Beyond Mandated Reporting 3.0

Participant Toolkit

Washington State Department of Social & Health Services

Transforming lives

Thanks to the team of stakeholders who helped to develop the content of this course and to Service Alternatives for making it apply to supported living. Other contributors include; DDA staff, Sandi Miller, Residential Quailty Assurance Program Manager and Jan Sprow, Residential Training Program Manager.

This course is dedicated to the memory of T.M.

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Agenda

- Review of law regarding mandated reporting
- What you can do to go beyond mandated reporting
- Practice with scenarios

Learning Objectives

By the end of this workshop, participants will:

- Recognize your responsibility for the safety of the people you support
- Identify the supports and partners you have to maintain a safe environment
- Identify plans in place and how to locate information to support you as the staff
- List two questions to ask hospital and medical staff before discharge
- Represent confidently, the needs of the individual you support
- Demonstrate how to obtain additional supports

Workshop Goals

- Recognize that your responsibility is for the safety of the person you support in ANY setting
- Identify what supports & partners you have to maintain a safe environment
- Identify plans in place and how to locate information to support you as the staff
- List two questions to ask hospital & medical personnel before discharge
- Represent confidently the needs of the individual you support
- Demonstrate how to obtain additional supports

The National Association of Direct Support Professionals (NADSP) Code of Ethics Preamble

Direct Support Professionals (DSPs) who support people in their communities are called upon to make independent judgments on a daily basis that involve both practical and ethical reasoning. The people who assume the support role must examine and call upon values and beliefs, as well as creative vision, to assist them in the complex work they perform.

A primary purpose of the DSP is to assist people who need support to lead self-directed lives and to participate fully in our communities and nation. This emphasis on empowerment and participation is critical because the prejudices of society form powerful barriers that prevent many people with mental or physical disabilities from enjoying a high quality of life. And, too often, the very social policies and service systems designed to help can create other barriers.

Therefore, it must be the mission of the DSP to follow the individual path suggested by the unique gifts, preferences, and needs of each person they support, and to walk in partnership with the person, and those who love him or her, toward a life of opportunity, well-being, freedom, and contribution. Unfortunately, there have been no set criteria to guide these journeys as there are for other professional groups (such as doctors, nurses, service coordinators, and social workers) who have intimate knowledge of and responsibility for another person's emotional, financial, or physical being. There is no other position today in which ethical practice and standards are more important than direct support. DSPs are often asked to serve as gatekeepers between people needing support and almost every aspect of their lives, including access to community, personal finances, physical well-being, relationships, employment, and everyday choices. The whole landscape of a person's life can change with the coming and going of these critical supports for people.

As a result of these work duties, DSPs face ethical decisions on a daily basis and consistently feel the tension between the ideals of the profession and its practice. There are numerous pressures coming from organizations, government, social policy, and societal prejudice that can shift focus and allegiance away from those supported. In order to maintain the promise of partnership and respect that must exist in a helping relationship, a strong ethical foundation is critical to help DSPs navigate through the maze of influences that bombard them.

This issue has led to the efforts on the part of the National Alliance for Direct Support Professionals (NADSP) to identify the kinds of ethical situations that DSPs face and to develop a set of ethical guidelines. The NADSP convened a national panel of DSPs, advocates, families, professionals, and researchers who constructed this code of ethics. Focus groups and surveys regarding the draft language were conducted throughout the country and were integrated to create the final code. This Code of Ethics is intended to serve as a straightforward and relevant ethical guide, shedding some light on the shared path to a self-directed life. It is intended to guide DSPs in resolving ethical dilemmas they face every day and to encourage DSPs to achieve the highest ideals of the profession.

The skills and knowledge of community support practice must be joined with the ethical principles to create the environment needed to fully support people. To do so effectively, we must all work toward recognizing DSPs as professionals who have skills, knowledge, and values that constitute a unique and important profession. There must be a commitment to hiring, developing, and supporting DSPs who have a healthy sense of their own worth and potential, and the worth and potential of the people they support, and who can infuse these beliefs into practice. DSPs themselves must know that it is part of their role to foster a spirit of cooperation and mutual responsibility with other DSPs regarding ethical practice.

Direct Support Professionals, agency leaders, policymakers, and people receiving services are urged to read the Code and to consider ways that these ethical statements can be incorporated into daily practice. The beliefs and attitudes that are associated with being an effective human service professional are the cornerstones of this code. This code is not the handbook of the profession, but rather a roadmap to assist us in staying the course of securing freedom, justice, and equality for all.

1. Person-Centered Supports:

As a DSP, my first commitment is to the person I support; all other activities and functions I perform flow from this commitment.

As a DSP, I will:

- Cultivate a culture of a person who can direct his or her own life and support and that the unique social network, circumstances, personality, preferences, needs and gifts of each person I support must be the primary for guide the selection, structure, and use of supports for that individual.
- Commit to person-centered supports as best practice.
- Provide advocacy when the needs of the system override those of the individual(s) I support, or when individual preferences, needs or gifts are neglected for other reasons.
- Honor the personality, preferences, culture and gifts of people who cannot speak by seeking other ways of understanding them.
- Focus first on the person, and acknowledge that my role in direct supports will require flexibility, creativity and commitment.

2. Promoting Physical and Emotional Well-Being:

As a DSP, I am responsible for supporting the emotional, physical, and personal well-being of the individuals receiving support. I will encourage growth and recognize the autonomy of the individuals receiving support while being attentive and intentional in reducing their risk of harm.

As a DSP, I will:

- Develop a relationship with the people I support that is respectful, based on mutual trust, and that maintains professional boundaries.
- Assist the individuals I support to understand their choices and the possible consequences of these choices as they relate to their physical health and emotional well-being.
- Promote and protect the health, safety, and emotional well-being of an individual by educating the person in preventing illness and avoiding unsafe activity. I will work with the individual and his or her support network to identify areas of risk and to create safeguards specific to these concerns.
- Know and demonstrate respect for the values of the people I support and facilitate their expression of choices related to those values.
- Challenge others, including support team members (e.g. doctors, nurses, therapists, co-workers, family members) to recognize and support the rights of individuals to make informed decisions even when these decisions involve personal risk.

- Be vigilant in identifying, reporting, and documenting any situation in which the individuals I support are at risk of abuse, neglect, exploitation or harm.
- Consistently address challenging behaviors proactively, respectfully, and by avoiding the use of aversive or deprivation intervention techniques. If these techniques are included in an approved support plan I will work in partnership with team members to find suitable alternatives partnered with advocacy for the eventual elimination of these techniques from the person's plan.

3. Integrity and Responsibility:

As a DSP, I will support the mission and growth of my profession to assist people in leading self-directed lives and to foster a spirit of partnership with the people I support, other professionals, and the community.

As a DSP, I will:

- Be conscious of my own values and how they could influence my professional decisions.
- Maintain competency in my profession through training and ongoing communication with others.
- Assume responsibility and accountability for my decisions and actions.
- Actively seek advice and guidance on ethical issues from others as needed when making decisions.
- Recognize the importance of modeling valued behaviors to co-workers, persons receiving support, and the community at-large.
- Practice responsible work habits.

4. Confidentiality:

As a DSP, I will safeguard and respect the confidentiality and privacy of the people I support.

As a DSP, I will:

- Seek information directly from those I support regarding their wishes in how, when and with whom privileged information should be shared.
- Seek out a qualified individual who can help me clarify situations where the correct course of action is not clear.
- Recognize that confidentiality agreements with individuals are subject to state and agency regulations.
- Recognize that confidentiality agreements with individuals should be broken if there is imminent harm to others or to the person I support.

5. Justice, Fairness and Equity:

As a DSP, I will promote cultural competency by practicing justice, fairness, knowledge and equity for the people I support and the community as a whole. I will affirm the human rights, civil rights and responsibilities of the people I support.

As a DSP, I will:

- Help the people I support use the opportunities and the resources of the community available to everyone.
- Provide education to individuals I support, regarding their rights and responsibilities.
- Understand the guardianship or other legal representation of individuals I support, and work in partnership with legal representatives to assure that the individual's preferences and interests are honored.

6. Respect:

As a DSP, I will respect the dignity and uniqueness of the people I support. I will acknowledge each person I support as valuable and help others understand their value.

As a DSP, I will:

- Seek to understand the individuals I support today within context of their personal history, their social and family networks, and their hopes and dreams for the future.
- Honor the choices and preferences of the people I support.
- Protect the privacy of the people I support.
- Uphold the human rights of the people I support.
- Interact with the people I support in a respectful manner.
- Recognize and demonstrate cultural competency with regard to a person's beliefs around religion, sexual orientation, ethnicity, socio-economic class and that of his/her social network.
- Provide opportunities and supports that help the individuals I support be viewed with respect and as integral members of their communities.

7. Relationships:

As a DSP, I will assist the people I support to discover, develop and maintain relationships.

As a DSP, I will:

- Advocate for the people I support when they do not have access to opportunities and education to facilitate building and maintaining relationships.
- Assure that people have the opportunity to make informed choices in safely expressing their sexuality.
- Recognize the importance of relationships and proactively facilitate relationships between the people I support, their family and friends.
- Refrain from expressing personal opinion regarding relationships (including sexual relationships) from those desired by the people I support based on their personal preferences. If I am unable to separate my own beliefs/preferences in a given situation, I will actively remove myself from the situation.
- Refrain from expressing negative views, harsh judgments, and stereotyping of people close to the individuals I support.

8. Self-Determination:

As a DSP, I will assist the people I support to direct the course of their own lives.

As a DSP, I will:

- Work in partnership with others to support individuals leading self-directed lives.
- Honor the individual's right to assume risk in an informed manner.
- Recognize that each individual has potential for lifelong learning and growth.

9. Advocacy:

As a DSP, I will advocate with the people I support for justice, inclusion, and full community participation.

As a DSP, I will:

- Support individuals to speak for themselves in all matters where my assistance is needed.
- Represent the best interests of people who cannot speak for themselves by finding alternative ways of understanding their needs, including gathering information from others who represent their best interests.

- Advocate for laws, policies, and supports that promote justice and inclusion for people with disabilities and other groups who have been disempowered.
- Promote human, legal, and civil rights of all people and assist others to understand these rights.
- Recognize that those who victimize people with disabilities either criminally or civilly must be held accountable for their actions.
- Find additional advocacy services when those that I provide are not sufficient.
- Consult with people I trust when I am unsure of the appropriate course of action in my advocacy efforts.

10. Be Professional

- Develop professional relationships
- Exhibit professional behavior
- Respect diversity and inclusion
- Create meaningful documentation
- Education, training and self-development
- Organizational participation
- Exhibiting ethical behavior
- Know when to call 911, report abuse, neglect, and exploitation, or get help
- Coming together with participants for better commendation, to truly understand and support participants

Your Role

- Know the needs of individuals you support & the ability to provide those supports
- Ask for training & assistance you may need to support individuals
- Assess critically the situation and act on what you see
- Inform your supervisor and department if the individual's support needs change or are unmet
- Observe the environment, speak up about potential risks, & immediately take action or report to someone who can act

Law

Mandatory Reporting the Law States

- Chapter 26.44 RCW
- Chapter 74.34 RCW
- When suspected sexual or physical assault it must be reported to both DSHS and law enforcement!

Reasonable Cause

- You DO NOT need to be certain
- You have reason to believe there is an incident of abuse, neglect, or mistreatment
- Safety might be compromised
- Report first to CRU/RCS, CPS/APS, and then your supervisor and others in your chain of command
- Report incidents that occur in other settings – Home, School, Work

Factors Increasing Risk to Commit Abuse

- High levels of stress (job or personal)
- Not coping effectively
- Exhaustion
- History of abusive behaviors (doing or being)
- Drug or Alcohol abuse
- Lack of food
- Lack of adequate staff oversight

Abuse and Neglect Definitions

Abuse means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, personal exploitation and improper restraint of a vulnerable adult. These various types of abuse will be described in more detail later.

Abuse or neglect means sexual abuse, sexual exploitation, or injury of a child by any person under circumstances which cause harm to the child's health, welfare, or safety, excluding conduct permitted under RCW 9A.16.100; or the negligent treatment or maltreatment of a child by a person responsible for or providing care to the child. An abused child is a child who has been subjected to child abuse or neglect as defined in this section.

Specific Forms of Abuse and Neglect

(WAC 74.34.020 for adults; WAC 26.44.020 for children)

Please note that some of the definitions are specific to a child or to an adult but may have different meaning for the word.

Negligent treatment or maltreatment (child) means an act or a failure to act, or the cumulative effects of a pattern of conduct, behavior, or inaction, that evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to a child's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100. When considering whether a clear and present danger exists, evidence of a parent's substance abuse as a contributing factor to negligent treatment or maltreatment shall be given great weight. The fact that siblings share a bedroom is not, in and of itself, negligent treatment or maltreatment. Poverty, homelessness, or exposure to domestic violence as defined in RCW 26.50.010 that is perpetrated against someone other than the child does not constitute negligent treatment or maltreatment in and of itself.

Physical abuse (adult) means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving or prodding.

Physical abuse (child) means the non-accidental infliction of physical injury on or physical mistreatment of a child. Physical abuse includes doing any other act that is likely to cause and which does cause bodily harm greater than transient pain or minor temporary marks or which is injurious to the child's health, welfare, and safety. This is also stated as "doing any other act that is likely to cause and which does cause bodily harm greater than transient pain or minor temporary marks or which is injurious to the child's health, welfare, and safety.

Abandonment (adult) means action or inaction by a person or entity with a duty of care for a vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.

Abandonment (child) means the parent deserts the child with the intent to abandon, leaves the child without the basic necessities of like, such as food, water, shelter, etc.: or forgoes parental rights, functions, duties, and obligation for extended period of time.

Personal Exploitation (adult) means an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior, or causing the vulnerable adult to perform service for the benefit of another.

Improper use of Restraint means or the inappropriate use of chemical, physical, or mechanical restraints for convenience or discipline or in a manner that: (i) Is inconsistent with federal or state licensing or certification requirements for facilities, hospitals, or programs authorized under chapter 71A.12.RCW; (ii) is not medically authorized; or (iii) otherwise constitutes abuse under this section.

Financial exploitation (adult) means the illegal or improper use, control over, or withholding of the property, in-come, resources, or trust finds of the vulnerable adult by any person or entity for any person's or entity's profit or advantage other than for the vulnerable adult's profit or advantage.

Mental abuse (adult) means any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing.

Neglect (adult) means (a) a pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or (b) an act of omission that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety.

Neglect treatment or Maltreatment (adult) means an act or failure to act or cumulative effects of a pattern of conduct, behavior, or inaction that shows a serious disregard of consequences and constitutes a clear and present danger to a child's health, welfare, or safety. Actions, failures to act, or omissions that result in injury to or that create a substantial risk of injury to the physical, emotional, and/or cognitive development of a child.

Sexual abuse (adult) means any form of nonconsensual sexual contact, including but not limited to unwanted or inappropriate toughing, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse includes any sexual contact between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under chapter 71A.12 RCW, and a vulnerable adult living in that facility or receiving service from a program authorized under chapter 71A.12 RCW, whether or not it is consensual.

Sexual Exploitation (child) means allowing or causing a child to engage in prostitution; sexually explicit, obscene, or porno-graphic activity to be photographed, filmed, or electronically reproduced or transmitted; or sexually explicit, obscene, or pornographic activity as part of a live performance, or for the benefit or sexual gratification of another person.

Possible Signs of Abuse or Mistreatment

Remember that you are not a doctor and cannot make this determination. However, it is important that you know the signs that are considered.

Physical and Behavioral Indicators of Neglect:

- Constant hunger
- Poor hygiene
- Inappropriate clothing
- Constant lack of supervision
- Constant fatigue or listlessness
- Unattended physical problems or medical/dental needs
- Child under 12 left alone or to care for younger children

- Begging or stealing food
- Constantly falling asleep in school/work
- Sporadic or occasional attendance in school/work
- Spending excessive time away from home
- Addiction to drug and/or alcohol
- Stating that there is no one to look after him/her

Physical and Behavioral Indicators of Sexual Abuse:

- Difficulty in sitting or walking
- Torn, stained, bloody underclothing
- Complaints of itching or pain in genital, anal area
- Bruises in external genitalia, vaginal or anal area
- Venereal disease, for individuals not in a sexual relationship
- Pregnancy, especially in early adolescence
- Bladder infections
- Body odors
- Bruises, hickeys
- Whisker burn
- Weight gain or loss
- Sudden changes in behavior
- Lack of concentration in school, at work, or during other tasks
- Numerous fears, needing more reassurance than usual, clinging to or recoiling from caregiver
- Depression, excessive crying
- Lack of eye contact
- Crankiness, short-tempered, irritable
- Decline in school/work performance
- Contradictory stories
- Poor peer relationships, isolated, severe withdrawal, excessive fantasy, regressive behavior
- Low self-esteem
- Explicit knowledge of sexual acts, using "sex talk" a lot
- Bizarre, sophisticated, and/or unusual sex knowledge for age
- Not wanting to participate in PE
- Displays appearance of overwhelming responsibilities
- Inappropriate dress
- Overly restricted social activities
- States that he/she has been sexually assaulted
- Running away
- Suicide attempts or ideation

Indicator of physical abuse:

- Unexplained bruises or welts on:
  - Face, lips, mouth, torso, back, buttocks, thighs
  - In various stages of healing
  - Clustered, forming regular patterns
  - Reflecting the shape of the object used
  - On several different surface areas
  - Frequently appear after absence, vacation or weekend
- Unexplained burns
  - Cigar, cigarette burns especially on palms, back, buttocks
  - Immersion burns - sock-like, glove-like, donut shaped on buttocks or genitalia
  - Patterned like electric burner, etc.
  - Rope burns on arms, legs, neck, torso
- Unexplained lacerations or abrasions
  - To mouth, gums, lips, eyes
  - In various stages of healing
  - Widespread superficial injuries
- Unexplained fractures
  - To the skull, nose or facial structures
  - In various stages of healing
  - Multiple spiral fractures
  - Swollen or tender limbs
- Unexplained abdominal injuries
  - Swelling of the abdomen
  - Localized tenderness
  - Constant vomiting
- Human bite marks
  - Especially when they appear adult size
  - Recurrent
- Wary of contact with caregivers
- Becomes apprehensive when other children cry
- Shows extremes in behavior outside the expectations for age group
- Seems frightened of caregivers
- States he/she is afraid to go home, cries when it is time to leave, hangs around places other than home
- Reports injuries by caregivers
- Is unpleasant, hard to manage, causes trouble, is destructive
- Avoids other people, even children, seems too anxious to please, accepts teasing, etc., without protect
- Frequently late, absent or too early
- Wears concealing clothing even in hot weather
- Explanations of injuries unbelievable
- Show little or no interest at being separated from caregivers or others close to them

Factors Increasing Risk to Commit Abuse

Mandatory Reporting Requirements

- Ensure the person you support is safe
- Report to police first (if appropriate)
- Report to CRU/RCS
- Then your management & chain of command
- Always think of the well-being of the person you support & NOT whether your co-worker or anyone else will be upset if you report it.
- Maintain the confidentiality of all persons involved
- Write a clear description of what you observed.
- Do not add your opinion

Do NOT talk about the person you support or others involved in the incident.

Documentation Activity

4/16/16 Sam went out in the community today. He ambulated well and his behavior was appropriate. He likes looking at the creepy bugs on the sidewalk. Man that's just weird and then he picks them up and stares at their antlers or antenna or whatever they are. I wouldn't want to pick them up but to each his own. Then he kind of went blank like he does every now and then, you know, and he fell over. I manage to catch him but it was hard to keep him from hitting his head so sorry if he got a bump. He was out for about a minute. By the time I got my watch to time how long he was staring, he was awake again. Man that just sucks that he gets these weird episodes. *jes*

How would you rewrite this report to meet the simplicity of the guidelines we discussed?

Expectations After Reporting to CRU/RCS, CPS/APS

- Your Supervisor or Manager will address the incident promptly
- DDA staff may visit the home
- CRU/RCS or CPS/APS may investigate
- You may never know the outcome

Report or Don't Report Scenarios

- Are there any gray areas or issues?
- Always document even if you decided not to report
- Always document case numbers
- Document names of those you notify

What Should You ALWAYS Do?

Look Beyond Mandated Reporting • Think…Person first – Client second • Expect the Unexpected!

You are accountable for your own actions. If you make a mistake tell someone. If someone else made a mistake correct it.

Safety Issues and Provider Practice

- Your inaction
- Your underreacting
- Your overreacting

Scenario 1 – William

You are the direct support staff person for William, an individual with a mental health diagnosis (dual diagnosis) and a history of making false allegations. William's brother is his legal guardian. During your morning shift, William reports to you that he was sexually assaulted by the night staff person. When you ask more questions, William changes his statement. He says he doesn't like the new night staff person because he stares at him and gives him the creeps. Later, towards the end of the shift, William says he doesn't like the new guy because he touches him in his private parts.

How should you handle this?

Things That May Indicate Failure to Protect

- Severe injuries
- Repeated falls
- Potential for poisoning & chemical dangers
- Non-consenting sexual contact
- Physical restraint without justification
- Lack of supervision
- Medication errors (given and documenting)
- Continuous injuries of unknown origin
- Water temperatures too hot
- Lack of monitoring & follow up on issues

Safety Response

- Be assertive when you find health & safety issues requiring immediate correction
- Secure all potentially dangerous items when necessary (knives, toxins, hand soap, cleaners, spoiled food). BE VIGILANT!
- Is there adequate food available & is it properly stored?
- Are there any obvious hazards to the persons you support?
- Is the home in good repair and reasonably clean?
- Are there working smoke detectors?
- Are there working fire extinguishers & do you know their locations?
- Do your co-workers know the home safety plan and locations of safety equipment?

Be Proactive

- Remember safety
- They must feel safe
- Check yours and client's clothing & Body
- How does your supported individual perceive the situation

Do Environmental Checks

- Locked doors at night
- Items off the floor
- Appropriate temperature
- Outside lighting
- Spills cleaned up
- Rugs or loose wires on the floor
- Expired foods or medication
- Weather related issues (ice, slippery)
- Uneven paths leading to and from the house
- Reasonably clean home
- All chemicals properly stored
- Any safety issue that does not fall under reporting

Scenario 2A – Julie

You are a direct support staff person for Julie. She receives Supported Living services and experiences PICA. Julie has a documented history of ingesting inedible items, including toxic chemicals. There is a PBSP in place for Julie with clear instructions to lock up all cleaning supplies, laundry soap and even toothpaste in Julie's home. As you come into the house, you notice a bottle of detergent has been left on top of the dryer in the laundry room. When you point this out to Cindy, the staff person who was working with Julie before your arrival, she minimizes the need to lock up such items, stating, "Julie hasn't had any problems like that since she's been with us." She also mentions that this is Julie's private bottle of detergent and she prefers to keep it on top of the washer, as it is hard for her to reach in the cabinet.

What should you do?

Scenario 2B – John

You are the direct support staff person for John, who lives in his own home with 24-hour supervision through supported living. During your shift, John is visited by his sister, Adrienne, who is also his guardian. While spending time with John, Adrienne becomes concerned that her brother is acting differently than she has ever seen him act. She tells you that she has noticed his speech is slurred and he is lethargic. She also says that she thinks the medication John is taking is not the same color as the one he had before.

You have only been working with John for a week and are not very familiar with him. You are confused by Adrienne's comments.

What should you do?

Scenario 2C – Bill

You are a direct staff support person for Bill, a Community Protection Program (CPP) participant. He lives in a home with two other participants and 24-hour awake staffing supports. Over the last two months, several new staff began working in the home. Bill has become increasing frustrated with the restrictions associated with his program. After being told he would be unable to attend an activity due to a staffing/scheduling error, Bill became very physically aggressive toward staff and his housemates and broke several windows in the home. Police were called and they declined to arrest Bill and instead transported him to the local Hospital Emergency Department (ED). The ED physician reports Bill is now calm and needs to be picked up and returned home. His housemates are fearful of him and a guardian for one is saying they can no longer live together.

What should you do?

Scenario 2D – Lori

You are the direct staff support person for Lori, an individual who receives supported living services. Lori's mother is not her guardian, but she is very involved in her daughter's life. When you come into Lori's home for your afternoon shift, she already has her coat on, as she is eager to leave for her trip to the grocery store. Lori's twice-weekly shopping trips are one of her favorite parts of her plan. As you and Lori are preparing to leave, you discover that she doesn't have enough funds on her EBT card to pay for her purchases. When you tell Lori that the shopping trip must be delayed, she becomes very upset and begins hitting her head on the wall. You try to calm her down, but she becomes more agitated, eventually kicking a hole in the wall. You call the police and they arrest Lori for "malicious mischief." You are now second-guessing your response to the situation.

What should you have done and what should you do now?

Scenario 2E – Helen

You are a direct support staff person who has been working in a home with three young men for about a year. You are asked by your agency to help train a new staff person, Helen. Helen is a mature woman who tells you that she raised three boys of her own and "knows how to handle them" to keep them in line. She continues to refer to the young men as "boys" and talks to them in a very motherly tone. Helen constantly reminds the young men about their manners, such as washing their hands and saying "please" and "thank you." One of these young men, Michael, seems to be a bit irritated by this, while another starts jokingly referring to her as "mom."

What do you do?

Scenario 2F – Mary

You are a direct support staff person working with two young women, who live in a two bedroom apartment. The staffing schedule is 24/7 and most times there is a two-to-two staff/individual ratio with one staff person at night. You are usually on the night shift. Mary, one of the young women you support, is 35 years old and very independent. Mary often uses poor judgment when she is in the community alone. She's quite interested in relationships with men and frequently reports to you that she just "had sex" with a man during one of her outings in the community. Mary's parents are also her guardians. They are aware of her behaviors and don't seem to have a problem with it. Occasionally she will bring men she just met home with her. Mary takes these men into her bedroom and closes the door. She is a very private person and is quite sensitive to anyone interrupting her activities when she's in her bedroom. During your shift tonight, you receive a phone call from Donna, the mother of Evelyn, who lives with Mary in the apartment. Donna is very upset about how Mary's behavior of bringing strange men into the apartment at night compromises her daughter's safety. She demands that you and your agency take action.

What should you do?

Scenario 2G – Emily

You are the direct support staff person for Emily, who lives alone and receives 60 hours/month of supported living services. Emily takes pain medication related to a leg injury. When you are working with Emily today, you notice that her pain medication has run out two weeks ahead of schedule. You ask Emily about it and she says she doesn't understand why this has happened. You know that Emily is always very careful to take the right amount of medication. Emily's mother is a frequent visitor to her home and has been there several times in the past week. You ask Emily if anyone else has visited with her recently and she says "no." You are aware that Emily's mother has a history of drug abuse.

What should you do?

Scenario 2H – David

You are a direct staff support person for David, who lives in a house with two other men. When you come onto your evening shift on Saturday, there is a commotion going on in the house. David is upset and crying. He has been brought back early from a weekend visit with his parents. David's parents are upset because they discovered while helping him shower that morning, that his body had been shaved from the neck down. They consider this an invasion of his privacy and an abuse of his rights. They demand that you do something about it. When you ask David what happened, he tells you that Noah shaved him. Noah is not on duty but you reach him by phone. He tells you that David was willing to be shaved and that in his country; shaving is done routinely for hygienic reasons.

How should you handle this?

Scenario 2I – Craig

You are the direct staff support person for Craig, a 22 year old man who lives in his own apartment. Craig receives 40 hours/month of supported living services. He earns good wages from his grocery bagging job at Safeway so he is able to enjoy many activities in the community and purchases things he enjoys. Craig's father is dead and his mother had taken care of him until he got his own place two years ago. He has no guardian. Craig tells you that he wants to buy his mom a nice Christmas present and you support him in this idea. However, when he telephones his mother to ask her what she would like, you can see by his facial expression he has become upset. He agrees to whatever his mother is asking, but after he hangs up he seems unhappy. You ask him what has happened. Craig explains that his mom told him that she is short on cash and what she would really like is for him to give her $300. She also said that since she supported him for so long, it only makes sense for him to support her now and suggests he give her this amount monthly. Craig agreed with his mom, but is unhappy that he won't have the money to buy the things he wants if he gives his mom money on a regular basis. He also confides to you that he already gave his mom $300 last month. When you suggest to Craig that it isn't his responsibility to help his mom in this way he becomes upset and says that he has to.

What do you do?

Scenario 2J – Don

You are the direct support staff person for Don, a 40 year old man with moderate intellectual disabilities. Don has diabetes and is morbidly obese. Don lives in his own home and receives supported living services.

Recently Don fell and fractured his hip. He was hospitalized and had his hip repaired. He has returned home and is now four weeks post-surgery. Don's recovery is complicated by his diabetes and weight. Post procedure compliance is extremely important, as he is at high risk for infection from poor wound and bone healing. Don needs to cooperate with physical therapy.

Don is having difficulty understanding what he needs to do and why. He has refused physical therapy, which is difficult for him because of his weight. His physical therapist, Anna, visits him during your shift. Anna is concerned because Don hasn't been cooperating with physical therapy or following his diabetic diet. She's sure he's gained at least 15 pounds. After Anna leaves, you talk to Don about the importance of following his PT routine but he gets mad and says, "You can't make me do it."

What should you do?

Scenario 2K – Steve

You are a direct support staff person working with two men who live in their own home. They have 24/7 staffing schedule with a two-to-two staffing ratio between 6:00 am and 10:00 pm. You arrive to work shortly before 4:00 pm for the evening shift and notice that Steve, one of the individuals you support, has a deep cut on his cheek. Steve is non-verbal and therefore unable to tell you what happened to him. You ask your co-workers from the previous shift if they know how Steve was injured and they say "no." As these coworkers are preparing to leave, you see one staff person, Jane, telling another staff person, Brandy, "sshh" and putting her finger to her lips. You ask Brandy to come into one of the bedrooms and talk to you. Brandy reports that on a shopping trip to Safeway Steve fell over in his wheelchair in the van. This occurred because the staff had forgotten to tie Steve's wheelchair down before driving away from the Safeway parking lot. Brandy is fairly certain that is how Steve got the laceration on his cheek.

What should you do?

Individual Instruction and Support Plan

- Read ALL plans written for the individuals you support
- Re-read all client plans at least every 6 months
- The IISP contains a Risk Summary and detail on Risks and Interventions
- There is also a summary of risks which may be life threatening – these should always remembered!
- Know ALL the medical conditions, diagnoses, and medical protocols for the individual
- Know the individual you support as a PERSON first to understand their needs
- Ensure you properly track all behaviors and medical and safety issues
- Do follow up checks on ALL issues
- Be prepared to show visiting partner (CRM, RCS, DSHS licensor) where plans (IISP, FA/PBSP, CSCP) are kept.
- Be prepared to demonstrate knowledge of the plans, their location, & if they are all current.

Positive Behavior Support Plans

- Be aware of earlier minor incidents that can lead to bigger incidents
- Document all restrictive procedures
- Notify plan author when the individual's incidents change
- Follow plans as written
  - They are written that way for a reason
  - It may appear to be more work but the pay off is fewer incidents in the future
- What is the quality of co-worker interactions with the person(s) you support?
- Was the PBSP followed correctly?
- Are there restrictions and if so, is there documentation to justify them?
- Are there approved restrictions?
- Were the approved restrictions properly implemented?
- Be prepared to show visiting partner (Case Resource Manager, RCS, DSHS licensor) where plans (FA/PBSP) are kept.
- Re-read Functional Assessment (FA) & PBSP every 6 months

What Should You ALWAYS Do?

Look Beyond Mandated Reporting • Think…Person first – Client second • Expect the Unexpected!

Physical/Sexual Assault

- Is the person you support safe?
- Has law enforcement been contacted?
- Preserve ANY evidence
- Have any other investigatory agencies been contacted (CRU/RCS)?
- Has the person you support been referred to other support services/medical exam?
- If the alleged perpetrator was a staff member, do they have unsupervised access to other vulnerable persons?
- Has agency supervisor been notified?

Medical Systems Advocacy

- Call 911! Empower yourself to do so.
- Require hospital discharge plans for the person & your agency
- Expect step-down from ICU

Hierarchy of Medical Support

- Intensive Care Unit (ICU)
- Specialty area of the hospital
- Regular hospital bed
- Assisted Living
- In-home support
- No in-home support

Medical Systems Advocacy: Residential Agency Readiness

- Be Assertive! Act confidently when questioning the actions of medical personnel, when it relates to your client returning safely to the residential setting.
- Describe the person's skill set & limitations to hospital staff.
- Explain limitations of home environment (equipment needs, lack of licensed medical staff, etc)
- Decline person's return to home if agency cannot support needs
- Call for support from DDA
- Expect that DDA CRMs will talk to social workers/discharge planners on your behalf and that all will communication with the health team.
- Expect that DDA will uphold YOUR decision if the person you support is not ready to return home.
- DDA may provide consultants such as Registered Nurse Delegators to evaluate person's condition

Speak up & contact supervisor when you:

- Are uncomfortable with something you are asked to do
- Believe the person is being discharged prematurely
- Are asked to implement a restrictive procedure
- Know that necessary safety measures are not in place.
- Report YOUR issues/concerns about hospital practice to the Department of Health (DOH)

Special Considerations Before Hospital/Facility Discharge

Remember some conditions may require special protocols

- Seizures
- Blood sugar
- Bowel
- Supervision
- Safety
- Cross System Crisis (may be applicable for mental health hospitalizations)
- Medication changes
- Support needs
- Nurse delegation task changes
- Eating/Swallowing

Medical System Advocacy Plan

So…

- Review your program to ensure supports are adequate & give special consideration to weekend discharge
- Have clear written conditions and support needs for the person you support

Scenario 3 – Carrie

You are the direct support staff person for Carrie, a 38 year old woman with moderate intellectual disabilities who lives in her own home with three other women and is supported through supported living services. Two days ago Carrie developed severe abdominal pain and was taken to the hospital, where it was discovered she had acute appendicitis. This resulted in an appendectomy. The hospital discharge nurse has called you to let you know that Carrie will be discharged the same day after lunch with pain medication.

She won't be able to take this medication independently. She also has an abdominal incision, which means she'll need more intensive assistance with her ADLs.

You don't believe that your agency can meet Carrie's post surgical needs. Carrie's parents/guardians have been with her during her hospital stay, but they can't take her home and want her to return to her own home.

What should you do?

Services DDA Can Provide

- Nurse oversight
- Nurse delegation
- Consultation & training with regional DDA nurse
- Behavioral consultation (regional psychologists/MH team)
- Mental health referral
- Additional staff hours to meet safety needs
- Technical assistance and collaboration & problem solving (not computer TA)

Cross System Advocacy and Collaboration

You must work with the following systems to advocate for your client:

- Employment/Day programs
- Transportation
- Family, friends & neighbors
- Community settings (grocery store, library)
- You must advocate for the health & safety for the individuals you support
- You must communicate with system partners for assistance

What Should You ALWAYS Do?

Look Beyond Mandated Reporting • Think…Person first – Client second • Expect the Unexpected!

Resources

Reporting Procedure to DSHS Hotline

Reports of abuse, neglect or maltreatment:

Adults (18 years and over) receiving DDA supported Living (SL) Services, DDA Group homes, living in long term care facilities or Residential Habilitation Centers (RHC)

- CRU statewide number: 1-800-562-6078
- TTY: 1-800-737-7931

Non-DSHS support vulnerable adults contact local county

County	Contact Number
Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Klickitat, Lincoln, Okanogan, Oreille, Pen, Spokane, Stevens, Walla Walla, Whitman	1-800-459-0421 TTY: 1-509-568-3086
Island, King, San Juan, Skagit, Snohomish, Whatcom	1-866-221-4904 TTY: 1-800-977-5456
Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Kitsap, Lewis, Mason, Pacific, Pierce, Skamania, Thurston, Wahkiakum	1-877-734-6277 TTY: 1-800-977-5456

Children (under 18 years)

- DSHS Child Protection Services statewide number: 1-800-363-4276 or (1-866-ENDHARM).
- Nights and weekends: 1-800-562-5624
- To find local county numbers go to:
  https://fortress.wa.gov/dshs/f2ws03apps/caofficespub/offices/general/OfficePick.asp

References

Adult Protection Services (2009). Reports of abuse, neglect, self-neglect, exploitation of the person, financial exploitation or abandonment. Retrieved from http://www.dshs.wa.gov/altsa

Policy 6.12 Mandatory Incident Reporting Requirements for Residential Services Providers this link: https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/policy/policy6.12.pdf

Washington State Legislature RCW. (2015) Retrieved from http://apps.leg.wa.gov/RCW/default.aspx?cite=74.34&full=true

Washington State Legislature RCW. (2015). Retrieved from http://apps.leg.wa.gov/RCW/default.aspx?cite=26.44.020

After this class, cut this section out and place it in your wallet.

Questions to Ask During Incidents

1. Is everyone safe?
2. What are the support needs of the person in this incident?
3. Does this situation call for an immediate intervention to help ensure healthier and safety? If so, what?
4. Do I need to call for further support from co-workers or management?
5. Does this situation or some individual need to be reported? If so, to whom?
6. What should I do to follow up to ensure any initial safety plan was fully implemented?
7. How/where would any plans or actions be documented?
8. What follow up do I need to ensure occurs?
9. What happened to trigger or cause the situation to escalate?
10. What can or could I do to prevent any future issues?

CRU Statewide number: 1-800-562-6078
TTY: 1-800-737-7931

Beyond Mandated Reporting 3.0 End of Class Review

1. List two questions you would ask before you take someone home from the hospital?

2. Name two thing you need to do when you find something out of place?

3. What is your responsibility when you note that a person's behavior changes?

4. When do you call 911 before your supervisor?

Evaluation – Beyond Mandated Reporting

Date: _____

Trainer: _____

1. List three things you learned today.

1.

2.

3.

2. Something you will do differently in the future as a result of this training:

3. Something that surprised you:

		Low			High
4.	The material was relevant to my job.	1	2	3	4
5.	The material was well presented and held my interest.	1	2	3	4
6.	The presenter was knowledgeable.	1	2	3	4
7.	The presenter was respectful.	1	2	3	4

8. My favorite thing about this training:

9. Please contact me: (optional)

Name: _____

Date: _____

Email: _____

Please make sure you turn this in and receive your certificate. It is your responsibility to keep the certificate to prove that you have taken continuing education. Make sure you share a copy your certificate with all the of the agencies you work for.

Washington State
Department of Social
& Health Services

Transforming lives

(2/17)