stephen and Lauren. Susan administered a breathalyzer test and confirmed that both Stephen and Lauren were under the influence of alcohol. However, Susan did not feel they needed to be sent to the hospital for further assessment. Susan instructed staff to closely monitor Stephen and Lauren throughout the night and to contact them if their symptoms worsened.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

EFFECTIVE MEDICAL CARE - 1

COULD THIS HAPPEN IN YOUR PROGRAM?

Monique required 15-minute checks by staff for safety and to confirm signs of life. During the evening shift, Monique refused their dinner, and their gait appeared unsteady when they walked to their room. During the 7:30 p.m. “signs of life” check, staff observed Monique lying in their bed with their eyes open; however, when staff called Monique’s name, they did not respond. Staff documented that the signs of life checks were completed for Monique and moved on to check on the next person. During the 8:15 p.m. check, staff discovered Monique was unresponsive, and staff contacted 911. When emergency personnel arrived, they began CPR and Monique was transported to the hospital.

Click below to access the Justice Center’s Spotlight on Effective Medical Care.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

EFFECTIVE MEDICAL CARE - 2

COULD THIS HAPPEN IN YOUR PROGRAM?

Kevin fell and hurt their arm during recreation time at their day program on Friday. They were seen by the day program nurse, who called Kevin's group home and told staff they would need to be seen by their primary care doctor. Sierra took the call from Kevin's day program and documented it on a scrap of paper since they could not find the communication log to document the call. They did not tell anyone about the call, and when they left to go to the grocery store, the scrap of paper fell into the trash. Kevin was brought home by the day program and dropped off in front of the residence as usual. Kevin is non-verbal and could not tell anyone that their arm hurt. Staff noticed light bruises on Kevin's arm but did not document the bruising or alert the RN. By Monday morning, Kevin's arm was bruised, swollen, and they could not move it. Staff then alerted the RN, who directed them to bring Kevin to the emergency department, where Kevin was diagnosed with a fractured arm.

Click below to access the Justice Center's Spotlight on Effective Medical Care.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

EFFECTIVE MEDICAL CARE - 3

COULD THIS HAPPEN IN YOUR PROGRAM?

Ana is medically frail and diagnosed with terminal cancer. During a recent hospitalization, Ana's residence determined they were unable to meet their medical needs. Ana was discharged from the hospital to a different residence to provide them with the medical care and the support they required. The nurse from the new residence did not visit Ana in the hospital or attend their discharge meeting. The nurse wrote a medical care plan for Ana's diagnoses, posted it in the communication log at the house, and assigned staff an independent "read and sign" review of the plan. At the new residence, staff were only able to give Ana Tylenol for pain as they were not discharged with any prescription for pain medication. After contacting the on-call RN multiple times for assistance with managing Ana's pain, the RN contacted their primary care doctor, who finally prescribed pain medication.

Click below to access the Justice Center's Spotlight on Effective Medical Care.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

EFFECTIVE MEDICAL CARE - 4

COULD THIS HAPPEN IN YOUR PROGRAM?

Paul was living in a residence where alcohol and drugs were not permitted while receiving treatment for their substance use disorder. One evening, they were slurring their words, walking with an unsteady gait, and appeared to be intoxicated. Staff monitored Paul while they took their evening medications and as they crawled into their bed. Staff documented Paul's suspected use of drugs or alcohol in their progress notes. Since Paul was independent in the home, they did not require any safety checks, and staff did not check on them until the next morning. When staff walked into Paul's room, they saw that at some point during the night, they had vomited in their bed. Paul was not immediately responsive when they tried to wake him, so staff called 911. Paul was taken to the hospital for testing. It was later determined that they had suffered a stroke.

Click below to access the Justice Center's Spotlight on Effective Medical Care.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

ENVIRONMENTAL SAFETY

COULD THIS HAPPEN IN YOUR PROGRAM?

On November 15, the boiler broke at a residence that housed eight people receiving services, which left the residence without heat. Staff called and informed the residential supervisor that the boiler was broken and there was no heat. The supervisor called and informed maintenance of the issue, then directed staff to monitor the temperature inside the residence during each shift to ensure it was within a “normal range” (about 68 degrees Fahrenheit) and to document their recordings in the residence logbook. When the residential supervisor arrived three days later, the boiler was still not repaired. The staff and people in the home were wearing coats inside the house because of the uncomfortably cold temperatures. The staff told the residential supervisor that maintenance had not yet repaired the boiler. The residential supervisor asked what the temperatures were for the last three days. Staff said they checked each shift and it “wasn’t too cold.” However, when the supervisor reviewed the logbook, they read that the residents had asked staff for extra blankets and wanted to wear their coats inside, but they did not see any temperature recordings for the past three days during any of the previous shifts. The residents were then moved to alternative locations, temporarily, until the boiler was repaired, and the heat was working in the residence.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

FALLS - 1

COULD THIS HAPPEN IN YOUR PROGRAM?

Bernadette is 76 years old and prides themself on their strong work ethic. Bernadette lives in a group residence, works part-time, and volunteers at their local synagogue to keep active. Bernadette's circles of support, both natural and paid, have started to notice that Bernadette is slowing down physically and is struggling to recall recent events. However, Bernadette is still energetic and motivated to participate in their community, so no one discussed their observations about Bernadette slowing down and needing more assistance.

One night, Bernadette told their evening staff, Lora, that they were feeling tired and asked for some help getting into bed. Lora told Bernadette that they had just sat down, and that Bernadette was more than able to get themselves to bed. Bernadette said, "You're right, I'm sorry," and went to their bedroom. A few moments later, Lora heard a loud thump from Bernadette's room. Lora rushed to Bernadette's room and found them sitting on the floor beside their bed. Bernadette said they were fine, and Lora helped Bernadette off the floor and into bed.

The next morning, Bernadette was unable to get out of bed and was crying and saying, "My hip hurts." Bernadette was transported to the Emergency Room via ambulance. At the ER, it was discovered that Bernadette's right hip was fractured. Bernadette also received a DEXA scan, which revealed that they had undiagnosed and untreated osteoporosis.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

FALLS - 2

COULD THIS HAPPEN IN YOUR PROGRAM?

Nellie is a 65-year-old person with a history of falls and requires a gait belt during transitions from seated to standing positions. Tim is a new Direct Support Professional who recently completed general training on people's plans of care and the House Plan of Protective Oversight. During the overnight shift, Tim heard a loud sound from Nellie's bedroom and responded to the noise. Tim found Nellie on the floor and assisted them back into their bed. The following morning, a staff member went to check on Nellie and noticed that they seemed lethargic and did not want to get out of bed. Nellie is typically very excited to wake up and start their day, so staff checked the overnight General Event Reports to see if anything was written about Nellie not feeling well; however, no report was written. Staff contacted the nurse, and the nurse examined Nellie. The nurse noticed Nellie had a bump on their head. However, the Fall Chart for Nellie did not indicate that they had fallen recently. When Tim's supervisor asked them if anything had happened during their overnight shift, Tim explained that they had found Nellie on the floor and had assisted them back into bed. Tim indicated they were unaware of the agency's fall protocol or procedures, as this was not part of their general onboarding training.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

FALLS - 3

COULD THIS HAPPEN IN YOUR PROGRAM?

Charles is blind and non-verbal, uses a wheelchair, and requires a mechanical lift and two staff members to support them to get in and out of their wheelchair. Tom is a relief staff member who usually works at another residence but is familiar with Charles. Tom offered to help transfer Charles from their wheelchair and bring them to the bathroom for their shower. Tom put Charles in a sling, attached the sling to the mechanical lift, and then proceeded to push the lift down the hallway. When Tom attempted to push the lift over the threshold to the bathroom, the lift jerked and Charles fell onto the floor, hitting their head on the doorway. Tom called out for help and, working with a second staff member, was able to get Charles up and onto their shower chair, where they did a quick body check to look for injuries. Charles did not appear injured because of the fall, so Tom proceeded to shower them and bring them back to their room. The next morning, staff observed that Charles's eye was bruised and swollen.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

FIRE SAFETY - 1

COULD THIS HAPPEN IN YOUR PROGRAM?

Ally recently moved into a group residence. Ally loves collecting things and has a lot of storage totes, boxes, and plastic bags with the items they have collected over the years that were important to them. Ally was unpacking everything and putting some things in the closet, some in drawers, and some on the bed or the floor while they tried to figure out how to make everything fit in the room. Amir, a staff member working at the residence, looked in on Ally to see if they needed help unpacking. Amir quickly realized that Ally would not be able to fit all of their belongings in the room. Amir talked with Ally to let them know there was a storage area in the basement of the home where Ally's things could be stored, and Ally could access them whenever they wanted to. Ally agreed to put three of their storage totes in the basement. Amir offered to bring the totes to the basement for Ally since they were heavy. Amir brought the totes to the kitchen one at a time and set them by the back door while they went back upstairs to get the remainder of the totes. While Amir was upstairs getting the last tote, the fire alarm went off. When Amir and Ally came downstairs, they saw several people standing in the kitchen, unable to exit because the totes blocked the back door.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

FIRE SAFETY - 2

COULD THIS HAPPEN IN YOUR PROGRAM?

Trevor and John work full-time as direct support staff. One evening, Trevor was cooking dinner and got distracted by their personal cellphone, which led to the food burning. The smoke from the burned food created a lot of smoke and set off the fire alarm. Agency policy noted that staff are only to use their personal cellphones on breaks, away from the people they support. John came into the room to see what was wrong. When John saw there was no fire and the smoke was just from food burning, they unhooked the fire alarm. Neither staff called 911 to report the incident, nor did they evacuate the people in the home, as "they knew what the cause was and did not need to." A month later, a person refused to evacuate during a fire drill as "Trevor and John did not make me do it last time."

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

HEAT ILLNESS

COULD THIS HAPPEN IN YOUR PROGRAM?

On a hot summer day in July, Sam, a direct support professional, was working alone at the residence while they supervised and supported Dean. Dean uses a wheelchair but is unable to propel themselves, is non-verbal, and uses hand gestures to communicate their needs. Dean indicated they wanted to go outside to sit on the porch. Dean requires periodic checks every 15 minutes. Sam brought Dean out to the porch and positioned them in the partial shade. The agency had policies and protocols regarding sun safety that required staff to apply sunscreen to people, ensure they are in lightweight clothing, and are not left in direct sunlight for prolonged periods of time. Training records indicated that Sam had not completed the training on these policies and protocols. Sam continued to complete household chores while Dean sat on the porch. Sam then received a call from the residential manager, which they took in the staff office. Fifteen minutes later, Sam ended the call with the residential manager and went on to complete the remainder of their household chores. Dean had been outside alone on the porch for approximately 40 minutes by the time Sam checked on them. Sam found Dean now sitting in direct sunlight with the skin on their face and arms reddened. Sam brought Dean inside and laid them onto their bed to cool off as they went to begin meal preparations. Twenty minutes later, staff arriving for their evening shift found Dean drenched in sweat, with labored breathing and dry lips. The evening staff called the nurse and was told to bring Dean to the emergency room for evaluation. At the emergency room, doctors determined Dean was suffering from heat exhaustion, dehydration, and a sunburn.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

HOT WATER SAFETY

COULD THIS HAPPEN IN YOUR PROGRAM?

Steven required 15-minute checks from staff when at home and required staff to remain in the bathroom when they showered. Steven relied on the staff to assist them with safely controlling the water temperature, placing shower mats on the floor, and gathering the supplies they needed to shower. This information was in Steven's plans of care, which all the staff who worked with Steven had been trained on. Steven told their staff that Trevor wanted to take a shower. Trevor told Steven to head to the bathroom and set things up, and they would meet in there. Thirty minutes later, Trevor heard the water in the shower running and went to check the noise. Trevor discovered Steven sitting on the bathroom floor, crying, holding their arm. Trevor asked Steven what had happened. Steven pointed to their arm, which was red, and then pointed to the running water in the shower. Trevor touched the water and realized it was extremely hot. When Trevor asked Steven if they had been burned, Steven nodded, "Yes." Trevor texted their wife asking what they should do if someone was burned by hot water. Trevor's wife responded to put the burned area under cold water. However, Trevor did not contact the nurse. When the manager came in the next day and saw Steven's arm, which now had blisters, they contacted the nurse of the program.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

INCIDENT MANAGEMENT - 1

COULD THIS HAPPEN IN YOUR PROGRAM?

Jessie informed their residence counselor that the maintenance person, Darryl, asked for their telephone number, told them they were pretty, and asked them out to dinner. Jessie stated they felt a little uncomfortable and did not share their phone number with Darryl or accept their invitation for dinner. The residence counselor thought that because Darryl was not working directly with Jessie, they did not need to report this to anyone.

A few days later, Jessie needed a new light bulb in their bedroom, and Darryl said they would replace it if Jessie would share their phone number with them. Jessie gave their phone number to Darryl, and over the course of the next few weeks, Darryl sent Jessie inappropriate pictures and requested that Jessie send them pictures. Jessie moved out of the group home because they were afraid of Darryl. Jessie stopped taking their medications and was admitted to a psychiatric unit in a hospital. Jessie told the admissions counselor at the hospital about what happened with Darryl. The admissions counselor at the hospital reported the incident to the Justice Center.

Click below to access the Justice Center's Spotlight on Corrective Action Plans.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

INCIDENT MANAGEMENT - 2

COULD THIS HAPPEN IN YOUR PROGRAM?

Theo, a youth receiving services at a residential center, told the manager of the center that Donnie, a direct support professional, punched them in the face during a physical restraint. The manager asked Donnie what happened, and Donnie denied punching Theo. Donnie was moved to another unit at the facility, away from Theo. No other safeguards were put into place, and this allegation was not reported to anyone else. Two nights later, during a physical restraint with another youth, a staff person observed Donnie slap the youth in the side of the face. Donnie was placed on leave and eventually terminated from the program.

Click below to access the Justice Center's Spotlight on Corrective Action Plans.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

INCIDENT MANAGEMENT - 3

COULD THIS HAPPEN IN YOUR PROGRAM?

Courtney lives at a residence for people with intellectual disabilities. One morning, Courtney began choking on their toast during breakfast. Tyler, Shawn, and Erin were all scheduled to work during breakfast, but Tyler was running late, so the program was understaffed. Management was not contacted to alert them that there were not enough staff on duty. Shawn was new to the program, and Erin usually worked the overnight shift. Neither Shawn nor Erin was aware that Courtney's toast was to be cut into ¼-inch pieces, per their dietary plan. Shawn had their back to Courtney when they started choking, and Erin was busy giving out medications, so neither was initially aware that Courtney was choking. Another person from the residence began yelling in response to Courtney choking, and Shawn turned around and began giving back blows to Courtney. After a few back blows, Courtney coughed up and spat out some toast. No one notified the nurse or administration that Courtney had choked.

Click below to access the Justice Center's Spotlight on Corrective Action Plans.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

INCIDENT MANAGEMENT - 4

COULD THIS HAPPEN IN YOUR PROGRAM?

Xiomara worked as a direct support professional for a residence while attending college part-time. Xiomara mainly worked at the Main Street residence, but one weekend, they were asked to work at the Jones Street residence instead, due to a shortage of staff there. When Xiomara arrived at the Jones Street residence, they saw that the house was messy and unkempt. The kitchen counters and tables had crumbs of food all over them and were sticky from food that had been spilled and not wiped up. When Xiomara looked in the refrigerator and pantry, there was hardly any food. Xiomara asked another staff member if there was a plan for dinner, and the staff shrugged their shoulders and said, “Just do the best you can.” Xiomara found a box of waffles in the freezer and some cereal in the pantry so people could have “breakfast for dinner.”

For the rest of Xiomara’s shift, they saw things that made them feel uncomfortable as well as sad and worried for the people who lived at the Jones Street residence. There were huge piles of laundry on the floor of the laundry room, and no one seemed to know whose laundry it was or who should be helping the people wash it. The people who lived at the residence sat in the living room with nothing to do except for Mira, who stayed in their room for most of the day. When Xiomara asked the other staff about Mira, the staff said, “As long as Mira stays in their room, we don’t have to supervise them. If Mira comes out of their room, we have to provide them with 1:1 staffing, so we give Mira things to keep them busy in their room because we don’t have enough staff for the 1:1.”

When Xiomara’s shift ended, they called the corporate compliance hotline to let them know about the lack of food, staffing, and engagement for the people at the Jones Street residence. Xiomara also shared the comments from staff about keeping Mira busy in their room so staff would not have to supervise them, and that Mira had stayed in their room all day. The next day, someone from the corporate compliance office called Xiomara to thank them for calling. Staff from the corporate compliance office sent a manager to the Jones Street residence to help them get “back on track.”

Click below to access the Justice Center’s Spotlight on Corrective Action Plans.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

INTESTINAL OBSTRUCTION

COULD THIS HAPPEN IN YOUR PROGRAM?

John resides in a residential program and requires physical assistance for all activities. John has limited verbal skills; however, they are able to communicate their wants and needs by yelling and gestures. John cannot toilet independently and requires complete staff assistance with their activities of daily living. John has a bowel management protocol in place due to a history of constipation.

As part of John's bowel movement protocol, staff were required to record John's bowel movements and contact the residential nurse or on-call nurse if a bowel movement did not occur within a 48-hour timeframe. Staff were also provided with directions to administer a prescribed PRN agent at bedtime if John did not have a bowel movement within 48 hours. Nursing staff were to be notified prior to administering the prescribed medication, and both the communication with nursing and the administration of medication were supposed to be recorded in John's Progress Notes, Medication Administration Record, and nursing notes. Staff were required to continue to monitor John's bowel movements, and if, after receiving the medication, a bowel movement did not occur by the third day, staff were required to notify nursing immediately to assess John and make a clinical decision as to whether John needed to go to the hospital.

One day, John returned home early from their day program because they were lethargic, withdrawn, and not acting like they usually did. John was offered lunch and dinner, but they did not eat them. John laid in bed all day. The residential nurse happened to stop by the residence, and the staff told them John did not seem to be feeling well. The nurse quickly reviewed John's daily bowel chart and Medication Administration Record and saw that no entries were recorded in John's bowel monitoring chart for the last three days, and there was no documentation concerning whether John received their PRN to assist with bowel movements. Additionally, the nurse was unable to locate recent bowel tracking documentation recorded by staff at John's day program and provided to the residence. The nurse spoke with the staff on shift, and no one could recall whether John had a bowel movement in the past 48 hours. The nurse immediately assessed John and sent John to the emergency room. John was admitted, diagnosed, and treated for a partial bowel obstruction. Four days later, John was discharged and returned to their residence.

Click below to access the Justice Center's Spotlight on Preventing Intestinal Obstructions.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

LGBTQIA+ SUPPORTS - 1

COULD THIS HAPPEN IN YOUR PROGRAM?

Jamie started using “they/them” pronouns six months ago and announced to their treatment team that they identify as non-binary. Jamie’s treatment team, including their psychologist, emailed the residential staff, “Please use they/them pronouns for Jamie as they identify as non-binary.” Staff took Jamie and other residents out for a community outing at the mall. Jamie went to use the restroom, and Kyle, a residential staff member, yelled out, “Jamie, you can’t use that bathroom!” Another staff member, Penny, inquired why, and Kyle responded, “They can’t use the men’s room.” Penny noticed other residents were listening. Penny did not know if Jamie needed emotional support or how to address Kyle for yelling out like they did. Later, when Jamie got home, they went to their bedroom and did not come out for dinner. When Penny knocked on their door, Jamie said, “Leave me alone.” Penny emailed the psychologist and asked for clarification on how to proceed.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

LGBTQIA+ SUPPORTS - 2

COULD THIS HAPPEN IN YOUR PROGRAM?

Tae was born male but identifies as a woman with preferred pronouns of “she/her/hers.” Tae came out about being transgender two years ago. Tae attempted hormone replacement therapy but was not able to continue with therapy because of the side effects. Tae wears dresses, paints her nails, and grows her hair long. Tae lives in a group residence with two women and three men. Tae’s family wants to be involved in her life, but Tae has chosen to cut contact with them because they still refer to her by her formerly used pronouns and call her by the name given at birth (this is also known as being “deadnamed”). Tae started living at the residence before she transitioned.

When Tae came out and began her transition, John, the House Manager, instructed staff at a house meeting to refer to Tae by her chosen name and to use her preferred pronouns. After the meeting, two of the staff, Mildred and Oliver, told John that Tae’s lifestyle was offensive to them and went against their beliefs, so they would only refer to Tae by their “given name and sex.” John needed to leave the program for another meeting, and told Mildred and Oliver that they would speak to them later about the situation. When John returned, Mildred and Oliver’s shift had ended, and they did not have a follow-up discussion.

At Tae’s annual meeting, she shared that she wanted to move to another residence. When her team asked her why, Tae shared that Mildred and Oliver continue to use “he/him” pronouns and deadname her. Tae added that Mildred and Oliver would not let her wear dresses on outings, stating things like, “I refuse to be seen in public with you dressed like that.” Tae shared that they had treated her this way since they came out, and that she spoke with John about it, and that the situation never got fixed.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

MECHANICAL LIFT

COULD THIS HAPPEN IN YOUR PROGRAM?

Deb uses a wheelchair and requires a mechanical lift and two staff to transfer them in and out of it. Staff were trained that they were only able to physically transfer Deb in or out of their wheelchair in the event of an emergency, such as a fire. While Jake, the manager of the house that Deb lived in, was on vacation, the mechanical lift stopped working. The staff who worked at Deb's house were not sure whether there was a manager covering for Jake while they were on vacation, and were unsure of who to alert that the mechanical lift was not working.

For one week, the staff who worked at Deb's house physically picked up Deb to transfer them in and out of their wheelchair and did not contact anyone to alert them that the mechanical lift was not working. One afternoon, after staff physically transferred Deb into their wheelchair, Deb began to cry.

Staff comforted Deb, and after a few minutes, Deb stopped crying, so staff did not alert anyone. The next day, a large bruise appeared around Deb's elbow. Staff contacted the nurse, and Deb was brought to the doctor, where they received X-rays, and it was determined that Deb had fractured their arm. It was believed that while being physically transferred by staff, Deb was dropped and fractured their arm.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

MEDICAL EMERGENCIES - 1

COULD THIS HAPPEN IN YOUR PROGRAM?

Barry started to pace back and forth in the living room of their group home after dinner one night. Staff member Janice noticed this and asked Barry if they were ok. Barry was mostly non-verbal but could typically indicate when they were in pain. Barry pointed to their stomach while they 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 their room earlier than was normal for them. When Janice checked on Barry at 9:00 p.m., they were lying quietly on the bed, facing away from Janice.

At 11:00 p.m., Gregor, the overnight staff, arrived and started to do room checks while Janice got ready to leave for the evening. When Gregor checked on Barry, they noticed that Barry was sleeping in an unusual position. Gregor went further into Barry’s room to check on them. Gregor saw that Barry had vomited and that Barry’s eyes were open and fixed.

Gregor called Barry’s name a few times and tried to find their pulse, but Barry did not respond and did not appear to have a pulse. Gregor 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 them 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 their bed.

Click below to access the Justice Center’s Spotlight on Prevention Toolkit on Responding to Medical Emergencies.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

MEDICAL EMERGENCIES - 2

COULD THIS HAPPEN IN YOUR PROGRAM?

James was complaining of stomach pain and pointing to their stomach. James' blood pressure was regularly monitored. Laureen, a direct care staff member, took James' 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 their co-worker to return from an outing. Laureen gave James a shower and a shave and changed them 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 their supervisor to tell them that James had collapsed. Some bystanders administered CPR to James while Laureen was on the phone.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Responding to Medical Emergencies.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

MEDICAL EMERGENCIES - 3

COULD THIS HAPPEN IN YOUR PROGRAM?

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. They 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, they found a medication bottle with a week's supply of hydrocodone. Amelia took the pills out of the bottle and put them in their pocket. Inpatient staff did not conduct a search of their person when Amelia arrived back at the inpatient unit since they had come from another area in the hospital. Amelia settled into their room and then crushed the pills and snorted them. Staff found Amelia unconscious on the floor between the wall and their 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 Amelia because several staff members were crowded around their bed. Staff also discovered the Narcan was expired, and they were unsure if they should use it.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Responding to Medical Emergencies.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

MEDICAL EMERGENCIES - 4

COULD THIS HAPPEN IN YOUR PROGRAM?

Georgiana was admitted to an inpatient psychiatric unit for depression, stating that they did not want to live anymore. Georgiana had a specific plan for ending their life and was placed on 15-minute checks for safety. While on the inpatient unit, Georgiana's doctor made changes to their medication regimen. Georgiana appeared to be less depressed and began to talk about plans for the future. Nancy, a mental health therapy aide, was assigned to provide supervision and 15-minute safety checks to Georgiana. However, Nancy had been having trouble at home and had argued with their partner just before their shift started. Nancy's partner called them while they were working, and Nancy stepped into an empty stairwell to speak privately. Nancy was on the phone for approximately 20 minutes. When they came back onto the unit, they spent time at the nurse's station reviewing shift reports and chatting with some other staff. When Nancy went to check on Georgiana, it had been 35 minutes since the last check. As Nancy walked down the hall to Georgiana's room, they saw that Georgiana's door was closed. As Nancy opened the door, they found that Georgiana had used the blanket from their bed to hang themselves 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 them to the floor and begin CPR.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Responding to Medical Emergencies.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

MEDICATION MANAGEMENT / ADMINISTRATION - 1

COULD THIS HAPPEN IN YOUR PROGRAM?

John is assigned to administer medications for the evening on the behavioral health unit. John typically works on a different unit but occasionally works extra shifts on the behavioral health unit. John proceeds to review the Medication Administration Records and prepare the medications. John notes there are several names they do not recognize from the previous week, but assumes that the correct person will come into the office when their name is called. John calls for Juan, a person receiving services on the behavioral health unit, to enter the medication area, and a person appears in the medication area. John asks them if they are Juan, and the person nods their head. John hands the person the medications and some water. Right before the person takes the medications, they inform John that they are not Juan. John is able to retake possession of the medications before the wrong person takes them. John does not report the incident to their supervisor or nursing staff as they are embarrassed that this happened. Later that day, the person who was handed the wrong medications informs the program director of the incident.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

MEDICATION MANAGEMENT / ADMINISTRATION - 2

COULD THIS HAPPEN IN YOUR PROGRAM?

Andy, a person who lives in a group residence, is prescribed several medications. Paul, the staff member in charge of administering medications that morning, was in a hurry. Paul needed to leave as soon as their shift ended for an appointment. Paul handed Andy their medication and watched as Andy self-administered their medication. Paul rushed to finish administering medications to the remaining people at the residence. Paul didn't complete the medication logs before they left their shift or before Ronnie, another staff member, arrived for their shift. Paul left a Post-it note on the refrigerator that said, "Everyone got their morning meds."

When Ronnie arrived at the residence, Andy approached them and requested their medication. Ronnie asked Andy if they had taken their medications already, and Andy responded, "No, not yet." Ronnie checked Andy's medication log and saw that no one had signed that they had administered Andy's medication that morning, so they handed Andy their medication and watched as Andy self-administered them. Ronnie recorded it on the medication log. A short time later, Andy stated that they were not feeling well. Ronnie found Paul's Post-it note on the refrigerator and realized that Andy's medications were administered twice. Ronnie contacted their supervisor and described the situation. Ronnie then contacted the on-call nurse and informed them that Andy received two doses of their medication. The nurse advised Ronnie to call 9-1-1. Andy went to the hospital and was admitted as a result of the incident.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

MEDICATION MANAGEMENT / ADMINISTRATION - 3

COULD THIS HAPPEN IN YOUR PROGRAM?

Lithium was added to Charlee's medication regimen when they were admitted to a psychiatric unit for mood instability. Charlee was discharged home to their apartment with lithium added to their medication record and an appointment scheduled for the following month for a lab draw to check their lithium levels. A week later, Charlee called their case manager, Isabella, to ask when they were coming to the apartment. Isabella let Charlee know that they were not scheduled to see Charlee that day. Charlee was adamant that Isabella was supposed to be at the apartment and started shouting at Isabella over the phone, slurring their words. Isabella assumed Charlee was upset because of their mood instability. Isabella reminded Charlee that they were scheduled to be at the apartment the following day.

When Isabella arrived at Charlee's apartment the next day, they observed Charlee take two tablets of ibuprofen. Isabella asked Charlee the reason why, and Charlee stated that they had been taking ibuprofen for a few days because of a bad headache. Charlee was shaking and slurring their speech, so Isabella called the program's nurse. The nurse instructed Isabella to take Charlee to the emergency room. Charlee's bloodwork at the ER visit revealed that their lithium level was at a toxic level, and the attending physician indicated that the ibuprofen Charlee had been taking for their headache was likely the cause. Charlee stated that they did not know they had to avoid taking ibuprofen once they started taking the Lithium. Isabella confirmed that Charlee had ibuprofen on their standing orders at home and that they had not been updated after lithium was added to their medication regimen.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

OVERDOSE PREVENTION

COULD THIS HAPPEN IN YOUR PROGRAM?

Jane lives in a community residence that supports people who have addiction issues and a history of substance use. Over the last year that Jane was at the program, staff observed Jane becoming more outgoing, talking with other staff and residents, and engaging with activities in the residence. Jane had not visited their family since they arrived at the program and wanted to visit them. Jane met with their treatment team, and they helped Jane arrange a weekend to go on a home visit. During a program meeting, the residential staff and the clinical team discussed Jane's home visit and the support to offer to Jane when they returned. Jane returned to the residence after their home visit just in time for dinner. Taylor, one of the staff at the residence, asked if Jane was hungry after their big weekend. Jane grunted and sat down at the table. Taylor sat down with Jane and asked how the weekend went. Jane nodded their head and sighed. Taylor noticed Jane's skin was sweaty and clammy.

Taylor asked Jane if they wanted to talk about the weekend. Jane slumped over the table and did not respond to Taylor calling their name. Taylor called for another staff member, Cliff, to grab the Narcan that was kept in the supervisor's office. Cliff went to the office, but the door was locked. Cliff ran back to Taylor and asked if there was another key to unlock the office. Taylor responded, "No, the supervisor must have taken them when they left to get the pizza for dinner. I don't know if there's another key." Taylor then directed Cliff to call the supervisor and the on-call nurse while Taylor called 911.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

PERSON-CENTERED CARE

COULD THIS HAPPEN IN YOUR PROGRAM?

Nick recently moved into a group home. One of Nick's housemates had a rights restriction in place calling for the refrigerator to be locked when they are at home. The person's plans also noted that if the person was not at home, the refrigerator could be unlocked. Nick does not require any supervision from staff while dining, and does not have any restrictions on the foods they can eat or timeframes when they can eat. However, when Nick moved into the house, they were not offered a key to unlock the refrigerator. One day, when the person who required the refrigerator to be locked was not home, Nick tried to get a yogurt from the refrigerator, but it was locked. Nick had to go to the staff office to find someone to unlock the refrigerator. Nick was very frustrated that the refrigerator was locked, and that they had to wait to get their yogurt. When the staff saw that Nick was getting irritated, they scolded Nick and told them that they needed to be more patient.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

PICA - 1

COULD THIS HAPPEN IN YOUR PROGRAM?

Bob is a person who has pica. Bob requires 1:1 supervision within arm's length, and pica "sweeps" to be completed on each shift to ensure no small items or cleaning supplies are present due to their behavior of trying to ingest inedible items. Linda, a staff member, was assigned to complete the pica sweeps prior to Bob returning to the residence from their day program and was assigned to provide Bob's supervision once they arrived at the residence.

Linda was busy decorating the residence for the upcoming holiday and did not complete the pica sweep before Bob returned home. That evening, while watching television together in the living room, Bob was seated in a recliner and Linda was across the room on the couch. Bob grabbed a tack that held up one of the decorations and ingested it. Linda was watching television and did not immediately notice Bob had eaten the tack. Once Linda noticed that the decoration had fallen and Bob had ingested a tack, they removed the remaining tacks and decorations and called the residential manager. The manager instructed staff to report the incident to the on-call nurse as it was after hours. Linda called the residential nurse's cell phone and left a message. However, the nurse did not listen to the message until the following workday. The nurse then instructed the staff to bring the person to the hospital for evaluation.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

PICA - 2

COULD THIS HAPPEN IN YOUR PROGRAM?

Tina is a person who has a diagnosis of pica and will seek out items to chew or ingest. These items include erasers, rubber bands, hair ties, latex gloves, and foam. With the exception of their bedroom and the bathroom, staff assigned to provide supervision for Tina were to remain within arm's length of them at all times, because Tina was able to obtain inedible items to ingest quickly. Staff were to complete sweeps of Tina's environment at the beginning of each shift to identify and remove anything that Tina could ingest. Staff were also instructed to complete sweeps of the bathroom and bedroom before leaving Tina alone in those rooms.

A relief staff member, Gail, was assigned to provide supervision for Tina when they returned home from their day program around 3:30 pm. Gail arrived on shift at 3:00 pm and was given the plans of care for all eight of the people living at the residence to review, along with the house plan of protection and fire evacuation plan. Gail was unable to review all the plans before Tina arrived home. Gail was unaware that Tina required arm's length supervision and that pica sweeps were to be completed before Tina arrived home. Three other staff who regularly worked at the residence were also working on the evening shift with Gail and were assigned to supervise other people and complete house chores. While Gail continued reviewing house books and plans, Tina entered the kitchen area where they found latex gloves that were left on the kitchen counter by an unknown staff member. Tina was able to ingest one of the gloves before a staff member entered the kitchen and stopped them from putting the second glove in their mouth. Staff notified the on-call nurse of the situation and were instructed to bring Tina to the hospital. Tina required surgery to remove the glove.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

PROFESSIONAL BOUNDARIES - 1

COULD THIS HAPPEN IN YOUR PROGRAM?

Carlita works in an inpatient psychiatric center. Carlita loves their job and cares a great deal for the people they support at the center. As part of their job, Carlita assists with leading recreational activities such as movie or game nights in the community room. Carlita often takes pictures of the people on their cell phone when they are participating in these activities and posts them to their social media accounts. Other staff members have pointed out to Carlita that the agency has a strict policy about using social media related to their work. Carlita states that they are not breaking confidentiality because they do not identify anyone in the posted pictures other than by their first name, and do not post the pictures until they get home at night after their shift.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Maintaining Professional Boundaries.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

PROFESSIONAL BOUNDARIES - 2

COULD THIS HAPPEN IN YOUR PROGRAM?

Brandon is sixteen and has recently been discharged from a residential treatment facility. Brandon's parents are very grateful for the work the clinician, Matt, did to help Brandon and return them to their care. Matt went above and beyond for Brandon on more than one occasion, spending extra time with Brandon to help them feel comfortable attending groups and providing additional one-to-one support during transitions. When Brandon was discharged, their parents brought Matt cupcakes and a card. After they left, Matt found a $50 gift card in the envelope. Though the facility had a policy prohibiting staff from accepting monetary gifts from patients and families, Matt did not report this to their supervisor and used the gift card. Later, Brandon had another crisis, and their parents reached out to Matt directly to see if Matt could help get Brandon re-admitted. Matt explained that they could not help because they were not in charge of admissions. Brandon's parents were upset about Matt's response and repeatedly called Matt and left them voicemails at all times of the day and night.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Maintaining Professional Boundaries.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

PROFESSIONAL BOUNDARIES - 3

COULD THIS HAPPEN IN YOUR PROGRAM?

Rebecca is 37 years old and has arrived at a residential program for substance abuse treatment. They have a significant history of trauma, and this is their first time in a residential setting. Rebecca is expressing serious concerns about relapsing to Rob, a staff person they feel very connected to. Rob tells Rebecca about their own, similar struggles and treatment for substance abuse. Rebecca tells Rob that they struggle the most at night, so Rob offers Rebecca their phone number in case they need extra support. The agency policy states that calls after hours are not permitted between staff who are not on duty and people receiving services from the program. However, Rob feels they have a strong rapport with Rebecca and that they could help Rebecca if they needed it. Rebecca and Rob begin texting every night. Rob takes Rebecca outside with them to put out the agency garbage on several occasions, though agency policy prohibits unsupervised contact between staff and people receiving services from the program. Rebecca develops a crush on Rob and tells them they are interested in more than friendship. Rob tells Rebecca they feel the same way. Rebecca tells their roommate about their conversation, and their roommate tells the House Manager, who reports the incident to the Justice Center

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Maintaining Professional Boundaries.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

REDUCING RESTRAINTS - 1

COULD THIS HAPPEN IN YOUR PROGRAM?

Jacob, a nine-year-old in care, had more than the three books that were allowed in their room. Kyle, a staff member, told Jacob they could not have that many books. Jacob became upset and said that they needed the extra books for school. A supervisor intervened, and Jacob eventually agreed to put some books in the storage room. Kyle was annoyed that Jacob did not listen to them and that a supervisor had to get involved. As Jacob walked toward the storage room, Kyle began to antagonize Jacob and further escalated the situation by verbally threatening Jacob. Jacob pushed Kyle away and carried their books back to their room. Kyle followed Jacob and initiated a restraint. After the incident, Jacob reported that they were frustrated and confused and said they could not believe staff treated them this way just because they wanted more books. Jacob stated they felt fearful of Kyle.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Reducing Restraints.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

REDUCING RESTRAINTS - 2

COULD THIS HAPPEN IN YOUR PROGRAM?

Tom was a student in a classroom with a high staff-to-student ratio to meet their needs. Tom was struggling in class, and Mike, a direct care professional, asked Tom to go to the quiet room. When Tom attempted to enter a different room, Mike blocked Tom, so Tom tried to punch Mike in the face. Nearby staff intervened and attempted to put Tom in a standing restraint, but Tom continued to struggle. Mike grabbed Tom by the neck, took them to the ground, and placed their weight on Tom's back and neck area. Tom struggled for the entire duration of the restraint, kicking their feet. Another staff member assisting in the restraint removed Tom's shoe and turned Tom's foot sideways, applying pressure to the joint to stop Tom from kicking. Tom's crisis management plan prohibited staff from grabbing them from behind for concern of re-traumatization due to Tom's history of abuse. Tom sustained bruising to their face and head as a result of the restraint. The staff members involved had received training that prohibited the practices used during this restraint.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Reducing Restraints.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

REDUCING RESTRAINTS - 3

COULD THIS HAPPEN IN YOUR PROGRAM?

Wanda worked in a group home as a direct care professional. Upon arriving at work, they discovered the home was short a staff member for the day. Due to the shortage of staff, Wanda had to prepare dinner and administer the evening medications on their own while the other staff member took someone to an appointment. Wanda attempted to contact their supervisor for additional coverage but was unable to reach them. Jim, a resident of the home, used a wheelchair and liked to sit at the dining room table playing cards for enjoyment. Amy, another resident of the home, was non-verbal and also used a wheelchair. Wanda was concerned about getting dinner prepared for everyone in a timely manner and administering the evening medication. Wanda placed Amy and Jim in the living room, turned the television on, and locked the wheels of the wheelchairs so they could not leave. Jim said they wanted to go back to the dining room table and tried to move their wheelchair towards the kitchen. Wanda pushed them back into the living room and locked the wheels on the wheelchair a second time.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Reducing Restraints.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

REDUCING RESTRAINTS - 4

COULD THIS HAPPEN IN YOUR PROGRAM?

Sheila, a patient in a behavioral health unit of a hospital, was agitated because they were hungry. Sheila began pacing in front of the nurse's station, yelling and asking for assistance. When one of the nurses told Sheila to calm down and wait for dinner like everyone else, Sheila became so agitated that they assaulted the nurse. Dr. Jones ordered an intravenous medication to be administered so Sheila would not hurt themself or anyone else. After the medication was administered, Sheila calmed down. As a further precaution, Dr. Jones then ordered that Sheila be placed in mechanical restraints for further monitoring.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Reducing Restraints.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

REPOSITIONING - 1

COULD THIS HAPPEN IN YOUR PROGRAM?

Nick required staff's assistance with all activities of daily living. Nick also required physical repositioning every hour due to a history of pressure ulcers on their feet. Multiple staff members responsible for repositioning Nick indicated that they had also observed pressure ulcers on Nick's elbows for months, but did not report or document the concerns as they assumed the nurse was already aware of the pressure ulcers. Staff also noted they were attending to Nick's wounds, although they had not received in-person training for wound care.

Nick's repositioning logs reflected that staff had not turned or repositioned Nick for periods of time as long as four to five hours. Additionally, staff did not indicate why Nick was not repositioned or whether Nick had refused to be repositioned. The Residential Manager signed the repositioning logs reflecting that staff thoroughly completed the logs; however, they did not address or acknowledge the missing entries. The nurse was verbally informed of Nick's pressure ulcers and assumed staff were referring to the pressure ulcers on Nick's feet and did not conduct an evaluation of Nick.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

REPOSITIONING - 2

COULD THIS HAPPEN IN YOUR PROGRAM?

Ryan was hospitalized for two weeks for a respiratory infection. When they returned to their residential program, the nurse discovered that Ryan had pressure sores on their lower back. At the morning staff meeting, the nurse gave verbal instructions to staff to reposition Ryan every 30 minutes to help the pressure sores heal. The house manager left a note in the shift log for the staff who were not at the training to let them know that Ryan needed repositioning every 30 minutes. Two days after Ryan returned to the residence, the nurse came to check on Ryan and observed that their pressure sores were worse. The nurse looked for documentation of Ryan's repositioning and did not find any records that documented that Ryan had been repositioned. Ryan was taken to the emergency room for further treatment.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

SAFETY AWARENESS – "STRANGER DANGER"

COULD THIS HAPPEN IN YOUR PROGRAM?

Jeremy was working the evening shift at a group residence. Jeremy and the four people who worked in the home were relaxing in the living room. Though a movie was playing on the television for everyone to watch, several people were also using their iPads to play games. The doorbell rang, and Jeremy went to answer the door. When they opened the door, there was a man standing there wearing a yellow vest, holding a clipboard. The man said they were from the local electric company and were going door to door to check people's electric bills to see if there was a charge on the bill that should not be there due to a recent initiative to help people save money. Jeremy knew that the electric bills went to the main office, so they invited the man into the home to wait while Jeremy called the administrator on call. Jeremy left the man in the entryway to the house while they went to the staff office to make the phone call. When Jeremy came out of the office, the man was gone, and an iPad that had been charging near the entryway was missing.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

SELF-NEGLECT

COULD THIS HAPPEN IN YOUR PROGRAM?

Walter lived in a supervised apartment setting and received visits from their staff, Lilliana, one to two times a week. Walter's apartment became increasingly cluttered as they found things in the community and brought them back to the apartment. Lilliana noticed Walter was needing more reminders to keep the apartment clean and to take showers. Lilliana also noticed that Walter had not been taking all of their medications. When Lilliana asked Walter about cleaning the apartment and taking medications, Walter replied that they did not want to clean or take their medication. Walter said, "I don't have to do either, I have the right to refuse." For several weeks, Lilliana and Walter repeated the same discussion. Lilliana also noticed Walter had lost some weight. When Lilliana went to Walter's apartment for their next scheduled visit, there was no response to their knock on the door. Lilliana documented that they attempted to complete a visit, but no one was home. Lilliana went to the apartment the next day, and again, there was no answer to their knock on the door. Lilliana contacted their supervisor, who advised them to find a maintenance person to let them into the apartment. When maintenance unlocked the door, they found Walter unconscious on the bed.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

SEPSIS

COULD THIS HAPPEN IN YOUR PROGRAM?

Due to a history of urinary tract infections leading to sepsis, Kristen's plans of care required staff to check and/or change their disposable briefs every two hours to monitor for any changes in skin tone, urinary output, and abdominal pain. On Friday evening, while completing the two-hour checks, staff discovered that Kristen had a low-grade fever, appeared lethargic, and was complaining of abdominal pain. Staff provided Kristen with medication for their fever and documented this in their daily communication log. Over the course of the weekend, staff observed and documented that Kristen's disposable briefs were often dry. Kristen continued to appear lethargic and pale, and their fever worsened, so staff gave them additional medication. When Judy, the residence manager, arrived for their shift on Monday morning, they reviewed the daily communication logs and discovered that staff did not document whether they had called the on-call nurse to discuss Kristen's symptoms. Judy called the nurse and informed them of Kristen's symptoms and the multiple doses of medication that had been provided. The nurse directed Judy to contact emergency medical services immediately. Emergency medical services took Kristen to the hospital, where they were admitted to the emergency room and diagnosed with sepsis.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

SOCIAL MEDIA - 1

COULD THIS HAPPEN IN YOUR PROGRAM?

Callum and Maura, program staff, took six people on a community outing. All of the people were laughing, and Callum used their personal cell phone to take pictures of them. Callum mentioned to Maura, "Our supervisor will love seeing how happy everyone is!" Callum posted the pictures to their personal social media account. Callum asked Maura to send them a "friend request" so Callum could "tag" Maura in the pictures. Several of the people on the outing asked if they could also "friend" Callum on social media and "tag" themselves in the pictures. Callum accepted all of the "friend requests" they received. Liberty, a person on the outing, began direct messaging Callum on a regular basis. Callum did not want to continue direct messaging Liberty, but did not want to hurt their feelings, so they brought their concern to their supervisor. The supervisor told Callum they had violated the agency's social media policy. Callum responded that they were not aware that the agency had a social media policy.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

SOCIAL MEDIA - 2

COULD THIS HAPPEN IN YOUR PROGRAM?

Richard is a 27-year-old person who was receiving services in an inpatient treatment facility and was discharged one week ago. Richard is very close to Joe, the Peer Specialist. Joe always helped Richard by having additional conversations with Richard outside of groups, where the two would often discuss their similar experiences. Prior to their discharge, Richard expressed to Joe that their cellphone was broken and that they could not afford a new one. Before Richard was discharged, Joe gifted Richard a cellphone and told them that they should keep in touch. Joe and Richard then exchanged social media information. After Richard was discharged, Joe would send Richard direct messages of motivational memes. Joe also messaged Richard and invited them over for lunch. Jamie, Joe's colleague, told Joe they also received a "friend request" from Richard. Joe responded, "Well, Richard and I are friends, we message all the time." Jamie told Joe they should report the messages to their supervisor. Joe seemed confused and mentioned they were not aware that peer supports could not contact or keep in contact with people after they were discharged. Jamie responded, "There is no policy, but it's implied that we cannot keep in contact with a person after they discharge because it's crossing a professional boundary."

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

STAFFING ASSIGNMENTS

COULD THIS HAPPEN IN YOUR PROGRAM?

Twyla, a residence manager, and Coco and Jax, direct care staff, worked the day shift at a residence supporting five people receiving services. One morning after everyone finished breakfast, Coco and Jax encouraged everyone to get ready to go to their day program. Two people stayed behind at the residence as they were not feeling well and wanted to sleep. Coco and Jax left the residence to bring the other three people to their day program and assumed that Twyla would provide supervision for the two people who stayed behind. However, Twyla had only seen Coco grab the car keys and leave, and assumed Jax had stayed behind at the residence to supervise the two people who did not go to the day program.

After Coco and Jax left, Twyla noticed the residence was out of toilet paper and went to the store to get more toilet paper. While Twyla was checking out at the store, they received a call from a member of the maintenance staff who was at the residence to complete a work order and noticed that two people were home alone. Twyla called Jax, who explained that they were on their way back to the residence from the day program with Coco. Twyla arrived at the residence shortly before Jax and Coco. Twyla instructed Jax to complete a body check on both people, as they had been left alone for a total of one hour. Twyla also checked the assignment sheet, which did not identify the residential manager as responsible for supervising the people, nor did it have a section to document staff assignments when people remained at home and did not go to the program. Both people appeared to be uninjured and slept the entire time they were alone.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

SUICIDE PREVENTION

COULD THIS HAPPEN IN YOUR PROGRAM?

Carlos had a history of suicide attempts. At their most recent appointment with their psychiatrist, Carlos identified that they had been having an increase in suicidal thoughts. Carlos' psychiatrist completed a suicide assessment and recommended that staff increase Carlos' supervision from 30-minute checks to 1:1 supervision, ensure all sharp objects were locked and secured, and asked Carlos to come back to the office to be seen again in two days.

Nikki, a direct support professional who was nearing the end of their shift, received the directives from the psychiatrist and transported Carlos home. Upon arrival at the residence, Nikki verbally informed Josh, the residence manager, that Carlos required 1:1 supervision, needed any sharp objects to be locked away, and that an appointment needed to be scheduled for Carlos to be seen again at the psychiatrist in two days. Nikki was already 30 minutes past the end of their shift, so they decided to clock out and document the discharge instructions in the person's electronic health record the next day. Josh was busy supporting other people on their shift and forgot to tell Scott, the overnight staff, about Carlos' change in supervision and the need for sharps to be locked.

During the overnight shift, Carlos approached Scott and told Scott that they were supposed to have a 1:1 staff due to suicidal thoughts. Scott contacted Josh, who confirmed this was accurate. Scott was then assigned to provide 1:1 supervision to Carlos, ensure that the sharps were locked, and contact nursing to schedule the follow-up appointment.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

TRANSFERRING SUPERVISION

COULD THIS HAPPEN IN YOUR PROGRAM?

Michael required 1:1 supervision due to their history of falls. Michael's plans of care noted that staff assigned to provide supervision would carry a "hand-off bracelet" to physically hand to another staff member whenever the person's supervision needed to be transferred. Julie was assigned to provide 1:1 supervision to Michael during the evening shift. That evening was chaotic at the program. Daryl was struggling to de-escalate another person and called to Julie from down the hall for help. Julie asked Yvonne, another staff member, to provide supervision to Michael, and left to assist Daryl. Julie was too far away to hear that Yvonne responded, "I can't, I'm busy making dinner!" Michael was left unsupervised and attempted to walk to their bedroom. When Julie returned from helping Daryl, they discovered Michael was not in the living room. Julie asked Yvonne, "Where's Michael?" Yvonne responded, "I don't know, I told you I was making dinner!" Julie left the kitchen and discovered Michael on the ground at the bottom of the stairs, moaning in pain.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

VACATION / OUTING PLANNING

COULD THIS HAPPEN IN YOUR PROGRAM?

Over the weekend, Gretchen, program staff, took three people receiving services, Teddy, Jimmy, and Calvin, to the movies. Teddy and Jimmy both required “range of scan” supervision, while Calvin’s supervision was “independent with staff present.” Teddy required “range of scan” supervision due to their diagnosis of Intermittent Explosive Disorder and history of sudden outbursts. Jimmy required “range of scan” supervision due to their tendency to elope when they feel anxious or unsafe.

Thirty minutes into the movie, Teddy wanted to buy candy from the concession stand. However, Teddy did not bring enough money to make the purchase. When Gretchen told Teddy this, they became very upset. Teddy began shouting in the theater and kicked the seat in front of them. Jimmy became anxious due to Teddy’s behavior and got up from their seat and left the theater. Gretchen was trying to calm and de-escalate Teddy and was unable to follow Jimmy. Gretchen called the residence, the Administrator on Duty, and the Behaviorist On-Call, but did not receive a response.

After 25 minutes, Teddy was calm, and Gretchen was able to leave the theater with both Teddy and Calvin. Gretchen had Teddy and Calvin sit in the agency vehicle and went to find Jimmy. Gretchen located Jimmy in the theater restroom and assisted them to the agency van.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

VEHICLE SAFETY - 1

COULD THIS HAPPEN IN YOUR PROGRAM?

Nick and Winston reside at a residential children's center. During the week, staff transport them to their respective schools. It is the center's policy that upon arrival at the school, staff are to walk all people present in the vehicle to the school when dropping each person off, so that no one is left alone in the vehicle. On Wednesday morning, the children's center assigned Katy, a temporary staff member, to transport both Nick and Winston to school. Katy had not reviewed the agency's transportation policy, Absent Without Consent policy, or the care plans for Nick or Winston. Katy transported Nick and Winston to Nick's school first. Upon arrival at the school, Katy and Nick got out of the vehicle and walked into the school while Winston remained in the vehicle. When Katy arrived back at the vehicle, Winston was gone. Katy searched the general area for 10 minutes and then went back into the school, asking if anyone had seen Winston. Katy then called the children's center to ask what they should do. Katy was given instructions to contact the police. Three hours later, Winston was located by the police.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on the Dangers of Being Left Unattended in Vehicles.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

VEHICLE SAFETY - 2

COULD THIS HAPPEN IN YOUR PROGRAM?

On a cold morning in December, direct support professionals Rosita and Terry were preparing to bring people to their day program. Terry asked Rosita to start the van so it could warm up before everyone got in it. Rosita started the vehicle and left it unlocked and running while they went back into the residence to let Terry know the van was warming up. Terry told everyone to head outside, and three of the people, Mena, Mike, and Porsha, went out to the van and discovered Rosita had left it unlocked. They entered the van, and Mena decided to sit in the driver's seat. Mena moved the vehicle's shifter to neutral, and the van rolled backwards down the driveway and into a parked car. Terry ran to the van, put it back into park, and assisted everyone out of the vehicle. The police were called, and the accident was reported. Mena, Mike, and Porsha were brought to the hospital for a medical evaluation.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on the Dangers of Being Left Unattended in Vehicles.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

VEHICLE SAFETY - 3

COULD THIS HAPPEN IN YOUR PROGRAM?

Ann is an adult with autism. Ann resides in a group residence and requires “line of sight” supervision at all times and support from their staff due to a lack of safety awareness. Ann has been attending the Main Street Day Program for 10 years. On Tuesday morning, Carl, the bus driver, and Patty, the bus aide, assisted Ann and their six housemates onto the bus and transported them to the day program. Ann was tired that morning, so they laid down in their seat at the back of the bus and fell asleep. Once at the day program, Patty assisted the six other people off the bus and into the day program while Carl did a check of the bus. However, Carl only did a visual check from the front of the bus and did not check each seat. As a result, Carl did not see Ann lying down in their seat at the back of the bus. The day program staff saw the other people from Ann’s bus entering the building and assumed Ann was with them. Patty returned to the bus, and Carl drove them back to the bus garage. Their shifts were over, so Carl and Patty left the bus without completing a final check and departed for the day. An hour after drop off, the Main Street Day Program staff realized Ann was not present. The day program staff searched the building for 20 minutes before reaching out to the residence to see if Ann was at the residence. Upon discovery that Ann was not home, the day program staff then contacted the bus garage, and Ann was found awake in the back of the bus.

Click below to access the Justice Center’s Spotlight on Prevention Toolkit on the Dangers of Being Left Unattended in Vehicles.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

WATER SAFETY - 1

COULD THIS HAPPEN IN YOUR PROGRAM?

On a hot day in July, program staff brought five people to their local lake to go swimming. Staff ensured that each person was provided a personal flotation device. Nancy, a program staff member, volunteered to stay on the beach and suggested that Kyle swim with Gerald, who required 1:1 supervision when swimming. Throughout the day, people would sit with Nancy for snacks and shade, and then return to the lake to swim. After swimming with Kyle for an hour, Gerald wanted a snack. Kyle told Gerald that Nancy would help them get a snack and to head to the shore. Kyle waved and called to Nancy, “Gerald’s on their way to you!” In response, Nancy waved back to Kyle. However, Nancy had not heard Kyle and assumed Kyle was just waving to say “hi,” and so Nancy waved back. While Gerald swam to the shore, Kyle was called over by another person swimming in the lake and went to supervise that person. When it was time to return to the program, Gerald was missing. Kyle found Gerald in the bathroom. Kyle and Nancy were unsure how long Gerald was alone.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

WATER SAFETY - 2

COULD THIS HAPPEN IN YOUR PROGRAM?

Nikolai is a 62-year-old man with a severe, uncontrolled seizure disorder as a result of a traumatic brain injury they sustained when they were 12 years old. Nikolai has a Vagus Nerve Stimulator implanted, is prescribed five anti-seizure medications, and has breakthrough seizures one to two times each month. Nikolai uses a wheelchair for ambulation and requires 1:1 supervision while in the bathtub or shower. Leona, a direct care staff member, was working their first shift at the facility where Nikolai lived. For their first shift, Leona shadowed Rodney, the Shift Supervisor. After dinner, Leona shadowed Rodney to observe Nikolai's bathing routine and the assistance needed for Nikolai to take a bath. After Rodney assisted Nikolai into the bathtub, they realized that they forgot to bring Nikolai's pajamas with them to the bathroom to change into after the bath. Rodney went to Nikolai's bedroom to retrieve the pajamas and left Leona alone with Nikolai. Leona stayed with Nikolai and tried to engage Nikolai in conversation until Rodney returned with the pajamas.

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

WHEELCHAIR SECUREMENT - 1

COULD THIS HAPPEN IN YOUR PROGRAM?

Jenny lives in a group residence. Although Jenny uses a walker in their home, they require the use of a wheelchair when traveling. Jenny's Staff Action Plan directs staff to ensure that they wear a seatbelt while in the vehicle. Jenny was going to the grocery store to help buy groceries for the week, so staff helped Jenny get into the wheelchair van. First, staff secured Jenny's wheelchair on the platform lift and raised the lift. Then, staff wheeled Jenny into the van and secured their wheelchair with the floor four-point restraint system using two floor restraints for the back of the wheelchair and two floor restraints for the front of the wheelchair. The staff knew that Jenny did not like the shoulder belt, so staff draped it behind Jenny's back instead. Jenny held their walker in front of their wheelchair during the drive to the store. Jenny's van was only a few blocks from their residence when a dog ran into the street in front of the van, causing the driver to slam on the brakes. When the van lurched forward due to the sudden braking, Jenny's chair stayed in place, but Jenny fell out of it and hit their face and head on their walker and the van floor because they were not wearing a shoulder harness.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Securing Wheelchairs in Vehicles.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

WHEELCHAIR SECUREMENT - 2

COULD THIS HAPPEN IN YOUR PROGRAM?

Sheila had new protocols in their service plan regarding their mobility while they were recovering from hip replacement surgery. Sheila now used a wheeled walker to ambulate and a self-propelling manual wheelchair for transportation and was able to stand by themself from a seated position and transfer with the use of a walker to stand or pivot. Sheila went shopping with a staff member, who told Sheila to take their walker to shop and not their wheelchair. Staff had Sheila use the steps to get on the van, which was hard for Sheila. After staff saw Sheila struggling to get on the van, they let Sheila use the van's lift to get off the van. Sheila stood on the platform lift with their walker as the lift was lowered to the ground to get off the van. As Sheila was getting off the lift, their walker got caught on the platform and they fell over. The staff member assisting Sheila stated that this was the first time they had taken Sheila out since their hip replacement, and the new protocols for transportation "slipped his mind." All staff at the agency were required to complete a "read and sign" training acknowledging changes to plans of care for people receiving services, but did not receive interactive training about the changes. The agency policy did not prohibit the use of the platform lift by people who are not in wheelchairs.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Securing Wheelchairs in Vehicles.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

WHEELCHAIR SECUREMENT - 3

COULD THIS HAPPEN IN YOUR PROGRAM?

Vicki and one of their housemates were getting dropped off by their residential provider for a hair appointment. Both Vicki and their housemate used wheelchairs in their homes and for transportation. The driver took Vicki's housemate off the van first and left the platform lift lowered to the ground. The driver then re-entered the van using the stairs, then proceeded to unhook Vicki's safety straps and wheel Vicki out of the van, pushing Vicki backwards using the arms of the wheelchair. The driver did not see that the platform lift was still lowered to the ground. Vicki fell out of the van and landed on their back while still strapped into their wheelchair. Staff from the salon came out to assist, and Vicki was evaluated for possible injuries after someone called 911.

Click below to access the Justice Center's Spotlight on Prevention Toolkit on Securing Wheelchairs in Vehicles.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

WHEELCHAIR SECUREMENT - 4

COULD THIS HAPPEN IN YOUR PROGRAM?

Ken reported that they were in the van on the way home from a medical appointment when their wheelchair tipped over while the van was in motion. Ken reported that this happened when the driver was going fast and made a sharp turn. Ken also stated that their wheelchair was not correctly secured and that when they fell, they cut their right palm. Ken said the staff person pulled over and helped them up and put a gauze pad on their cut, and then drove them directly home without calling a medical professional or reporting the incident to anyone. Ken said that the staff had secured both floor ties in the back but only secured one in the front. It was later discovered that the staff, a contracted transportation provider, was never trained on the safeguards related to transportation in Ken's service plans.

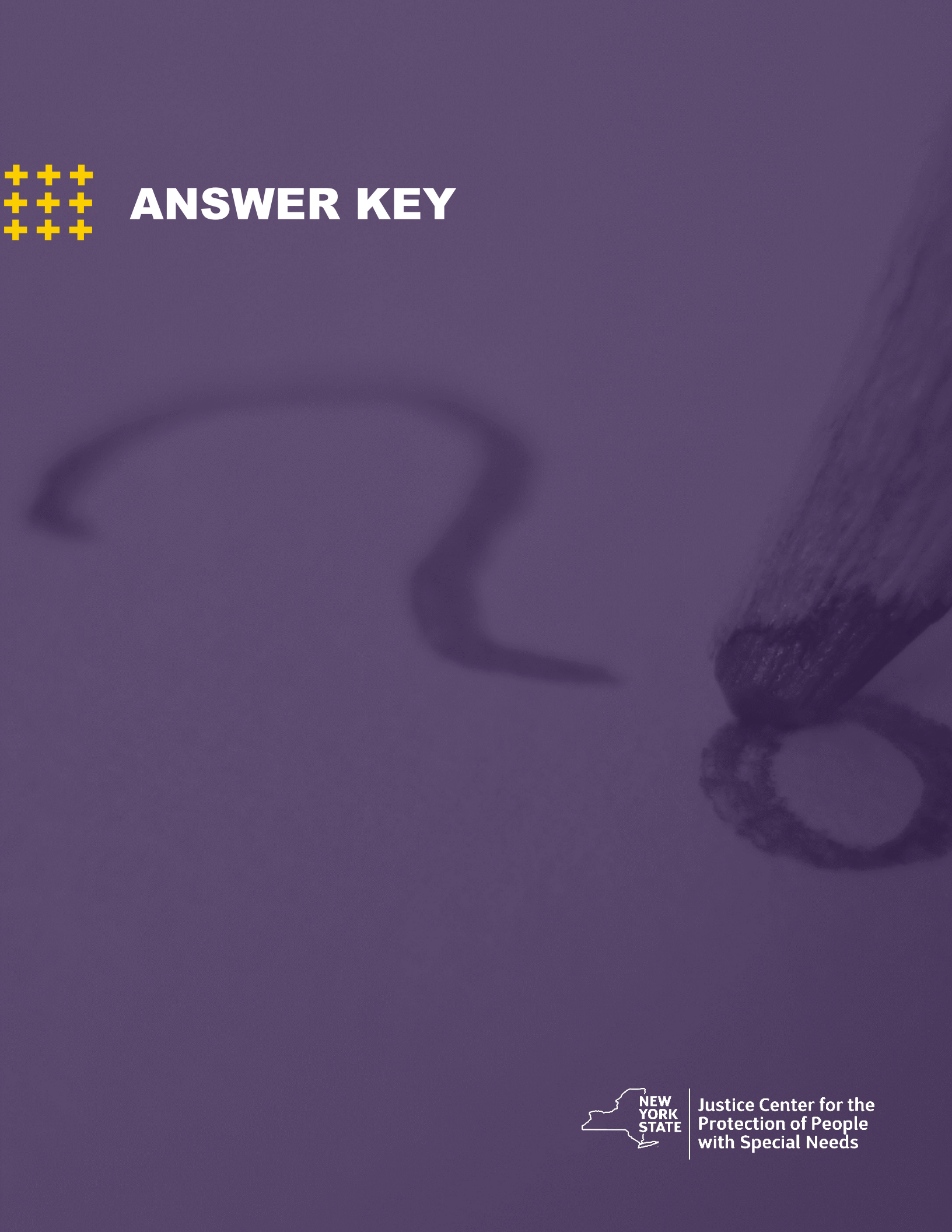
Click below to access the Justice Center's Spotlight on Prevention Toolkit on Securing Wheelchairs in Vehicles.

ACCESS TOOLKIT

CASE CONCERNS

Use the space below to identify the case concerns. Answers can be found in the back.

ANSWER KEY



NEW YORK STATE

Justice Center for the Protection of People with Special Needs

ANSWER KEY

COULD THIS HAPPEN IN YOUR PROGRAM?

Admissions Best Practices

Case Concerns

- The residence was not prepared for Taylor's early discharge from the rehabilitation facility.
- Staff did not know to assist Taylor when exiting the residence during the fire drill.
- The agency did not ensure a chest harness was available for Taylor.
- Staff were not trained on Taylor's safeguards and plans of care.

Allergic Reactions

Case Concerns

- Cullen was not given information about Sydney's allergy to peanuts.
- Cullen was not given access to Sydney's plans of care, plans of care for other individuals in the home, or the program-specific oversight documents.
- The severity of Sydney's mental health status was not conveyed to Cullen.
- It does not appear that the agency had a policy/process to ensure relief staff are trained on people's care and treatment plans or program-specific documentation prior to starting their shift.

Bathing Safety

Case Concerns

- The plans of care for Winston did not provide the specific directives for staff to follow while supervising and assisting Winston when they were bathing.
- Sam did not adequately supervise Winston while bathing when they left to assist another person receiving services.
- Sam did not document or alert anyone about the observed redness on Winston's body from the hot water.
- The hot water was too hot as it turned Winston's skin red.

Body Checks - 1

Case Concerns

- Relief staff did not review the communication log and did not know about Mary's history of falls.
- Staff did not complete a body check after Mary's fall, document the fall, or alert nursing staff about it.

- Staff did not ask Mary if they were hurt. Although Mary is primarily non-verbal, they may have been able to indicate if they felt any pain or point to a body part that hurt.
- Staff did not treat Mary with respect when they teased Mary about the fall.
- There were no other body checks documented for Mary in the days following their fall, so staff were not aware of the bruise on Mary's knee.

Body Checks - 2

Case Concerns

- Staff did not complete and document body checks as required by Henry's plans of care.
- The body check forms that were completed were either incomplete, or the staff's handwriting was hard to read.
- The body check forms were not routinely reviewed by a manager or a nurse, so missing, incomplete, or illegible documentation could not be addressed in a timely manner.
- The body check forms were not routinely reviewed to identify trends, concerns, or systemic issues.

Body Checks - 3

Case Concerns

- Though Kareem required "line of sight" supervision with staff within an arm's length proximity at all times, no one knew how or when Kareem fractured their rib.
- Body checks for Kareem were not completed on each shift as required.
- Body checks were completed while Kareem remained clothed, so staff did not see their bruise.
- Body check documentation was not consistent. Some staff marked the bruise as "other," and some marked the bruise as "old."
- The body check forms were not routinely reviewed to identify missing documentation, trends, concerns, or systemic issues.

Body Checks - 4

Case Concerns

- Staff did not demonstrate sensitivity to Alyssa's apprehension about the body check, which led to an increase in Alyssa's agitation and Alyssa needing a PRN medication.
- Staff did not attempt to contact the nurse to come see Alyssa or reassure them that their privacy and dignity would be respected during the body check process.
- Staff were not trained on what to do when a person refuses a body check.

Body Checks - 5

Case Concerns

- Lucas used their personal cell phone to take a picture of Sean.
- Lucas texted a photo of Sean to their co-worker.
- Sean's bruise was not documented on any body check forms.
- Once Lucas discovered the bruise, they did not document it on a body check form, complete an occurrence report, or notify a supervisor of the bruise.

Caregiver Fatigue - 1

Case Concerns

- There was no debriefing following the physical intervention with the person who would have identified that Brandon was injured.
- Brandon did not report their injury to the agency.
- Brandon did not practice self-care by taking the recommended time off.
- Brandon took prescription medication while they were working that could cause drowsiness.
- Brandon's decision to "power through" and keep working despite having an injury that required medication put people at risk.

Caregiver Fatigue - 2

Case Concerns

- Donna may have been given too much responsibility to work their shifts while also orienting new employees.
- Donna was fatigued but did not let anyone know or ask for help.
- Donna's fatigue led them to ask a new employee to complete rounds before that employee's 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.

Caregiver Fatigue - 3

Case Concerns

- Trevor did not feel comfortable saying no to the manager's request to work, even though they knew it would mean needing to stay awake later than usual.
- Because Trevor was tired, they rushed through the wheelchair securement process and forgot to lock the brakes on one of the people's wheelchairs.
- Trevor did not let anyone know they were tired or ask for help with the outing.

Caregiver Fatigue - 4

Case Concerns

- Victor was working too many hours between the two jobs.
- Victor was tired and distracted, forgot to give a person their medication, and failed to document the new medication in the person's medication record.

- Neither agency knew that Victor was working full-time hours at both agencies.

Caregiver Fatigue - 5

Case Concerns

- Amanda knowingly went to sleep when they were 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 they were tired or reach out for help to stay awake.

Choking Prevention - 1

Case Concerns

- When Sean transferred back to the behavioral health unit, their treatment plans were not updated to reflect the change in their dietary consistency or mealtime supervision requirements.
- The batteries on the portable suction machine had expired, and there was no extension cord on the crash cart.
- Staff were not aware that people often attempt to flee or leave staff supervision when choking.
- Staff should not offer water to anyone who is coughing excessively or choking.
- The response to the “code blue” was chaotic and disorganized because the hospital did not conduct mock or practice codes with staff.

Choking Prevention - 2

Case Concerns

- Alanna gave food to Ian and Steve while they were still in the vehicle, which was against agency policy.
- Alanna could not supervise Steve while they were eating since Alanna was driving.
- Alanna did not immediately pull over as soon as they saw that Steve was in distress.
- Neither Alanna nor Vaughan administered abdominal thrusts to Steve.

Choking Prevention - 3

Case Concerns

- Mateo’s lunch was not modified correctly to the required pureed consistency.
- Though staff put the food in a blender, they did not check it to ensure all of the food was pureed.
- There was no process at the day program to check Mateo’s lunch to ensure it was prepared to the correct consistency.

- Several staff members at the day program took their lunch breaks at the same time that people had lunch, so there were not enough staff members in the lunchroom to supervise people while they ate.
- Although Mateo took their lunch box from the refrigerator, there was no one supervising to make sure Mateo took the correct lunch box.

Choking Prevention - 4

Case Concerns

- Liam was still groggy from the sedation when they were given food.
- Penny left Liam unsupervised while Liam was eating.
- There was no process in place to modify Liam's food or beverage consistency following their extensive dental work.
- Penny panicked when Liam choked and did not provide any interventions.

Choking Prevention - 5

Case Concerns

- Lei failed to provide the required supervision to Maya.
- Although Lei was assigned to supervise Maya, they were also assigned other tasks like cleaning the dining room table, which impacted their ability to supervise Maya.
- There was no lid on the trash can nor was there a practice to remove the trash immediately after the meal.
- Staff left the keys to the refrigerator and pantry locks in the locks instead of in the staff office.

Choking/Responding to Medical Emergencies

Case Concerns

- The manager assigned Melissa to make dinner, although it was Melissa's first shift at the group home.
- Melissa was not formally trained on the dining consistencies required by people receiving services.
- Melissa did not cut Jacob's spaghetti into ½ inch pieces. Staff did not intervene when Jacob continued to eat their food after they choked.
- Sonia called the nurse rather than 911 when the person was choking.
- The nurse instructed Sonia to keep an eye on the person, rather than instructing them to bring the person to the hospital or to see a doctor.
- Staff were not aware that choking is an emergency and to call 911 before calling the nurse.

Contraband/Searches – 1

Case Concerns

- Sarah was not properly trained on the program's policies and procedures prior to being assigned to work at the program.
- Sarah did not search the person and their belongings, in accordance with policy, upon the person's re-entry into the facility with a delivery bag.
- Sarah could not initially reach Nicole and did not attempt to call other management or leadership or seek assistance from Jonathan, who was facilitating a group.
- Nicole's voicemail box was full therefore Sarah could not leave a voicemail for Nicole.
- Sarah delayed administering Narcan and calling 911 as they waited to talk with Nicole before taking action.

Contraband/Searches – 2

Case Concerns

- Stacey violated facility policies when they gave Megan a cellphone.
- Stacey failed to maintain professional boundaries with Megan when they gave Megan a phone and allowed Megan to ship items from Amazon to their house and brought prohibited items onto the unit for Megan.
- Staff were not adhering to and/or were not conducting thorough room searches as they did not observe and/or confiscate contraband from Megan's room.

Contraband/Searches – 3

Case Concerns

- Despite the youth's risks, only one staff member was present/supervising them during the transition, which allowed an opportunity for them to elope.
- Staff did not search Stephen or Lauren upon their return to the program.
- Damion waited 20 minutes after hearing giggling and observing movement between Stephen and Lauren's rooms before checking on them, during which time they consumed the alcohol they had stolen from the store.

Effective Medical Care – 1

Case Concerns

- Staff did not contact nursing when Monique refused their dinner, and their gait appeared unsteady.
- Staff did not contact the nurse or alert anyone else when Monique did not respond to their name being called.
- Staff did not initiate CPR when they discovered Monique was unresponsive; staff waited for emergency personnel to arrive.

Effective Medical Care – 2

Case Concerns

- Sierra did not tell anyone about the call from the day program or document it in the communication log or in another location where staff would read it.
- The day program nurse did not communicate with the residential nurse regarding Kevin's injury.
- The staff who brought Kevin home from the day program did not tell any staff at the residence about Kevin's injury.
- Staff did not document the bruising on Kevin's arm or alert the RN as soon as they noticed it.

Effective Medical Care – 3

Case Concerns

- The RN did not visit Ana in the hospital or participate in their discharge planning meeting and was not familiar with all of Ana's needs.
- Ana was discharged from the hospital with no prescription for pain medication.
- Staff did not receive face-to-face training from the RN on Ana's medical care plans.
- Staff had to reach out to the RN multiple times regarding Ana's pain before the RN contacted Ana's doctor to request medication to manage Ana's pain.
- Although Ana had a terminal diagnosis, they were not provided with hospice supports or palliative care.

Effective Medical Care – 4

Case Concerns

- Staff assumed that Paul's slurring and unsteadiness were due to drug or alcohol use and did not seek immediate medical assistance.
- Paul took their evening medications as usual. Still, neither they nor the staff alerted a supervisor or contacted Paul's primary care physician to determine whether it was safe for them to take their medications, given the suspicion that they had used drugs or alcohol.
- Staff did not monitor Paul for safety during the overnight hours.

Environmental Safety

Case Concerns

- Staff did not notify the residential supervisor when maintenance did not come to repair the boiler.
- Staff did not notify the residential supervisor again to inform them that the residents indicated they were cold.
- The residential supervisor did not follow up with staff or maintenance to determine whether the boiler was repaired.

- Staff did not document the date, time, and temperature in the residence as required.

Falls - 1

Case Concerns

- Lora did not assist Bernadette when they were asked for help.
- Lora moved Bernadette after their fall before contacting on-call administrators or nurses to ask for guidance and report the fall.
- Bernadette had not been screened for osteoporosis prior to their Emergency Room visit.
- Bernadette's paid circles of support did not discuss their concerns about Bernadette, and no preventative care measures were implemented.

Falls - 2

Case Concerns

- Tim moved Nellie before seeking medical care for them.
- After moving Nellie, Tim did not seek medical care for them.
- Tim did not notify anyone that Nellie had fallen.
- Tim failed to document Nellie's fall in the General Event Report and the Fall Chart for Nellie.
- Tim was unaware of the agency's fall protocol or procedures.

Falls - 3

Case Concerns

- Tom transferred Charles alone instead of using two staff as required.
- Rather than bringing the lift to the bathroom and then using it to transfer Charles out of their wheelchair, Tom transferred Charles out of their wheelchair in the bedroom and then pushed Charles down the hallway in the lift.
- Tom did not document Charles's fall or their body check, and no one informed the nurse that Charles fell from the lift.
- Charles was moved following a fall where they hit their head.
- Charles was not put on any head injury protocols following the fall.

Fire Safety - 1

Case Concerns

- Amir left the totes by the back door instead of bringing them to the basement.
- Because the totes blocked the back door, people were unable to exit during a fire drill.
- People did not know how to react when the exit was blocked and did not automatically look for another exit, which should be routinely practiced during fire drills.

Fire Safety - 2

Case Concerns

- Trevor violated agency policy and was distracted on their personal cellphone while cooking dinner.
- Trevor and John unhooked the fire alarm.
- Trevor and John did not evacuate the residence.
- Trevor and John did not contact 911.
- Trevor and John did not report the incident to management.
- Trevor and John's decision not to evacuate resulted in a person not wanting to evacuate during another incident.

Heat Illness

Case Concerns

- The agency failed to ensure Sam was trained on the policy and procedure regarding sun safety.
- Sam did not apply sunblock to Dean, change them into lightweight clothes, or ensure they would remain out of direct sunlight.
- Sam became distracted and did not provide 15-minute checks to Dean.
- Sam did not notify nursing of Dean's extended exposure to the sun or their reddened skin.
- Sam did not offer Dean a drink or take any actions to ensure Dean was comfortable and feeling okay after bringing them to their room to lie down.
- Sam did not complete 15-minute checks of Dean once they were inside and therefore, did not notice that Dean was not acting or feeling well.

Hot Water Safety

Case Concerns

- Trevor told Steven they would meet them in the bathroom to help them with their shower, but did not meet Steven in the bathroom until 30 minutes later.
- Trevor did not check on Steven every 15 minutes as required in Steven's plans of care.
- Trevor told Steven to set up their shower, although Steven's plans outlined that they needed staff's assistance to do so.
- Trevor contacted their wife to ask what to do if someone was burned, and the nurse was not contacted to be alerted of the person's injury until the next day.

Incident Management - 1

Case Concerns

- Darryl requested Jessie's phone number.
- The residence counselor did not report Jessie's allegation to anyone.
- The residence counselor did not follow up with Jessie to see if they had any other concerns about Darryl.

- The agency did not take immediate action to protect Jessie because the allegations were not reported.

Incident Management - 2

Case Concerns

- The manager of the residential center did not report Theo's allegation to anyone.
- Donnie was moved to another unit where they still had access to youth and engaged in another act of physical abuse.
- Theo did not receive any medical follow-up related to their allegation.

Incident Management - 3

Case Concerns

- No one was notified that Courtney choked and required back blows to dislodge food.
- The program did not have adequate staffing to complete necessary morning tasks.
- Staff did not contact administration to let them know the program was understaffed.
- Staff did not prepare Courtney's food in accordance with their dietary plan.

Incident Management - 4

Case Concerns

- The Jones Street residence did not have adequate staffing or supervision.
- There was not enough food in the residence to feed everyone a balanced, nutritious meal.
- Mira was kept in their room so staff would not have to supervise them.
- Xiomara contacted the corporate compliance office but did not also report the incident to the Justice Center.
- Staff from the corporate compliance office did not report the incident to the Justice Center.

Intestinal Obstruction

Case Concerns

- Staff did not recognize that changes in John's behavior could indicate that they were in pain and required medical attention.
- Staff did not notify nursing of changes in John's behaviors that were possible non-verbal cues indicating constipation.
- Staff were unfamiliar with or not adhering to John's bowel management protocol.
- Staff were not completing the required documentation for John's bowel movement management.
- Staff did not notify nursing when John did not have a bowel movement in a 48-hour period.

- There was no oversight or quality assurance to ensure staff completion of documentation and adherence to John's bowel movement protocol.

LGBTQIA+ Supports - 1

Case Concerns

- Staff were not trained on Jamie's updated needs, including their preferred restroom.
- Staff were not trained on how to best support Jamie when other people used the wrong pronouns.
- The staff used the wrong pronouns and misgendered Jamie.
- Kyle yelled out to Jamie in front of other people and community members, causing Jamie to feel upset.

LGBTQIA+ Supports - 2

Case Concerns

- John did not follow up with Mildred and Oliver to ensure Tae's rights were respected.
- Tae asked for help from John to make the discrimination stop, but it continued.
- Supports and education for staff and people living with Tae regarding the trans community was not made a priority by Tae's team.

Mechanical Lift

Case Concerns

- Staff were not trained on whom to contact if a mechanical lift stopped working.
- Jake did not inform staff whom they should contact for assistance while Jake was on vacation.
- Staff physically transferred Deb for one week, although their training instructed them that they could only do so in the event of an emergency.
- Staff did not alert anyone that Deb was crying after they were transferred.

Medical Emergencies - 1

Case Concerns

- Janice did not identify changes in Barry's behavior that indicated they were unwell and needed medical attention. Janice did not take Barry's vital signs when they indicated their stomach hurt, and did not notify a nurse that Barry was complaining of stomach pain.
- Although Janice checked on Barry at 9:00 p.m., they did not check them for signs of life, even though Barry had indicated that they did not feel well.
- Gregor did not immediately contact 911 when they realized that Barry did not have a pulse.
- Janice called the house supervisor instead of contacting 911 when they realized Barry did not have a pulse.

- Janice and Gregor began CPR while Barry was lying in their bed rather than moving them to a hard, flat surface.

Medical Emergencies - 2

Case Concerns

- Laureen did not tell the RN that James was complaining of stomach pain.
- Laureen did not tell the RN that they were waiting for another staff member 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 them a shower and changed their 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 to the ER.

Medical Emergencies - 3

Case Concerns

- Staff did not check the hallway bathroom for contraband prior to Amelia entering the room.
- Staff did not complete a search of Amelia and their belongings when they were re-admitted to the inpatient unit.
- The Narcan kit was behind a locked cabinet and had expired.
- Staff did not administer the expired Narcan, causing a delay in a potentially lifesaving intervention.
- Staff did not call for a code for a medical response.
- Treatment was delayed due to too many staff members attempting to help. No coordinated response efforts were made to ensure that only essential staff responded.

Medical Emergencies - 4

Case Concerns

- There was a delay in the 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-minute safety checks for Georgiana as required or transfer the responsibility to conduct the checks to another staff member when they left the unit.
- Nancy did not let anyone know that they were experiencing difficulty at home that might impact their ability to provide supervision to people on the unit.
- The hospital did not have a policy or practice in place to monitor the completion of safety checks.

Medication Management/Administration - 1

Case Concerns

- John did not introduce themselves to the people they were unfamiliar with and find out their names.
- John did not ask for any assistance in finding the correct person to give the medications to.
- John handed one person's medications to the wrong person.
- John did not report the error to their supervisor or nursing staff.

Medication Management/Administration - 2

Case Concerns

- Paul was in a hurry and not solely focused on administering medications.
- Paul did not complete the medication logs to reflect that they administered the morning medications.
- The Post-it note about medications was left in a public space rather than in a communication or shift log, and there was no change of shift discussion between the outgoing staff and incoming staff.
- Ronnie first contacted their supervisor about the medication error instead of the nurse.

Medication Management/Administration - 3

Case Concerns

- The program nurse did not update Charlee's standing orders to remove ibuprofen and add an alternate pain reliever that is safe to take with lithium.
- Charlee was not educated on what over-the-counter medications they could take with lithium or what medications they should avoid.
- Isabella assumed Charlee's erratic behavior was symptomatic of their psychiatric diagnosis despite Charlee taking a new medication.
- Though Charlee had been admitted to the psychiatric unit for mood instability and was prescribed a new medication, there was no change to the supports provided to Charlee to monitor their adjustment to the medication.

Overdose Prevention

Case Concerns

- Taylor did not immediately call 911 when they suspected that Jane was overdosing.
- The Narcan was kept in a locked staff office and was not easily accessible.
- The supervisor locked the office and took the keys with them when they went to pick up pizza, and did not provide staff with a way to access the Narcan.

Person-Centered Care

Case Concerns

- Nick was not offered a key to the refrigerator when they moved into the group home.
- Staff locked the refrigerator even though the person who required it to be locked was not at home.
- Nick was scolded for becoming frustrated over a situation that could have been avoided if the refrigerator had been left unlocked, as noted in the plans of care, or if Nick had a key.

Pica - 1

Case Concerns

- Linda did not recognize that the holiday decorations were a pica risk.
- Linda failed to complete the required pica sweep.
- Linda did not remain within arm's length of Bob.
- Linda was watching television instead of Bob.
- Linda either did not know the agency policy for whom to notify during a medical emergency or forgot the policy and notified the residential manager of the incident before notifying the nurse.
- Linda called the residential nurse rather than using the after-hours on-call system to get immediate nursing support.
- The nurse did not immediately respond to Linda's phone call, and Linda did not attempt to reach another nurse or administrator when they did not receive a response from the nurse.

Pica - 2

Case Concerns

- A relief staff member who was not familiar with Tina was assigned to provide them with enhanced supervision and support.
- A relief staff member was assigned to supervise Tina, although there were three other staff members working who were more familiar with the residence.
- Gail was not provided enough time to review the plans of care for the people at the residence, as well as the house-specific safety plans, before Tina returned home.
- Pica sweeps were not completed before Tina returned home.
- Gail did not provide arm's length supervision to Tina.
- An unknown staff member left latex gloves, a known pica hazard, unattended on the counter.

Professional Boundaries - 1

Case Concerns

- Carlita is sharing pictures without the consent of the people in care, their family, or a legal guardian.
- Fellow staff members have told Carlita that they are not adhering to an agency policy about the use of social media, but Carlita ignores them.

- Carlita thinks that only using people's first names and posting on social media after their shift has ended is okay.

Professional Boundaries - 2

Case Concerns

- Matt did not maintain professional boundaries when they spent extra time with Brandon and provided additional one-to-one support during transitions.
- Matt received a monetary gift and did not report it to their supervisor as required by policy.
- Because Matt accepted the monetary gift, the family became upset when they were not given preferential treatment.
- Matt has compromised clinical ethical standards and agency policy, putting their reputation at risk.

Professional Boundaries - 3

Case Concerns

- Rob violated agency policy when they gave Rebecca their personal phone number and did not encourage them to use the approved methods for reaching out for help when needed.
- Rob also violated agency policy when they took Rebecca outside with them and had unsupervised contact while taking out the garbage.
- Rob failed to maintain professional boundaries when they texted with Rebecca every night.
- Rob also failed to maintain professional boundaries when they told Rebecca they were interested in a romantic relationship.

Reducing Restraints - 1

Case Concerns

- Kyle got into a power struggle with Jacob over the extra books in Jacob's room.
- Kyle escalated the situation by making comments about Jacob's mother and verbally threatening Jacob.
- Kyle initiated a restraint, though there was no reason to do so.
- The supervisor who intervened did not recognize that Kyle was taking things personally and separate Kyle from Jacob.

Reducing Restraints - 2

Case Concerns

- There was no attempt by staff to de-escalate the situation before initiating a restraint.
- Staff grabbed Tom by the neck, from behind, which was not consistent with Tom's crisis management plan.
- Staff applied pressure to Tom's back and neck, which increased the risk of injury.

- Staff deliberately twisted Tom's foot and applied pressure to the joint in order to subdue Tom.
- Tom was bruised on their head and face as a result of the bad restraint.
- There was no debriefing after the restraint to discuss the incident and what went wrong.

Reducing Restraints - 3

Case Concerns

- There was insufficient staffing to meet the needs of the people in the home.
- The supervisor was not available to support the staff and did not return Wanda's call.
- Wanda locked the wheels on people's wheelchairs for staff convenience.

Reducing Restraints - 4

Case Concerns

- The nurse was not respectful or empathetic to Sheila when Sheila said they were hungry.
- There were no prevention or coping strategies offered to support Sheila when they were upset.
- There were no alternative de-escalation techniques used with Sheila prior to the administration of the IV medication.
- Though Sheila had already calmed down due to the intravenous medication, they were placed in mechanical restraints.

Repositioning - 1

Case Concerns

- Staff did not report or document the pressure ulcers they observed on Nick's elbows.
- Staff were dressing Nick's wounds without appropriate training.
- Staff were not thoroughly completing repositioning logs.
- The Residential Manager did not indicate whether there was any follow-up to address the missing entries on the repositioning logs.
- Staff did not adequately communicate with the nurse or document their communication with the nurse.
- The nurse assumed the location of the person's wounds and did not conduct an evaluation of the person.

Repositioning – 2

Case Concerns

- The nurse did not update Ryan's plans of care or treatment records to reflect that Ryan had pressure sores.

- Not all staff received training from the nurse about Ryan's pressure sores and their repositioning requirements, so Ryan was not repositioned as required.
- Staff were not trained on the requirements to document repositioning for Ryan.
- Staff did not notify the nurse when the pressure sores on Ryan appeared worse.

Safety Awareness- "Stranger Danger"

Case Concerns

- Jeremy did not ask the man for identification to verify that they were from the electric company
- Jeremy invited the man into the home despite not knowing who they were.
- Jeremy left the man alone with the people in the home when they went to the staff office to call the administrator on call.

Self-Neglect

Case Concerns

- Walter did not receive any additional supports or interventions when they refused to take their medications or keep the apartment clean.
- Lilliana did not notify the nurse or supervisor that Walter was not taking their medication.
- After Walter did not answer the door the first time, Liliana did not try to call Walter to ensure they were okay or alert anyone that Walter had not come to the door.

SEPSIS

Case Concerns

- Staff did not inform the nurse of Kristen's initial symptoms.
- Staff provided Kristen with multiple doses of medication without contacting nursing for approval.
- Although staff were monitoring Kristen's symptoms, they did not inform the nurse that their symptoms did not improve after taking medication, appeared to be worsening, and/or seek additional guidance.

Social Media - 1

Case Concerns

- People were photographed during an outing, though staff did not ask for their consent or the consent of their family or guardians.
- Callum shared pictures of people on their personal social media account.
- Callum accepted "friend requests" from people they provided support to and sent private messages back and forth with a person.
- Callum was not trained on or aware of the agency's social media policy.
- Maura did not intervene with Callum when they took photos of people and posted them on social media or report the action to their supervisor.

Social Media - 2

Case Concerns

- The agency failed to develop a policy regarding cellphone or social media use and the parameters or limitations regarding connecting with a person before or after their discharge.
- Joe connected with Richard on social media before they were discharged from the program.
- Joe invited Richard to their home for lunch.
- Joe purchased a cellphone for Richard.

Staffing Assignments

Case Concerns

- Though two people identified that they were not feeling well enough to attend program, no one notified the nurse.
- The staff who left the residence to bring people to program did not communicate with the residential manager to let them know they would need to supervise the two people who remained at home.
- The assignment sheet was not updated to reflect that two people were remaining at home or to assign the residential manager to provide supervision and support to the two people.
- The assignment sheet did not include a section to document staff assignments when people remained at home instead of attending day programming.
- The residential manager did not complete a sweep of the home to ensure everyone was gone before they left to run their errand.

Suicide Prevention

Case Concerns

- Nikki failed to immediately update Carlos' electronic health record after the psychiatrist appointment to include the psychiatrist's recommendations and changes to Carlos' supervision level.
- Josh failed to inform the next shift that Carlos required an enhanced level of supervision.
- There was a delay in the implementation of the locked sharps and enhanced supervision.

Transferring Supervision

Case Concerns

- Julie did not physically hand the "hand-off bracelet" to Yvonne or otherwise confirm that Yvonne would supervise Michael.
- Staff failed to communicate thoroughly to see if another staff member could assist Daryl to ensure Michael's supervision requirements were maintained.
- Michael had an unwitnessed fall due to a lack of adequate supervision.

Vacation/Outing Planning

Case Concerns

- Due to the supervision requirements for people receiving services, a second staff member was needed for the outing.
- Neither the residence, Administrator On Duty, nor Behaviorist On-Call responded to Gretchen's phone call.
- Gretchen left the people alone in the agency van while looking for their housemate, breaching their level of supervision.

Vehicle Safety - 1

Case Concerns

- The agency did not train Katy on the agency's transportation policy.
- Katy left Winston alone in the vehicle.
- Katy was not trained on the agency's Absent Without Consent policy or care plans for Nick and Winston.
- Katy did not immediately notify the police upon discovery that Winston was missing.

Vehicle Safety - 2

Case Concerns

- Rosita started the vehicle and left it unlocked and unattended.
- Terry told the people that they could go outside to wait, but did not inform the other staff.
- No staff were outside with the people receiving services.

Vehicle Safety – 3

Case Concerns

- Patty did not do a head count when people got on or off of the bus.
- No documentation or checklists were completed to confirm who was present on the bus.
- Carl did not walk through the bus to complete a thorough visual check of the entire bus at drop off.
- Neither Carl nor Patty completed a final check of the bus before leaving their shift.
- The day program did not have a formal process to track people's attendance at the program.
- The day program did not notice that Ann was not present for an hour.
- Time was lost while staff searched the entire day program building for Ann before someone contacted the residence, and then the bus garage.

Water Safety - 1

Case Concerns

- There were only two staff members to supervise five people receiving services, with one of those people requiring 1:1 supervision when swimming.
- Staff supervision assignments were not completed before people receiving services entered the water.
- Kyle did not stay with Gerald and provide 1:1 supervision until Gerald reached the shore and Nancy began to provide supervision.

Water Safety - 2

Case Concerns

- Nikolai was alone in the bathtub with a new staff member who was shadowing.
- Leona was not given directions on how to keep Nikolai safe during Rodney's absence.
- Rodney went to retrieve Nikolai's pajamas instead of having Leona retrieve them.
- Nikolai's dignity and emotional well-being could have been compromised when trusted staff left them alone with someone unfamiliar.

Wheelchair Securement - 1

Case Concerns

- Staff did not secure Jenny using the vehicle's lap and shoulder seatbelt.
- Staff did not secure Jenny's walker to prevent it from injuring Jenny or the staff during the accident.
- Jenny's individual safeguards did not direct staff to use wheelchair occupant and restraint systems, only to ensure they wore their seatbelt.

Wheelchair Securement - 2

Case Concerns

- Staff was not familiar with the new protocols in Sheila's service plan and did not have Sheila use their wheelchair on the outing to get groceries.
- Sheila stood on the van's wheelchair platform lift while it was being lowered to the ground.
- Staff training relied on a "read and sign" method of training rather than interactive training.
- Agency policy did not address the use of the platform lift by people who receive services who were ambulatory.

Wheelchair Securement - 3

Case Concerns

- The driver did not ensure the platform lift was raised after Vicki's housemate exited the van.

- The driver did not have Vicki facing forward as they were exiting the van, so the driver's view of the lift was blocked.

Wheelchair Securement - 4

Case Concerns

- Ken and their wheelchair were not properly secured.
- The transportation provider did not report the incident to anyone.
- Ken did not receive any medical attention after their fall.
- The transportation provider was not familiar with the safeguards for transportation in Ken's service plans.

RESOURCES

Click on the link below to visit our Cross Agency Prevention Sharing Initiative (CAPSI) resource repository. The document contains links to resources provided by the state oversight agencies (SOAs) and the Justice Center.

ACCESS RESOURCE