

ANE Reporting: Lessons Learned

South Carolina Department of Disabilities & Special Needs

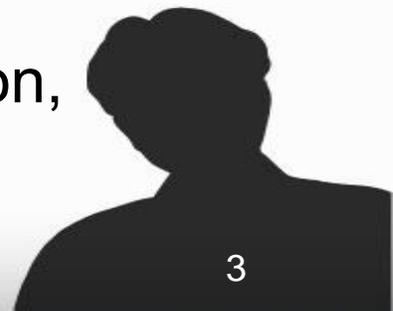
Recognizing ANE

- Allegations of Abuse, Neglect, and Exploitation are a product of our system as we provide care and support to people with disabilities and special needs. The review of each allegation is an opportunity for the agency to improve upon its communication and relationships with staff and the people supported.
- There is no one strategy that will prevent all allegations of ANE, but constant awareness, oversight, and training can promote a culture that supports people and reduces opportunities for mistreatment.
- Providers that have little to no allegations of ANE raise concerns about reporting issues and the need for additional training.



The Role of Supervision

- Supervisors and Management staff must remain diligent in their monitoring of staff and the daily challenges of their jobs.
- When agencies are short staffed, some shifts may not be covered. Homes that usually require enhanced staffing patterns may only have basic coverage. Fill-in or temporary staff may be working with people that are unfamiliar to them. Staff may not understand the Behavior Support Plans or Behavior Support Guidelines.
- Communication is important to ensure staff are aware of any changes to a person's health, medications, triggers for agitation, or even changes in routine.



Lessons Learned

What can we learn from recent case histories?

- In many instances of ANE, the staff reacted negatively to a given situation. In the heat of the moment, the staff acted in a manner that was inconsistent with policy. As examples, staff have been arrested after fighting back or striking a person supported by the agency when they were being physically aggressive. A seemingly reflexive push or hitting the person back can result in an arrest for Abuse. Using un-approved restraint techniques that cause injury can also result in an arrest.



Lessons Learned

What can we learn from recent case histories?

- In other cases, we find that staff have been poorly trained on behavior supports and how to effectively redirect the people they are supporting. Abuse results from attempts to “control” the person. In these cases, there seems to be a lack of understanding that staff should only put their hands on a person when providing direct support with activities of daily living, or in an emergency, when a restraint is required to protect the person or others from harm.
- Let’s look at a few examples...



Case History # 1

The Case of Suzie Brown

- Suzie Brown is in her mid-50s and has received services from DDSN since 1994. She resided in an ICF/ID community home until 1996 when she was transferred into her current CTH II. Suzie does not have a lot of family involvement, only an uncle that assists her with decisions, as needed.
- Suzie understands her human, constitutional and civil rights. Suzie attends a local Work Activity Center, five days a week. She is described as friendly and helpful to her housemates. Suzie stays connected to the community by attending various events sponsored by the organization, dining out in restaurants, attending church and shopping in the community. Suzie makes decisions about her daily routine by verbally communicating her needs and wants to staff.



Case History #1 (continued)

- A DSP working in the CTH II reported that a few months earlier, she witnessed another staff physically abuse Suzie Brown. The DSP reported that the other staff slapped, punched, and threw Suzie to the floor. The DSP further stated that when Suzie attempted to use a chair to get up from the floor, the other staff knocked the chair over. The reporting DSP also stated that other staff were working and observed the incident, but did not report it.
- A report of physical abuse was reported to SLED. SLED referred the case to the local Sheriff's Department for investigation. During the course of this investigation and additional interviews, additional allegations of abuse were reported and two other staff working in the CTH II were named as witnesses that failed to report. At the conclusion of the investigation, one staff was arrested for Abuse of a Vulnerable Adult. Four other staff were arrested for Failure to Report Abuse of a Vulnerable Adult.



Case History # 2

The Case of Sally Jones

- Sally Jones is in her mid-30s female and received services from DDSN since 1992. She resided at the regional center for 3 months about 15 years ago, then she was placed in an ICF/ID community home. Sally has lived in the same ICF/ID for 15 years. Her parents remain very involved in her life.
- Sally is described as playful, happy and has quite a sense of humor. She requires total assistance with all of her personal care and daily living skills. Her diagnosis include: Intellectual Disability, Impulse Control Disorder, Bi-Polar Disorder, Seizure Disorder, and Organic Brain Syndrome. She is non-verbal and communicates by signs and gestures. Sally currently attends a provider day program.
- Sally is on a formal Behavior Support Plan which targets: physical aggression, property destruction, noncompliance, and public disrobing. Sally requires one staff within arm's length at all times during her waking hours while at the residence and when other individuals are present. Additional staff are available to assist during behavior crisis.



Case History #2 (continued)

- In a recent incident, Sally was displaying physical aggression towards DSP A and another person receiving services while on the bus returning from day services. There were 3 DSPs on the bus at the time of the incident. DSP A reported that Sally grabbed her hair and DSP B tried to interrupt Sally's behavior. When Sally was redirected from physically attacking the DSP A, she then attacked the other person supported by the agency. Staff intervened and Sally ended up with scratches on the right side of her face, her cheeks, and lower jaw. A GER was completed for Sally, with mention of aggressive behaviors, but no injuries. DSP A reported that DSP B and DSP C used excessive force while redirecting Sally and DSP B physically attacked Sally by hitting her while she was redirecting her.
- The report was called in to SLED and local law enforcement began their investigation. After interviews, it was determined that DSP B and DSP C lied to the Provider Agency's management about the incident that occurred. DSP B and DSP C reported a different version of events, stating DSP C was driving the bus and not involved with the incident, but their story was disproved. At the conclusion of the investigation, two staff were arrested for Abuse of a Vulnerable Adult.

Case History # 3

The Case of Mary Smith

- Mary Smith is in her 20s and has lived in a CTH II for about 3 ½ years. Mary is diagnosed with Autism and an Intellectual Disability. Mary is also diagnosed with Cerebral Palsy, a seizure disorder, Bi-Polar disorder, and a sleep disorder. She is able to communicate when she wants to. Mary does not participate in long conversations. Due to her Cerebral Palsy, Mary is not able to walk for an extended period of time and needs to use a manual wheelchair. She likes to be active in the community and looks forward to shopping, eating out, and attending other social activities.
- It was reported that a DSP sprayed Mary in the face with a water bottle. A staff working a different shift made the initial report, but Mary's roommates at the CTH II also told the investigators that they seen and heard the DSP threaten Mary with a spray bottle. Upon conclusion of the investigation, one staff was charged with Abuse of a Vulnerable Adult.



Case History # 4

The Case of John Doe

- John Doe has received services from DDSN provider agencies since 1989. He is in his mid-40s now and has resided in various residential settings for almost 30 years. John is mostly independent in his personal care and he can follow two-step directions without difficulty. He has a significant hearing loss and his speech can be difficult to understand. He speaks very low and soft. John has a half-brother that has remained involved in his life. John and his brother were abused and severely neglected as children.
- John has a long history of inappropriate sexual behaviors, physical aggression, verbal aggression, non-compliance, and property destruction. He has faced criminal charges and now is judicially admitted to DDSN. Evaluations by Mental Health & DDSN have determined that John is not competent to stand trial for his criminal charges.

Case History # 4 (continued)

- An incident was initially reported by the provider agency due to John fighting with several people at the Work Activity Center. John was picking at another person supported by the agency and the two go into a fight. John ended up with knots on his head and went to the ER for evaluation. After being released from the ER, the report indicated that John was still being very disruptive and disrespectful to staff. He wanted to call his brother and report what happened, but his brother wouldn't answer the phone, so that made John even more upset. John then proceeded to walk to the police department and press charges against the individuals who attacked him at the Work Activity Center earlier that day.
- A local law enforcement officer went to the CTH II to speak with John. He was still very upset and started telling the officer what happened between him and the other individuals at the Work Activity Center. John also stated the Lead Residential Supervisor had struck him. The officer listened to John and made contact with day program staff who reported that the situation was handled. John became very upset when the officer explained everything to him and then he started yelling and cussing at the officer. The officer asked John to calm down but he wouldn't. John then started to get in the officer's face and John was arrested for disorderly conduct. John spent the night in jail.



Case History # 4 (continued)

- The following morning, the local Sheriff's Office called and reported that they needed someone to come and pick John up because he was being released. The Lead Residential Supervisor picked John up from the jail and he was still in a rage. John was asked to shower so he could go to the Work Activity Center, but he refused. The Residential Supervisor took John to the day program anyway.
- Later, on the van ride to another home, John struck the Lead Residential Supervisor in the back of head while driving. The other men on the van started fighting on the van. It was reported that John stumbled from the van and fell, injuring his face and head. John was transported to the ER for a second time for treatment. Local Law Enforcement was called to the ER to talk with John and the staff. John was in such a rage that they had to get security to get him to leave after his treatment and provided several medications to assist with his behaviors. John was then taken back to the CTH II.



Case History #4 (continued)

- A follow-up review was conducted by DDSN and John was found to still have black eyes from his injuries occurring nearly 11 weeks earlier. He was very honest about his behavior on those days and expressed frustration that no-one believed his side of the story. When asked about the current bruising, John described in detail how the Lead Residential Supervisor had pulled his shirt up over his head and repeatedly punched him in the face. The same staff then shoved him out of the van. John stated that another staff working at the home helped him from the ground.
- SLED became involved in the further investigation of this matter. After additional interviews, the Lead Residential Supervisor was charged with Abuse of a Vulnerable Adult. The provider agency's Residential Director was also arrested for Abuse of a Vulnerable Adult, as the investigation revealed that he knew about the supervisor's actions and failed to report them. A third staff was also arrested for Failure to Report Abuse of a Vulnerable Adult and hindering the investigation related to the Abuse of a Vulnerable Adult.

The Back Story

Here is what the review of the individual case studies has taught us:

- There was a hidden culture and accepted form of control among staff.
- The same staff initially accused was the same staff that had continued contact with the victim.
- There was a lack of follow-up/documentation related to substantial bruising.
- Staff failed to protect the residents during transport.
- Staff did not follow their MANDT training.
- Staff were not forthcoming with investigators.
- The witness was told to report to SLED, but there was no follow-up with supervisors or management staff.
- Management did not follow-up on Plans, training, and supervision of new employees.
- Providers need to take time to review policies/procedures and data when incidents occur. They can learn from their review.



Considerations during the Internal Review

- Keep in mind that there seems to be some truth to all allegations made, so keep an open mind during the review process (Even those with limited to no communication, history of not being truthful or a history of aggressive behaviors.)
- Everyone should report the allegation, whether independently or as a group call to be added to the SLED intake (in hopes of preventing failure to report)
- Clearly define 1:1 staffing needs. (The staff assigned should be within arms-length of the supported person at all times)
- Were there any clear signs of personality changes for the supported person in relation to the alleged perpetrator? Note there increased negative behaviors, unprovoked negative behaviors, was the person withdrawn, did the person voluntarily go into or put themselves in seclusion, etc.
- Has there been training on communication methods? sign language, communication boards, communication flip cards, etc.



After the Case is Closed

News stories about abuse, neglect, or exploitation of a vulnerable adult will always draw attention. Agencies must demonstrate that they have learned from the incident and take necessary actions to prevent future incidents.

Providers should utilize their process of coordinating unannounced visits to residential settings to monitor staffing levels, staff interactions with people supported, asking people how to recognize and report ANE, and ensuring Plans are current and relevant.



Public Trust

The public perception is guided by the following questions:

- *Why does the State/Provider allow this to happen?*
- *Who is monitoring that place?*
- *Why aren't staff trained better?*
- *Why would they hire someone like that?*
- *Where is the management of this house?*
- *Why was this allowed to go unreported?*
- *Why did it take so long to report?*



Provider Risk Management

The same questions asked by the public should be asked internally when there are substantiated cases of ANE.

- *When a provider receives notification of a substantiated ANE allegation, the agency should conduct an internal review of the incident to include collecting statements and conducting interviews. During this review process, the agency should determine if there were any policy/procedural violations as well as any risk management issues related to the event.*
- *The agency should discuss each ANE allegation during their risk management meetings, as outlined in the DDSN Risk Management Directive [100-26-DD].*

Provider Risk Management

When discussing the ANE final case status report during the Risk Management meetings, the agency should address the following:

- Ensure the personnel action(s) have been appropriately implemented.*
- Determine if there were any issues related to failure to report or delay in reporting.*
- Ensure all corrective measures have been implemented and personnel actions addressed.*
- Following the arrest, all charges should be noted and updated.*
- Following the court date, the findings should be updated to include the resolution and recommendations by the court.*

Provider Risk Management

- *Staffing concerns:*
 - *Is there a need for additional staff on duty?*
 - *Determine whether remaining staff should be relocated or remain at the site in question.*
 - *Are staff aware of current Behavior Support Plans/Behavior Support Guidelines (BSP/BSG) and how to implement them?*
 - *Are staff schedules monitored in an attempt to alleviate inappropriate responses due to staff being tired?*
- *Environmental Concerns:*
 - *Are there repeated concerns of abuse within the particular home in question or the managerial area of the home in question? (Is there an increase in reports in an area ran by the same House Manager, Area Coordinator, Director, etc.)*



Creating a Positive Environment

Has the provider created a positive environment for each home and communicated its expectations for respectful, supportive services?

- Sometimes staff that have been in the system for a while, and even those just coming in, may not understand changes in the agency's mission or be willing to adhere to the vision/plan. What happens to staff, to include management, who are not on board with the vision the agency has set in place?
- Is there an atmosphere of retaliation?
- Is there a fear of management—that the management will “sweep the incident under the rug,” or that the reporter will be seen as the problem?
- Are there clear policies in place as needed regarding ANE and related issues?
- Is there consistency on how infractions are handled—to include both middle and upper management staff?



Positive Environments (continued)

- Each staff should know and be familiar with their own limitations.
What is it that triggers a staff reaction? How does the staff handle stress?
Is there an open door policy to discuss concerns/issues?
- Has there been a clear “game plan” discussed ahead of time to deal with stressful situation? If I am hit/spit on/called out my name/not relieved on time/left to deal with negative or aggressive behaviors on my own/left to deal with physical or verbal aggression for an extended time I will do the following...

Provider Risk Management

- *Training Concerns:*
 - *Are all staff up to date on training requirements?
If not, has training been scheduled?*
 - *Is there a need to update/amend BSP/BSG?*
 - *If any redirection/restraint methods were used, were staff trained to appropriately implement and were they appropriately utilized by the staff in question?*
 - *Are all staff current on ANE awareness, prevention and reporting protocols?*
 - *Has there been any recent training on dignity and respect for those supported?*
 - *Is additional training required on Therap and documentation within the system?*

The Take Away

- Failure to Report will result in criminal charges.
- Providers will be held accountable for training & reporting.
- DDSN will provide additional ANE training materials, oversight of provider ANE training, and oversight of the provider risk management review of substantiated ANE cases.
- Placing your hands on a person to try to control their behavior is not an option.
- Restraints are only to be used when the person is in imminent danger and all other crisis management tools have failed to work.
- Staff may not be totally honest or may not be forthcoming when talking with management about the incident.
- Silence is not in anyone's best interest.



Moving Forward

- Remember... When in doubt, REPORT!
- If you need help, ASK!
- Think before your react.

