

## Causes and Contributing Factors & Prevention Planning



MUI Registry Unit

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## Defining Cause and Contributing Factors (C.F.s)

According to Dan Guzman

**Cause** is a condition that produces an effect; eliminating a cause(s) will eliminate the effect.

**Contributing Factor(s)** is a condition that influences the effect by increasing its likelihood, accelerating the effect in time, affecting severity of the consequences, etc.; eliminating a contributing factor(s) won't eliminate the effect

Wikipedia defines **Root cause analysis (RCA)** as a method of [problem solving](#) that tries to identify the [root causes](#) of faults or problems. A root cause is a cause that once removed from the problem fault sequence, prevents the final undesirable event from recurring.

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## Rule References

### For Major Unusual Incidents

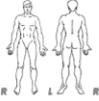
**O.A.C. 5123:2-17-02(K)(2):** The individual's team, including the county board and provider, shall collaborate on the development of preventive measures to address the causes and contributing factors to the major unusual incident. The team members shall jointly determine what constitutes reasonable steps necessary to prevent the recurrence of major unusual incidents. If there is no service and support administrator, individual team, qualified intellectual disability professional, or agency provider involved with the individual, a county board designee shall ensure that preventive measures as are reasonably possible are fully implemented.

### For Unusual Incidents

**O.A.C. 5123:2-17-03(M)(2)(d):** Requires the agency provider to investigate unusual incidents, identify the cause and contributing factors when applicable, and develop preventive measures to protect the health and welfare of any at-risk individuals.

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## Incident Report Form

Provider Name & Address: _____ _____ _____		Additional Information or Administrative Follow-Up: A. Further Medical Follow-Up: _____ B. Administrative Action: _____ Signature: _____ Title: _____ Date: _____	
Individual's Name: Address: _____ DOB: _____ City/County: _____		Body Part Injured: <input type="checkbox"/> Head or Face <input type="checkbox"/> Neck or Chest <input type="checkbox"/> Back or Neck <input type="checkbox"/> Stomach <input type="checkbox"/> Hand or Arm <input type="checkbox"/> Skin or Surface <input type="checkbox"/> Feet or Leg <input type="checkbox"/> Other	
Date of Incident: _____ Time of Incident: _____ Address: _____ Location of Incident (Home in bathroom, at the mall, school, at work) Description of Incident (What, where, when?) _____ _____ Injury - Describe type & location: _____ Immediate Action to Ensure Health & Welfare of Individual: _____			
Name of PPI(s): _____ Relationship to Individual: _____ Witnesses to Incident: _____ Other(s) Involved: _____ Role of Individual: _____ Gender: _____ Age: _____ SSA (required for Independent Placement): _____ Location of Current Residence: _____ Staff or Family (using the individual's name & responsible for the individual's care): _____ <input type="checkbox"/> If Home Safety Number, jurisdiction and contact information required for Law Enforcement OPIA (name and contact information required for change services): _____ County Board: _____ Administrator (required for ICF): _____ Incident Number (if applicable): _____		Causes and Contributing Factors: _____ Preventive measures: (For Provider's internal use) _____	
Administrator Review: _____ Date: _____		Administrator Review: _____ Date: _____	

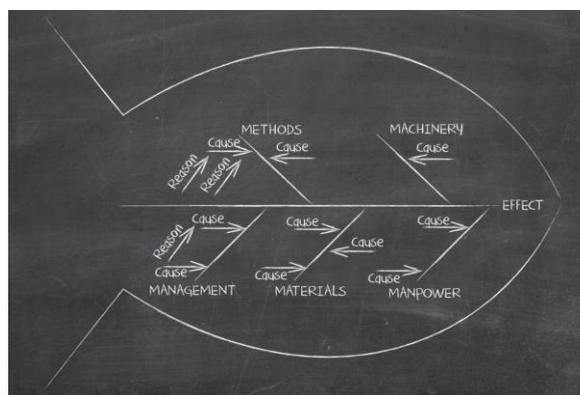
This incident report is located in the Health and Safety Toolkit and contains space for immediate actions, causes/contributing factors and preventative measures. This form can be found <http://dodd.ohio.gov>

## The Process



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## Fishbone Diagram

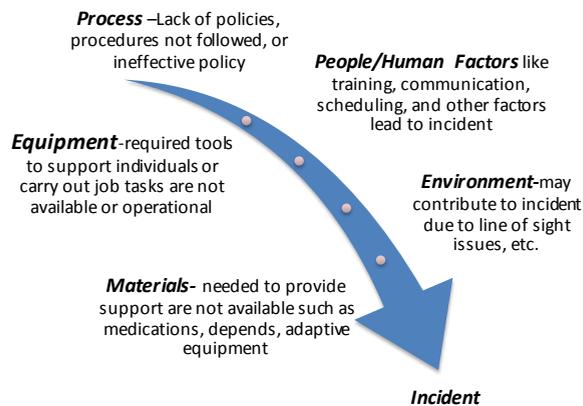


The tool called a “fishbone diagram” because it takes the shape of a fish. The effect (the problem) is the “head” of the fish. Leading from this is the “backbone” and connected to this are the “main bones” which represent major categories of causes. Commonly used categories include: People, Process (or methods), Equipment, Materials and the Environment. These categories are only suggestions; you can use any major categories the team deems appropriate.

-Lean Ohio

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## Identifying Causes and Contributing Factors



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## Problem Solving

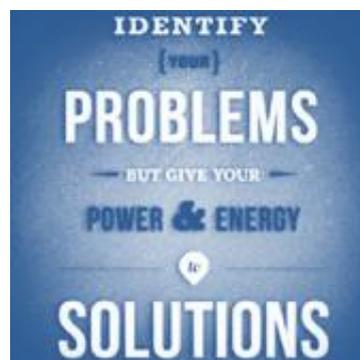
*National Center for Patient Safety* stresses that when describing why an event occurred, you should show the link between cause and effect. Negative descriptions should be avoided and replaced with a more accurate and clear description.

Examples:

Wrong: Poorly Trained Nurse

Correct: The level of the nurses' training increased the likelihood that he misunderstood the IV pump controls which lead to missing steps in programming of dose and rate.

<http://www.patientsafety.gov>



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## Breaking Down a Choking Incident

Human	Process	Environment	Equipment
<ul style="list-style-type: none"> <li>• Staff not trained on individual's needs</li> <li>• Supervisor did not update staff on change in diet orders</li> <li>• Misunderstanding of what mechanical soft meant</li> <li>• 1:1 Staff was not available to sit with individual at lunch as required by plan</li> <li>• Individual refused to have his/her food per diet</li> <li>• Substitute Staff</li> <li>• Peers giving individual their lunch items</li> <li>• Individual getting items from vending machines</li> </ul>	<ul style="list-style-type: none"> <li>• There is no policy in place to inform staff of diet changes</li> <li>• ISP Addendum was not available to staff</li> <li>• No listing of which individual uses which adaptive equipment</li> <li>• No process for home and work staff to document and communicate changes in orders</li> </ul>	<ul style="list-style-type: none"> <li>• Staff can not visually monitor individual due to assisting in another area of home</li> <li>• Work area is large making it difficult to visually monitor all individuals</li> </ul>	<ul style="list-style-type: none"> <li>• Food Processor was not available at the restaurant</li> <li>• Food was not prepared properly at home and Day Program does not have a food processor</li> <li>• Adaptive Equipment (nosey cup, spoon, high sided plate) are not available at the work</li> <li>• Adaptive Equipment was lost and never replaced</li> <li>• The work provider was not supplied with the adaptive equipment</li> </ul>

## Causes and Contributing Factors Examples

MUI	Human	Process	Environment	Equipment
<b>NEGLECT</b>	<p><b>Training</b></p> <ul style="list-style-type: none"> <li>• <i>Transportation staff are not aware that individual cannot be home alone</i></li> <li>• <i>Staff that took individual on medical appointment did not have necessary information and was not able to explain individual's past medical history.</i></li> <li>• <i>Scheduled staff is not Medication Administration trained as required and so medication is not administered</i></li> </ul> <p><b>Scheduling</b></p> <ul style="list-style-type: none"> <li>• <i>No staff scheduled, Staff doesn't show or staff leaves</i></li> <li>• <i>Not two staff to do lift as required</i></li> <li>• <i>There was a traffic accident and scheduled staff was running 15 minutes late for shift</i></li> <li>• <i>Staff scheduled to take individual to the doctors did not know them well and could not provide a good medical history, this contributed to the person not getting adequate care</i></li> <li>• <i>Staff was rushing around to complete all job duties and passed medication to wrong individual</i></li> <li>• <i>Staff Turn Over</i></li> </ul>	<ul style="list-style-type: none"> <li>• There is no clear instruction on who to contact if you cannot reach your supervisor</li> <li>• Staff are instructed to call supervisor prior to seeking emergency medical care</li> <li>• Bus driver did not follow procedure for checking bus and left child on bus</li> <li>• There are many staff assigned to a group and so it is believed another staff person is caring for that person</li> </ul>	<ul style="list-style-type: none"> <li>• Individual's family home has been condemned and they are still living there</li> <li>• There was no available mat which was to be placed on the floor to prevent injury from falling</li> <li>• Door Alarms that are outlined in the plan are not turned on or not operational</li> <li>• Medications are not secure per plan</li> <li>• Individuals home is not accessible and they cannot safely evacuate</li> </ul>	<ul style="list-style-type: none"> <li>• Tie Downs on van are not operational</li> <li>• Hoyer Lift is broken</li> <li>• Wheel chair is not working</li> <li>• Lights are bumed out in hallway making it difficult to maneuver</li> <li>• Harness/Seatbelt was not fastened</li> <li>• Food Processor is not available</li> </ul>

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## Causes and Contributing Factors Examples

MUI	Human	Process	Environment	Equipment
<b>NEGLECT</b>	<p><b>Staff Factors</b></p> <ul style="list-style-type: none"> <li>• Staff fell asleep on their awake overnight because they had worked 20 consecutive hours</li> <li>• Staff works two-three jobs with little rest</li> <li>• Staff is not feeling well but came to work because no coverage</li> <li>• Staff is distracted; texting while driving, talking on cell phone, having personal issues</li> <li>• Staff is impaired</li> <li>• Driving Recklessly</li> <li>• Staff doesn't take action in a medical situation due to fear of doing something wrong</li> </ul> <p><b>Team Dynamics</b></p> <ul style="list-style-type: none"> <li>• Team did not address individual's supervision</li> <li>• Perceived lack of Management Support</li> <li>• Poor Judgment</li> <li>• Lack of Oversight by Management</li> <li>• Staff dislike each other</li> </ul> <p><b>Communication</b></p> <ul style="list-style-type: none"> <li>• <i>There was confusion about what the diet was supposed to be</i></li> <li>• <i>Language Barrier</i></li> <li>• <i>Family instructed staff to do something differently than plan states</i></li> </ul>	<ul style="list-style-type: none"> <li>• No agency limit on the amount of hours you can work in a row</li> <li>• No system in place to make sure that staff are appropriately reporting</li> <li>• Staff did not follow reporting policy</li> <li>• No reliable system to ensure that notifications from Day Program and Home staff are made.</li> <li>• Unclear what staff/natural supports are to provide</li> </ul>	<ul style="list-style-type: none"> <li>• Individual engages in hoarding behaviors, home is unsafe-no one acts on this information</li> <li>• Family home poses a health and safety risk due to animal feces, bugs, no running water, and unsanitary conditions.</li> </ul>	<ul style="list-style-type: none"> <li>• Bed Alarm was not utilized</li> <li>• Car seat not secured information</li> <li>• Back up wheelchair is not outfitted with a safety belt</li> </ul>

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## Causes and Contributing Factors Examples

MUI	Human	Process	Environment	Equipment
<b>MISAPPROPRIATION</b>	<ul style="list-style-type: none"> <li>• Individual's family is payee and has access to large lump sum payment with no oversight</li> <li>• Home Manager is well trusted and therefore no one sees need to provide additional oversight</li> <li>• Eight people have keys to the Individual's home</li> <li>• Family/Staff has addiction to medication and was taking from individual for personal use</li> <li>• Staff person was given debit card to shop for the individual</li> <li>• Several people have access to Food Stamp Card</li> <li>• Individual has lots of friends and family who come in and out of her home who have access to belongings</li> <li>• Individual wants staff to like them agrees to sell their Play Station for \$5.</li> </ul>	<ul style="list-style-type: none"> <li>• Home Manager is the only one with access to individual funds</li> <li>• There is no policy that large purchases are verified</li> <li>• There is no company policy to address what to do when a staff person separates from the agency and still has keys or access to individual's belongings/accounts</li> <li>• Agency doesn't have Code of Ethics that addresses borrowing funds or property from individuals</li> <li>• Narcotic Counts are not being conducted</li> <li>• No routine verification of individual funds</li> <li>• Change of address did not occur</li> </ul>	<ul style="list-style-type: none"> <li>• Individual's Personal records are all over the home and many people have access to them, placing them at risk for identity theft</li> <li>• Garage was often left unlocked</li> <li>• Money was left in an unlocked drawer in a desk at the Day Hab Site</li> <li>• Gift Cards were left on kitchen table and not secured</li> </ul>	<ul style="list-style-type: none"> <li>• I pad was always left out and so it went unnoticed when it went missing</li> <li>• Lock on Safe was broken</li> <li>• Key to lock box is kept on the refrigerator</li> </ul>

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## Causes and Contributing Factors Examples

MUI	Human	Process	Environment	Equipment
<b>ABUSE</b>	<ul style="list-style-type: none"> <li>Staff was overwhelmed by responsibilities</li> <li>History of Domestic Violence</li> <li>Abuser is impaired</li> <li>Staff are embarrassed when individual has an outburst in public</li> <li>Staff has worked 20 hours straight</li> <li>Control Issues</li> <li>Lack of value and positive culture training</li> <li>Abuser does not have empathy for the individual being served</li> <li>Individual has poor relationship with neighbors which leads to physical altercations</li> <li>Individual refuses to be "complainant"</li> </ul>	<ul style="list-style-type: none"> <li>No real mentoring or on the job shadowing</li> <li>Lack of reporting due to retaliation by co-workers</li> <li>Staff unclear who to call if they have a concern with their supervisor</li> <li>Agency doesn't have a solid system for supporting staff</li> </ul>	<ul style="list-style-type: none"> <li>Staff work by themselves and may feel isolated</li> <li>Staff works with a group of unhappy workers which has created a culture where people are constantly looking for the worst in each other</li> </ul>	<ul style="list-style-type: none"> <li>Wheel chair is not functioning which causes frustration</li> </ul>

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## Causes and Contributing Factors Examples

MUI	Human	Process	Environment	Equipment
<b>PEER TO PEER ACTS</b>	<p><b>Staff Factors</b></p> <ul style="list-style-type: none"> <li>Supervision level not followed</li> </ul> <p><b>Team Dynamics</b></p> <ul style="list-style-type: none"> <li>Staff have favorites</li> <li>Guardian does not want to address individual's sexuality or safe ways for individual to meet their sexual needs</li> </ul> <p><b>Training</b></p> <ul style="list-style-type: none"> <li>Behavior Plan Not Implemented</li> <li>Staff not Trained on Supervision</li> </ul> <p><b>Communication</b></p> <ul style="list-style-type: none"> <li>Individual is unable to communicate</li> <li>Team isn't aware of individual's history (stealing, offending or physical aggression)</li> </ul> <p><b>Individual Factors</b></p> <ul style="list-style-type: none"> <li>Roommates incompatible</li> <li>Individual may be trying to get attention from staff</li> <li>No appropriate ways to meet sexual needs.</li> <li>One of the individuals may have more family contact and this causes rift with roommate who does not.</li> <li>One individual is given items and gifts from family and these items may be taken from roommate.</li> <li>Lack of meaningful personal relationships</li> </ul>	<ul style="list-style-type: none"> <li>Change in Routine</li> <li>Provider does not have a procedure for reviewing incidents with staff (debriefing)</li> <li>There is no accurate/updated inventory and so items go missing are unnoticed</li> </ul>	<ul style="list-style-type: none"> <li>Peers live together, ride the bus together and work together</li> <li>Individual's belongings not secured</li> <li>Individual does not have opportunity to have alone time</li> </ul>	<ul style="list-style-type: none"> <li>Lack of Electronic Items; maybe 1 TV in the home</li> <li>Alarms not functional</li> <li>Staff do not test equipment to make sure it is functioning. I.e. batteries are not working and alarm not functioning</li> </ul>

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## Causes and Contributing Factors Examples

MUI	Human	Process	Environment	Equipment
<b>SIGNIFICANT INJURY</b>	<p><b>Staff Factors</b></p> <ul style="list-style-type: none"> <li>Staff rushing to get the individual somewhere</li> <li>Staff ask other individuals to help peer with walking and dressing</li> <li>Not providing level of support in kitchen or bath which results in burns</li> </ul> <p><b>Team Dynamics</b></p> <ul style="list-style-type: none"> <li>Staff may have own mobility issues or barriers that enable them to assist individuals</li> </ul> <p><b>Communication</b></p> <ul style="list-style-type: none"> <li>There is a lack of communication about what happened on previous shift</li> </ul> <p><b>Training</b></p> <ul style="list-style-type: none"> <li>Staff not trained on adaptive equipment which could lead to falls</li> <li>Not trained on level of assistance needed</li> </ul> <p><b>Individuals</b></p> <ul style="list-style-type: none"> <li>Individual refuse adaptive equipment such as helmet, walker, wheelchair, cane contributing to unsteady gait and higher risk for injury</li> <li>Individuals losing balance and vision due to aging or disability</li> </ul>	<ul style="list-style-type: none"> <li>There is no procedure of who is to clear walkways during inclement weather</li> <li>Agency does not link with OT and PTs to evaluate an individuals environment for safety</li> <li>Assessing individual needs i.e. need for bedrails, handrails, shower chair, lifts and other adaptive equipment</li> <li>Staff working do not call for assistance when someone has fallen and they cannot get person up. The individual is left lying on the floor for hours.</li> </ul>	<ul style="list-style-type: none"> <li>Low Lighting</li> <li>Change in Flooring that could cause trip hazards</li> <li>Rugs that slip easily</li> <li>Rain, snow, ice</li> <li>Walk way not clear</li> <li>Carrying objects while going down stairs that may limit visibility</li> <li>Not using hand rails</li> </ul>	<ul style="list-style-type: none"> <li>Adaptive Equipment not provided</li> <li>Bed or Chair Alarm malfunctioned</li> <li>Staff do not test equipment to make sure it is functioning. I.e. batteries are not working and alarm not functioning</li> <li>No anti-scald valves</li> <li>Malfunctioning water heater</li> <li>Whirlpool tub not functioning</li> </ul>

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## Causes and Contributing Factors Examples

MUI	Human	Process	Environment	Equipment
<b>UNAPPROVED BEHAVIOR SUPPORT</b>	<p><b>Staff Factors</b></p> <ul style="list-style-type: none"> <li>Control Issues</li> <li>Power Struggle</li> <li>Staff take a "Parental Role"</li> <li>Staff are afraid for their safety and for the safety of others</li> <li>Staff incompatible</li> </ul> <p><b>Team Dynamics</b></p> <ul style="list-style-type: none"> <li>Lack of relationship with individual</li> <li>Individual has lack of control in lives</li> </ul> <p><b>Communication</b></p> <ul style="list-style-type: none"> <li>There is a lack of communication between shifts and work about the person's day when may be giving person time/space could avoid frustration for all</li> <li>Lack of respectful communication</li> <li>Individual unable to communicate feelings</li> </ul> <p><b>Training</b></p> <ul style="list-style-type: none"> <li>Staff are not trained on Positive Interventions and Less Restrictive Interventions</li> <li>Staff are not trained on Mental Health Symptoms</li> <li>View everything as a "behavior"</li> </ul>	<ul style="list-style-type: none"> <li>Provider does not have a procedure for reviewing incidents with staff (debriefing)</li> <li>Change in Routine</li> <li>Lack of Agency training program on specific syndromes and diagnosis which would enable them to understand/empathize better with those they serve</li> </ul>	<ul style="list-style-type: none"> <li>Peers live together, ride the bus together and work together</li> <li>Lack of space for individuals to get away in their own home</li> <li>Loud Noises</li> <li>Lots of other people in environment like workshop or day program</li> <li>Unsafe Environment- close to street and traffic</li> </ul>	<ul style="list-style-type: none"> <li>Alarms not functional</li> <li>Staff do not test equipment to make sure it is functioning. I.e. batteries are not working and alarm not functioning</li> <li>Safety Locks not engaged in car per plan</li> </ul>

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## Test Your Knowledge

### 1. When Should Prevention Planning begin?

- Immediately Following the Incident
- Only After the Investigation has been completed
- After the MUI has been closed
- When Chuck Davis says

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## Test Your Knowledge

### 2. Who Develops the Prevention Plan?

- The County Board or COG
- The Provider
- The Individual and guardian (if applicable)
- The individual's team including the County Board and provider

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## Test Your Knowledge

### 3. Prevention Plans...

- Create More Work for Everyone
- Always Require a Special Team Meeting
- Place Blame
- Prevent or minimize future adverse incidents or even close calls

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## Prevention Planning

Prevention Planning should address:

- *How can we decrease the chances of this incident occurring again?*
- *How can we prevent injury?*
- *What happened, what should have happened?*

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## Have you ever?

- Wished it won't happen again
- Crossed your fingers
- Said you would "Monitor"
- Ignored the underlying issue
- Continue to do the same thing over and over again producing the same results

You will increase your chances of success if you are specific and clear in prevention plan.

Example: Instead of "Provide Training", say something like "All Residential and Workshop Staff will be provided training on Susan's new diet by 7/18/14 by the Program Director.



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## Elements of a Good Prevention Plan

- Based on a thorough investigation which gives an explanation of “cause”. The prevention plan should attempt to address each cause identified not just “the obvious case.”
- Addresses other significant factors that played a role in the incident.
- Is not just “a plan to plan,” but is specific in identifying WHO is going to do WHAT, WHEN, WHERE, and HOW.

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## Elements of a Good Prevention Plan

- Takes into account not only “people” issues, but “systems” issues.
- One that not only addresses immediate action, but attempts to address long term planning towards a desired outcome.
- Includes involvement of the person and their guardian (as applicable) in the planning process.
- Shared across a variety of settings and includes feedback from a variety of disciplines for a holistic approach to a desirable outcome.

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## Elements of a Good Prevention Plan

- Are not developed in a vacuum and should not be a means to an end
- Are both specific for the individual case and far reaching system
- Address the cause of the incident
- Is within the control of responsible person
- Ensures that necessary resources available
- If effectively implemented, can minimize the recurrence of the incident

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## Prevention Plan Examples

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## Physical Abuse

### Immediate Action and Prevention:

- Separation of family/staff (PPI) from individual.
- Immediate medical assessment (as applicable).
- LE and CSB Notifications
- Counseling if necessary for the individual victim.
- Training on crisis intervention – COPE, PACES.
- Monitoring of staff providing services
- Special team meetings to get team input into support for the victim/peer (if consumer)
- Education for all staff indicating that physical abuse will not be tolerated
- Discussion of Abuser Registry/outcomes

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## Sexual Abuse

### Immediate Actions

- Get the individual appropriate medical attention.
- Take immediate action to protect the person from further assault
- Report immediately to law enforcement or CSB
- Report to the County Board immediately but within 4 hours
- Sexual assault assessment, when appropriate, should be sought immediately.
- Remember to NOT imply blame on the victim.

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## Sexual Abuse

### Immediate Actions

- **Take action** if an individual communicates that he or she has been abused.
- Do not ignore or dismiss any such reports regardless of whether or not they appear plausible. The proper authorities will determine what occurred.
- **Report according to O.A.C. 5123:2-17-02 to Law Enforcement or CSB immediately. Reports to County Board should immediate but within 4 hours. Immediately protect the individual from continued contact with the Primary Person Involved (PPI).** If the PPI is a staff member, the staff member should be removed from a position of direct contact with individuals. If the alleged PPI is someone other than staff, necessary precautions should be taken to protect others who may be at risk.

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## Sexual Abuse

### Immediate Actions

- Ask questions like “Were you able to...?” instead of “Why didn’t you?” when talking to the individual.
- Emotionally support the alleged victim
- Remember to refer the individual for counseling and victim’s assistance as appropriate.
- Notify DODD MUI Unit if the alleged PPI is a County Board Employee. Screen the individual for pregnancy and/or sexually transmitted disease.

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## Verbal Abuse

- Separation of family/staff/(PPI) from individual.
- Counseling, if necessary, for the individual victim.
- Training on crisis intervention, sensitivity training for employees
- Administrative oversight/monitoring of staff interventions.
- Special team meeting to get team input into the supports for the peer/victim (if consumer).
- Education of all staff indicating verbal abuse will not be tolerated.

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## Neglect

- Separation of family/staff (PPI)/ individual during investigation.
- Immediate medical assessment (as applicable).
- Disciplinary action for specific offense.
- Staff training – ISP (supervision levels, treatment requirements).
- Special Team Meetings with recommendations.
- Guardian/family notification/feedback.
- Specify who is responsible for what follow-up (evaluation, team meeting, staff training, revising the ISP, etc.).

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## Misappropriation

- Has a system problem been identified?
  - Locking the lockbox
  - Keys to the home
  - Lack of accounting for funds used
  - Accessibility of funds to numerous people
- Have outcomes been reviewed for all homes, not just the one identified in the MUI?
- Administrative oversight/review of system.
- Are policies/procedures revised as a result of these changes?

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## Peer to Peer Acts

- Assess living arrangement of peers involved in physical abuse; any patterns, appropriateness of roommate selections.
- Is the BSP appropriate/interventions understood?
- Is supervision maintained/appropriate?
- Training interventions, program revisions for peers involved in verbal act of one another.
- Assess the placement situation.
  - Are the individuals compatible?
  - Is the placement a nice fit for those involved?
  - Is the guardian included in discussions
  - Does there continue to be unresolved health/safety issues?

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## Law Enforcement

- Why was the person arrested?
- Is there treatment being sought for the issue? (Drug/alcohol counseling, psychiatric follow-up, anger management, etc.).
- Was supervision an issue in the person being able to offend?
- Training interventions, program revisions for peers involved in verbal act of one another.
- What has changed to help support the individual?
- Who is responsible for follow-up?
- What are the timeframes identified?
- Verify implementation of outcomes.

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## Attempted Suicide

- How did the person attempt to harm themselves? Have steps been taken to eliminate opportunities for similar risks (e.g., removal of knives, securing of medications, etc.)?
- Has a suicide risk assessment been completed? What is being done to proactively address the issues?
- Has supervision been discussed?
- Staffing Changes?
- Who is responsible/What are the timeframes?
- Verify implementation of outcomes.

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## Missing Person

- Have supervision levels been addressed? Are they appropriate?
- What are the risk factors? How is the team addressing the absence to avoid future situations like this?
- Is the person really missing? Are adjustments required to the ISP regarding community involvement? This is clearly related to the risk/analysis.

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## Medical Emergency

- What is the person's current medical condition?
- Are any follow-up medical orders/recommendations being implemented? Who is responsible? What are the specific timeframes?
- Are any changes required for the ISP? Who is following up? What are the specific timeframes?
- Choking Incidents - diet textures, Supervision, meal pace, adaptive equipment.

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## Significant Injury-Unknown

- Has the source of the injury been identified?
- Are there suspicions as to how the injury occurred?
- Has the environment been modified to address the source of the injury?  
(Actual/suspected); (coffee table, corner of bed, light fixture, etc.) e.g., bruises match up to the corner of the coffee table, etc.

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## Unapproved Behavior Support

- Are staff trained appropriately in crisis intervention?
- Are the behavior plan/interventions addressing the problematic behaviors?
- Are staff trained on the plan? If not, who is responsible and when will it be done?
- Has a risk assessment been conducted regarding the intervention techniques?

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## Unapproved Behavior Support

- Has a physician reviewed the program for any intervention that may be contraindicated?
- Is a plan necessary to address the behavior?
- Is a revision to a current plan required?
- Has a team meeting been held? Are there any outcomes? Who, what, when? Be specific and include timeframes and deadlines.

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## Rights Restrictions

- What right was violated?
- Has appropriate disciplinary action been taken with the support staff?
- Has retraining occurred with the alleged PPI?
- What about overall rights/sensitivity training for agency personnel

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## Scenarios for Review

The following cases were taken from the  
**The New York Times**  
 series about the treatment of the  
 developmentally disabled in New York State.

These articles were published in  
 April 2012 in a series titled  
 “Could this Happen in Your Program?”

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### **In the Matter of Janet Nastori\*: Staff Become Fall Guys for Systems’ Failures; A Case for Asking “Why?” More Often Background**

#### **Background:**

Janet was the third of Mr. and Mrs. Nastori’s five children. During birth, she suffered severe anoxia, resulting in profound mental retardation, cerebral palsy, spastic quadriplegia and a seizure disorder. As an infant, Janet suffered from numerous ailments, including asthma and recurrent pneumonias, and was frequently hospitalized.

As her parents could not care for her multiple, everyday medical and developmental needs, at age four, Janet was admitted to a nursing home for children in a neighboring state. In addition to medications for her seizure disorder, Janet required a J-tube for feeding; adaptive equipment (braces and wheelchair) for proper body alignment and mobility; range of motion and positioning therapy for her spastic quadriplegia; and the use of a Bi-pap machine and pulse oxymeter for sleep apnea. Due to her chronic respiratory difficulties, Janet also required nebulizer treatments and postural drainage accompanied with chest percussion several times daily.

Postural drainage with chest percussion is intended to improve respiration by preventing the accumulation of secretions in the lungs, or facilitating their removal, through the use of gravity and mechanical action. The individual is placed in a series of reclining positions with the head and upper body inclined somewhat downward as a staff member gently percusses the individual’s chest and/or back with a cupped hand. After being percussed, the individual remains in each position for about three to five minutes to allow secretions to drain. Secretions are suctioned from the mouth and nose as needed.

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### **In the Matter of Janet Nastori\***

When Janet was nine, she was transferred to an Intermediate Care Facility in New York, closer to her family, which remained involved in her care. The single story, twelve-bed residence was designed for medically frail children. It offered round-the-clock nursing coverage, in addition to direct support staff, as well as in-house educational and specialty services, such as physical and other therapies. Although residents attended various medical clinics in the community, an agency physician would visit the facility periodically to assess and/or follow up on clients about whom nursing staff had concerns of a non-emergency nature.

Janet's plan of care in the residence addressed her wide range of medical and developmental needs and through her teenage years she remained relatively stable, considering the complexity of her needs. She was dependent on staff for all activities of daily living, was aware of her surroundings and, although non-verbal, expressed pleasure or discomfort through facial expressions and vocalizations. She particularly enjoyed music and humming along to familiar tunes.

#### **The First Incident**

One evening, just shy of her 16th birthday, Janet received one of her daily respiratory treatments. After having been percussed, Janet was left alone in her bedroom for an undetermined amount of time, lying in an inclined, head down postural drainage position. A passing nurse discovered Janet in this position, turned her over and discovered she was blue and not breathing. Thick saliva was found in her mouth and nose.

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### **In the Matter of Janet Nastori\***

While 911 was being called, nursing staff performed deep suctioning, to clear Janet's airway, and administered oxygen. Within minutes, Janet's coloring returned and she began breathing on her own. Responding EMS personnel monitored Janet's vital signs, which had returned to normal, and determined that transport to a hospital was not necessary.

The direct support staff member who was assigned to Janet was docked one day's pay and given a written counseling memo for having left Janet alone during postural drainage. The agency's investigation, completed three days later, revealed that this staff member was assigned to perform postural drainage for Janet and two other individuals, in their private bedrooms, all at the same time. The reason she left Janet alone was to tend to the other individuals. The agency investigator recommended that management and nursing staff review and modify assignments and schedules for postural drainage treatments to ensure that individuals receiving such care are not left alone. Staff were also to be instructed that they should not leave a client unattended during postural drainage.

The Incident Review Committee (IRC) met about one month later, accepted the findings and recommendations of the investigation without question, and closed the case the same day. The IRC did not schedule any review or follow up on the recommendations to ensure their implementation and appropriateness, or success in reducing risk of harm to individuals.

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### In the Matter of Janet Nastori\*

#### The Second Incident

One evening, approximately two years later, Janet was again found alone in her room in a postural drainage position. She was cyanotic, not breathing and had secretions around her mouth. A faint pulse was detected, but disappeared. While 911 was being called, nursing and direct support staff initiated CPR and administered oxygen. Responding EMS took over resuscitation efforts and transported Janet to a local hospital where she was pronounced dead.

Based on the autopsy findings, Janet's healthy clinical picture in the days and weeks prior to death, and the circumstances surrounding her demise, the Commission concluded that the most likely cause of death was anoxia due to airway obstruction caused by secretions.

The agency's investigation into Janet's death determined that the staff member assigned to Janet left her alone in a postural drainage position, after having percussed her, to tend to two other individuals assigned to her, one who needed to be changed and put to bed and a second who needed tracheotomy care. As she left Janet, this staff member called out to a second staff member asking that he check on Janet, which he did about five minutes later after he was done tending to another individual. It was then that he found Janet in distress and called for help.

The staff member assigned to Janet told the investigator that she had not received formal training on postural drainage; she was shown how to do it by another direct support staff member. She also stated that she was never told not to leave individuals alone while they were receiving postural drainage; she claimed that it was usual practice in the home to leave the individuals, checking on them periodically, while tending to other individuals. The staff member's comments on training and practices in the residence were echoed by other staff. The agency could find no documentation that this staff member had been trained in postural drainage. The staff member was demoted and assigned to another residence.

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## What do you think?

- What is the cause and contributing factors?
- Please provide a prevention plan regarding this scenario



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### In the Matter of Erin Federov

#### Background

Erin Federov (a pseudonym) was a 60 year old woman diagnosed with a mild developmental disability and Schizoaffective Disorder with Obsessive Compulsive traits. She also had a history of recurrent respiratory illnesses requiring hospitalization. Ms. Federov had twenty-two missing teeth but was not considered a good candidate for dentures. Ms. Federov's service plans at her residence and the day program she attended, noted that she was at risk of choking and required supervision at all meals to prevent choking. The service plans called upon staff to cut Ms. Federov's food into quarter inch pieces, and prompt her to chew slowly and drink liquids during meals.

#### Incident

On a warm July day, Ms. Federov arrived at her day program after a four month absence due to pneumonia. She was very happy to return to the program after being ill for so long. The day program staff, while happy to see Erin Federov again after such a long absence, were surprised because they had not been notified by the residence staff that Ms. Federov had been medically cleared to return to the program. The community residence staff that accompanied Ms. Federov in the van to the day program informed the day program staff that Ms. Federov no longer needed oxygen during the day and only needed nebulizer treatment. The day program supervisor reviewed the medical clearance that was sent with Ms. Federov and informed staff that Ms. Federov should not go on any trips until she had been observed to not have any breathing problems. Upon arrival, Ms. Federov went out into the garden with two staff and four other individuals. One of the staff members in the garden, Mr. Rivera, was completing paperwork at the picnic table and the other staff member,

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### In the Matter of Erin Federov

Ms. Walsh, picked cucumbers and beans with one of the consumers. Ms. Federov sat down at the picnic table with Mr. Rivera and shortly after sitting down, Ms. Walsh came over to the picnic table with a container of cucumbers and beans that had been picked from the garden. Ms. Walsh picked up a cucumber and asked if anyone knew what it was. Ms. Federov smiled and said it was a cucumber and then took it and bit into it. Ms. Walsh let her have the rest of the cucumber since she was standing right there and could observe Ms. Federov eating. While Ms. Walsh watched Ms. Federov eat the cucumber, she passed out cucumbers to the other program participants. She left the picnic table after observing that Ms. Federov had finished eating but she left a container of cucumbers on the table.

The staff person left sitting at the picnic table, Mr. Rivera, continued to do his paperwork while observing the other program participants. Mr. Rivera cut up some cucumbers for the program participants that he knew required this assistance. Mr. Rivera reported that since Ms. Federov had been absent from the program for so long and he was not routinely assigned to Ms. Federov, he did not know that Ms. Federov required her food to be cut up or that she should be supervised while eating. The Commission learned during its

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### **In the Matter of Erin Federov**

investigation of the incident that day program staff meetings routinely covered individual consumer safeguard considerations. However, Ms. Federov's choking risks were last reviewed more than a year prior to this incident and Mr. Rivera was absent from that meeting.

After Ms. Walsh left the picnic table, she went to talk to another staff person by the garden gate. Within about five minutes, Ms. Federov brushed past her and collapsed at the gate. She was unresponsive, foaming at the mouth and vomited a little bit. Ms. Walsh thought Ms. Federov was having a seizure and put her head in her lap. The other staff person went into the house to get the LPN on staff. When the LPN arrived on the scene, Ms. Walsh told her she didn't think Ms. Federov was breathing. The LPN found Ms. Federov to be unresponsive and unconscious and instructed staff to call 911. None of the staff on the scene checked Ms. Federov's airway or began CPR. The police arrived on the scene first after having been told that Ms. Federov was having a possible seizure. They administered CPR. When the paramedics arrived, they discovered that Ms. Federov's airway was obstructed with debris, which was later determined to be cucumber. The paramedics removed some of the debris, intubated Ms. Federov and transported her to the hospital. Resuscitative measures continued in the ambulance but Ms. Federov was pronounced dead on arrival at the hospital.

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## **What do you think?**

- **What is the cause and contributing factors?**
- **Please provide a prevention plan regarding this scenario**



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### In the Case of Mildred Thomas

#### Background

"Mildred Thomas" (a pseudonym) was a 37-year-old resident of a community-based Intermediate Care Facility (ICF) in upstate New York. She had lived at home with her family until the age of 12 and then lived in several institutional settings until she moved to the community-based ICF. Severely retarded, Mildred was ambulatory, verbal, and somewhat independent in ADL (Activity of Daily Living) skills. She did, however, exhibit maladaptive behaviors - including wandering from program, crying when she "didn't get her way," and engaging in self-abuse and property destruction. She was under the care of a psychiatrist, who prescribed psychotropic medications to control these behaviors. Health wise, however, Mildred suffered no major problems.

After several years, Mildred's maladaptive behaviors escalated, and her psychiatrist changed her medications, with little effect. Notes in the house log indicated that Mildred's head banging had created a hole in her bedroom wall, large enough to expose a steel beam. For the next several days it was noted that Mildred was up all night and screaming night and day, to the point that she was hoarse and could barely talk. Although there was an order for Tylenol "for a possible cold," there was no evidence that Mildred was examined by the agency nurse, nor was there any indication of the symptoms which prompted this order.

#### Nurse Contacts

On the following evening, after dinner, Mildred experienced bouts of vomiting and diarrhea. She was also trying to scream, but her voice was too faint. An agency nurse was contacted by phone who instructed staff to give Mildred Tylenol, spray her throat with Chloraseptic, and monitor her. The nurse also reportedly instructed staff "not to bother her again" (the nurse later claimed she was only kidding). As the evening progressed, Mildred continued to vomit, and at approximately 11:00 p.m. she had what appeared to be a seizure, which was significant, since she did not have a seizure disorder. At least one staff person at this time voiced concern that Mildred might be dying.

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### In the Case of Mildred Thomas

Staff again contacted the nurse by phone and reported that Mildred had had a seizure. Staff noted that Mildred was having difficulty sitting up straight and was "breathing hard"; she also did not respond to her name or to questions. Although facility policy requires that clients with no seizure history be brought to an emergency room if they experience a seizure, the nurse ordered that Mildred be "monitored" closely, without describing what was meant by "monitoring." (Most of the dialogue between house staff and the nurse was not documented in records.)

Oncoming night-shift staff registered concern over Mildred's condition, but were informed of the contacts with the nurse and her orders to monitor Mildred. Throughout the night no vital signs were taken. Although the nurse claimed that she instructed staff on how to take vital signs, staff reported they had never received such training. Reportedly, Mildred - who was placed on a couch in the living room for easier observation - was periodically checked during the night and was said to be sleeping. When day-shift staff arrived for duty the next morning, they found Mildred breathing hard and saw a dark stain on the couch under her mouth and face. They were informed by night staff that Mildred had been like this all night, and they then went about their other duties. One day-shift worker, however, returned to check Mildred and found her not breathing; she summoned her colleague who found no pulse, and 911 was called. As these staff were not trained in CPR, CPR was not started until EMS arrived.

Mildred was transported to a local hospital and admitted with a diagnosis of pneumonia. The emergency room record indicated that she had been without vital signs for at least a half hour. Although a pulse returned after treatment in the emergency room, Mildred expired shortly thereafter. The cause of death, after autopsy and discussion between the Commission's Medical Review Board and local Medical Examiner, was determined to be pneumonia.

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## What do you think?

- What is the cause and contributing factors?
- Please provide a prevention plan regarding this scenario



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### In the Case of Jesse Caron

#### Background

On the day after Christmas, Jesse Caron reported to his sheltered workshop, as he had for the past two years since moving from a developmental center to a community residence. On this day, though, something was different. Mr. Caron's left eye was black and blue and almost swollen shut; the white of the eye was completely bloodshot.

Concerned, workshop staff asked Mr. Caron what had happened. He told them a staff member from his residence punched him in the face on Christmas Eve. Workshop staff immediately called the director of Mr. Caron's residential program. The director arranged for a medical examination and commenced an investigation into the allegation of physical abuse by residence staff. The medical examination indicated that while the area around Mr. Caron's eye was severely bruised, the eye sustained no permanent injury. Mr. Caron reported to the agency's investigator, as he had to workshop staff, that he was punched by a residential staff member. He also requested to be moved to a new residence, a request which was accommodated.

Diagnosed as having a seizure disorder and moderate mental retardation, Mr. Caron was ambulatory, verbal and self-sufficient in most activities of daily living. He was, however, prone to temper tantrums when he did not get his way. On such occasions he became verbally abusive to others or engaged in property destruction. A plan was in place to address these behaviors through redirection, escorting Mr. Caron to a quiet or "calming down" area, and with approved hands-on physical interventions by staff to prevent him from harming himself or property, if his behavior escalated. Mr. Caron, however, had no history of striking out at others. And, according to a behavioral specialist who interviewed Mr. Caron following the allegation of abuse and reviewed his clinical record, Mr. Caron has a known history of making false accusations.

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### In the Case of Jesse Caron

#### Initial Agency Investigation Results

According to the agency's investigation, at approximately 4:00 p.m. on Christmas Eve, Mr. Caron asked to call a friend. The request was denied by the home manager who believed Mr. Caron might attempt, inappropriately, to invite himself to a Christmas party at a neighboring community residence. Disappointed, Mr. Caron became verbally abusive and stormed upstairs to his bedroom, from which thumping sounds were soon heard. The home manager asked fellow staff member, Mr. Romano, to check on Mr. Caron, who was found bouncing his basketball in his room. He appeared agitated. Mr. Romano escorted Mr. Caron downstairs to the residence's recreation room. The manager checked on Mr. Romano and Mr. Caron soon after their arrival in the rec room. Although the situation seemed under control, the manager asked the third staff member on duty, Mr. Philipson, to go to the rec room to assist Mr. Romano if he needed it.

Mr. Philipson reported that all was calm as he entered the rec room: Mr. Caron was sitting on a couch with Mr. Romano nearby. But shortly after his arrival, and while his back was turned as he worked on files, Mr. Philipson heard a scuffle. He turned to see Mr. Romano and Mr. Caron on the floor. Mr. Romano was asking Mr. Caron, "Why did you swing at me?" and the two were struggling, with Mr. Romano attempting to restrain Mr. Caron's upper body. Mr. Philipson assisted by grabbing Mr. Caron's legs. After about 10 minutes of being held face-down on the floor, Mr. Caron calmed down and staff released their grasp, allowing him to stand. It was then staff noticed his eye was somewhat swollen. The home manager was informed of the injury and contacted a nurse by phone. At her instruction, ice was applied to the injury.

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### In the Case of Jesse Caron

#### County Board Investigation

During the investigation, Mr. Caron maintained he was punched by a staff member. Staff, however, denied striking Mr. Caron. Mr. Romano, who claimed that Mr. Caron took a swing at him, initially stated that Mr. Caron's face hit the rec room door knob as he was being wrestled to the floor following the attempted punch. And Mr. Philipson claimed he saw nothing, as he was busy working on files. Mr. Romano's statement, however, did not convince the investigator: given the layout of the room, the location of Messrs. Caron and Romano, and the testimony of the home manager and Mr. Philipson, who stated the rec room door was closed, it was impossible for Mr. Caron to strike his face on the door knob. Furthermore, Mr. Philipson, who while not seeing anything as his back was turned, did not hear anything which sounded like a head hitting a door.

Confronted with these findings, Mr. Romano changed his story, somewhat. He told the CB investigator that it may well have been possible that in his restraint of Mr. Caron he accidentally struck him in the face. Troubled that he lied in his initial statements about the origin of Mr. Caron's injury, the agency transferred Mr. Romano to a different residence where he could be more closely supervised. However, the agency felt there was insufficient evidence that Mr. Caron was the victim of abuse. Based on Mr. Romano's revised statement, the agency concluded that Mr. Caron may have been accidentally struck by some part of Mr. Romano's body while being restrained.

#### Things Turn Ugly

The county board did not agree with the facility and contacted LE now that the information led them to believe that this is now an allegation of abuse. When LE interviewed Mr. Romano he again changed his story. In this version, he claimed that after Mr. Caron swung at him and was restrained to the floor, Mr. Philipson kicked Mr. Caron three to five times in the head. He also stated that when swelling around Mr. Caron's eye was noted, the home manager told him and Mr. Philipson to report Mr. Caron had struck his face on a door knob.

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### In the Case of Jesse Caron

In the ensuing investigation with LE, Mr. Philipson denied kicking Mr. Caron; he also became more forthcoming about what he saw in the rec room "while working on files."

According to Mr. Philipson, while Mr. Caron was sitting on the couch, Mr. Romano ordered him to lie on a floor mat, which had been used as a quiet, calming-down spot. Mr. Caron refused and Mr. Romano pulled him up by the shirt. At this point, Mr. Caron swung at Mr. Romano, but missed. In reaction, according to Mr. Philipson, Mr. Romano punched Mr. Caron in the face and chest several times and both fell to the floor where a restraint was employed. Mr. Philipson assisted by holding the client's legs. When Mr. Caron was released and his injury was noted, Mr. Romano became afraid he'd lose his job, according to Mr. Philipson. So, both staff told the home manager what had transpired and the manager instructed them to report that Mr. Caron hit his face on a door knob. Upon interrogation, the home manager confessed that he fabricated the door knob story to cover for Mr. Romano, who told him he had overreacted, punched Mr. Caron, and was afraid of being fired.

#### Resolution

Reinterviewed, Mr. Caron maintained, as he had in all previous interviews, that he was punched by a staff member. He denied that he was kicked, as Mr. Romano had most recently alleged. But, he could not name the staff member who punched him; he could only describe the car his assailant drove. The description matched the car driven by Mr. Romano.

Subsequently, the District Attorney's Office charged Mr. Romano with assault in connection with Mr. Caron's beating. He was fired by the agency for abuse, as were the residence manager and Mr. Philipson for their complicity in covering up the abuse.

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## What do you think?

- What is the cause and contributing factors?
- Please provide a prevention plan regarding this scenario



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### In the Case of Mr. Stevens

#### About Mr. Stevens

Mr. Stevens lived at home with his parents for most of his life. But as they grew older, and Mr. Stevens began presenting some behavioral challenges, his parents sought a residential placement. Mr. Stevens was accepted into an eight-bed group home in the town where he lived and moved there when he was in his late twenties.

In the group home, Mr. Stevens was independent in most activities of daily living: he could make simple meals, do his laundry, tend to hygiene and grooming needs, and needed only verbal reminders to take his medications. As part of his day habilitation program, Mr. Stevens did volunteer work at a couple of local charitable organizations. His long term goal, which staff at both the residence and day program were helping him towards, was competitive employment. Mr. Stevens communicated clearly and was described as being a very good self-advocate.

In addition to mild mental retardation, however, Mr. Stevens was diagnosed as having bipolar disorder that seriously impacted his daily life. During manic phases, Mr. Stevens was not overly energetic; but during depressed cycles, he would become extremely lethargic and communicate only minimally. During these phases, Mr. Stevens would refuse to participate in outings or routine household chores and activities. He would also refuse to get out of bed to attend day program.

In addition to seeing a psychiatrist and taking medications for his psychiatric condition, Mr. Stevens had a behavior plan in place to address his reluctance to do things during his "down" cycles. This entailed direct staff monitoring, verbal prompts and even physical assistance to help Mr. Stevens through each step of daily living activities, such as getting up in the morning, showering, dressing, and heading out for day program. If needed, the behavior plan allowed staff to physically escort or guide Mr. Stevens, one on each of his sides, out of his room and to the van to attend program. Day<sup>61</sup>

### In the Case of Mr. Stevens

program staff were also made available to assist residence staff in this process if the need arose. Once at day program, during these "down" cycles Mr. Steven's mood would brighten and he tended to get into the swing of things.

Although Mr. Stevens did not appear to be in a "down" cycle proximate to September 17th, he was experiencing increasing tremors and Parkinsonian-like symptoms. He had episodes of unsteadiness on his feet, difficulty in ambulating and brief periods of confusion. As a result, Mr. Stevens required increased staff supervision and assistance. He was also started on a course of neurological work-ups and medication adjustments to determine the origin of these symptoms.

#### The September 17th Incident

At about 8:30 on September 17th, Mr. Stevens went to his bedroom to retire for the night. As he was unsteady on his feet and might need assistance going up the stairs and getting undressed, one of the two group home staff on duty accompanied him. While taking off his shirt in his room, Mr. Stevens fell to the floor, landing first on his buttocks, then falling onto his back.

The staff member who had accompanied him and witnessed the fall immediately shouted downstairs for help. Her supervisor, who had heard the thud of the fall and claimed it shook the whole house, was already on his way upstairs to see what had happened.

Together, they assessed Mr. Stevens, who was verbal and responsive. He claimed his back hurt. His vital signs were normal. There was no bleeding, no evidence of broken bones, and he could move his extremities. When asked, however, he either could not or would not get up off the floor, according to the staff. When the two staff lifted him, he offered no assistance and seemed unwilling or unable to plant his feet beneath him and bear weight. When placed on the bed in a sitting position, Mr. Stevens "flopped"<sup>62</sup>

#### In the Case of Mr. Stevens

down onto his back. He seemed limp. Staff changed him into his bedclothes and he continued to claim his back hurt.

The supervisor telephoned the on-call nurse and reported Mr. Steven's fall, normal vital signs, and his not getting up off the floor, which the supervisor attributed to Mr. Steven's behavioral difficulties. He did not report Mr. Steven's claims of back pain. Nor did the nurse ask if there were any complaints of injury or pain. The nurse advised the supervisor to call back if Mr. Stevens would not get up or if his condition worsened.

The next morning, the supervisor, who had worked overnight, and another staffer who had relieved the second staff person of the night before, attempted to get Mr. Stevens up and ready for day program. Although awake and alert, Mr. Stevens did not respond to requests that he get ready. He continued to complain of back pain. Believing that Mr. Stevens was exhibiting a behavioral issue, staff dressed him with some difficulty. Mr. Stevens didn't actively resist or protest their efforts, he simply made no effort to assist. As he couldn't or wouldn't move from the bed, day program staff were called to assist in physically escorting Mr. Stevens to program. Again, he didn't resist residence and day program staff's efforts. But he didn't help either. When they lifted him from bed to a sitting and then a standing position, he didn't support his own weight. He felt like "dead weight" they said.

Unable to perform the approved two-person escort, given Mr. Steven's size, weight and inability/unwillingness to assist by bearing some weight and walking, three staff carried him down the stairs in a more-or-less horizontal position, sitting him down occasionally to catch their breath. Once down the stairs and on level ground, Mr. Stevens was placed in a wheel chair, taken to the van and transported to program.

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#### In the Case of Mr. Stevens

In the process of getting Mr. Stevens off the van at day program and transferred to a wheel chair and then to an easy chair, he was dropped once. Day program staff were alerted to the fall of the prior night, but they were also informed that he might be having a behavioral episode related to his bipolar disorder. As the morning went on, though, they became concerned that more was at play. They had never seen him like this before. His color was pale; he had no pink in his lips. Although responsive to questions, he kept his eyes closed most of the time. He needed a pillow placed in his easy chair to keep him propped in an upright position; his hands sat in his lap and he seemed unable to move them more than a couple of inches. Even when he was served a cup of coffee, a daily treat which he relished, he could not grasp the cup; when staff held the cup with a straw to his mouth, the coffee dribbled from his lips when he attempted to drink. Nursing and administrative staff were alerted. Initially, it was thought that he should be seen at the clinic, but as conversations ensued it was decided to call 911 for transport to an emergency room.

#### Subsequent Events

Mr. Stevens arrived in the emergency room of a local hospital on the afternoon of September 18th. The fall of the night before, as well as his complaints of back pain and his inability to ambulate, were noted. A CT of the head and x-rays of the spine were negative. As he couldn't walk, he was admitted with plans for additional neurological and psychiatric work-ups. An MRI was ordered. The MRI revealed that Mr. Stevens had suffered a severe spinal cord injury with a ligature rupture, compression at the C5 - 6 juncture and significant edema, resulting in quadriplegia. His respiratory function was also now compromised. On September 19th plans were made to transfer him to another hospital for surgery, though the odds of surgery significantly correcting the quadriplegia were bleak. He underwent surgery on September 20th. Following surgery, Mr. Stevens remained quadriplegic with only occasional slight movement of his feet and shoulders. Within days he developed pneumonia and other infections which did not respond to antibiotics over the course of his hospitalization. He also began having seizures. Despite aggressive treatment, Mr. Stevens died in early November.

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## What do you think?

- What is the cause and contributing factors?
- Please provide a prevention plan regarding this scenario



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## Questions and Answer Session



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