Section 10
Overview for Quality Assurance / Abuse & Neglect

In the Dane County DD system, brokers are considered mandatory reporters of Abuse and Neglect. Specifically brokers:

- must adhere to the Dane County Policy on Abuse and Neglect of Person's with Developmental Disabilities;
- having reasonable cause to suspect an adult seen in the course of professional duties has been abused or neglected, or having reason to believe an adult seen in the course of professional duties has been threatened with abuse or neglect and that the abuse and neglect will occur, shall make a report in accordance with Dane County Policy on Abuse and Neglect for Persons with Developmental Disabilities.
- Must adhere to the State of Wisconsin's Elder Abuse & Neglect Reporting Law.

Attached is the Dane County Abuse and Neglect Policy as well as information needed to complete critical incident reports. All abuse, neglect and critical incidents are reported to the Community Services Consultant, Maya Fairchild at 242-6466. In addition the Community Services Consultant is a resource for problem solving around these issues.

ABUSE AND NEGLECT CONTACT:

Maya Fairchild
Dane County Adult Community Services Division
1202 Northport Drive
Madison WI 53704

Phone: (608) 242-6466
Fax: (608) 242-6531
Fairchild@co.dane.wi.us

Mandated contact for Dane County contracted residential and vocational service provider agencies when abuse is suspected.

LEGAL ADVOCATE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES:

Christine White
The Arc-Wisconsin
2800 Royal Ave Suite 209
Madison WI 53713

(608) 241-4272 – Office
(608) 222-8908 – Office Fax
(608) 516-2701 – Cell
christinewhite@ameritech.net

Recommended contact to assist victims of all crimes when the criminal justice system becomes involved.

POLICY GUIDELINES

FOR ABUSE AND NEGLECT OF ADULTS WITH DEVELOPMENTAL DISABILITIES

November, 2000
(Revised November 2004)

Dane County
Department of Human Services

Division of Adult Community

1202 Northport Drive, Madison WI 53704 – (608) 242-6200
Director Lynn Green
Division Administrator Fran Genter
Dane County Executive Kathleen Falk

DANE COUNTY, WISCONSIN ADULT COMMUNITY SERVICES
POLICY GUIDELINES FOR ABUSE AND NEGLECT OF ADULTS WITH DEVELOPMENTAL DISABILITIES

November, 2000

Revised November, 2004

Introduction

The first abuse and neglect policy guidelines for adults with developmental disabilities were developed in 1993 for Dane County Department of Human Services, Adult Community Services Division, Developmental Disabilities Section (DCACS). They were researched and written by a group of individuals who work with people with developmental disabilities. Over the past eleven years, much has been learned in Dane County about responding to abuse, neglect, and unlawful activity towards people with developmental disabilities. Consumers of DCACS services have shared better ways to receive support, caregivers have contributed insight, and agencies have collaborated with DCACS to explore when and why abuse happens. People working in the developmental disabilities service system in Dane County have joined with people in the criminal justice, sexual assault, and domestic violence systems at the county and state levels to fashion better responses to abuse of vulnerable people.

With these new understandings and alliances, the work group reconvened in 1998 to formulate updated policy guidelines to respond to abuse. The guidelines were again revised in 2004. These guidelines represent many hours of discussion amongst the group members, interviews with professionals in the criminal justice and developmental disabilities systems, and research of laws and articles. The policies are modeled after best practices represented in the elder abuse, sexual assault, and domestic violence service systems. The Department of Health and Family Services' Wisconsin Caregiver Program provides a framework for screening agency staff.

The purpose of these policy guidelines is to give residential, vocational, and support broker agencies under contract with DCACS consistent direction for reporting abuse and for responding to the needs of abused consumers.

Policies don't keep people safe. Nor do these policy guidelines outline comprehensive prevention strategies. Agencies must provide employees with sufficient training regarding prevention of abuse and response to allegations of abuse towards the people they support. DCACS, in collaboration with consumers, agency staff, and other caregivers, will continue assessing and refining ways to prevent and respond to abuse.

1998 Abuse and Neglect Workgroup

Ellen Baur	Formerly of Work Alternatives for Rural Communities
Monica Bear	Case Manager Supervisor, Adult Community Services
Maya Fairchild	Abuse and Neglect Contact, Adult Community Services
Roy Froemming	Attorney in private practice, Formerly of Wisconsin Coalition for Advocacy
Olwen Blake	Executive Director, REM
Christine White	Legal Advocate for People with Developmental Disabilities, ARC

Thank you to the many people who reviewed the Policy Guidelines. Special thanks to:

Dyann Hafner	Dane County Corporation Counsel

Olwen Blake, Maya Fairchild, Dyann Hafner, Kim Turner, Dan Rossiter, and Christine White reviewed the 2004 Revised Guidelines.

Original and revised Guidelines written by Christine White
Abuse Resource Handbook compiled by Christine White

Using These Guidelines

The guidelines and accompanying Abuse Resource Handbook should be viewed in their entirety. Reading both the Guidelines and Handbook will give residential, vocational, and support broker agencies that are developing internal abuse and neglect policies an idea of how to proceed, as well as the laws and best practice behind required policy. Agencies have flexibility to create and implement policies that best meet their agency and consumer needs, and which incorporate required components of the guidelines. ***The parts delineated in bold are requirements of DCACS, and, by contract must appear in residential, vocational, and support broker agencies' policies.*** The remainder is considered best practice by DCACS, and is therefore not mandated, but "strongly encouraged". (Handbook 1–Schedule A)

Definition of Agencies/Agency Staff

"Agencies", as used in these guidelines, refers to any agency or entity under contract with Dane County Human Services, Adult Community Services Division, Developmental Disabilities Section. "Agency staff" refers to employees of residential, vocational, and/or support broker agencies that contract with DCACS. Directors of agencies or their specific designees are responsible for carrying out the directives of these policy guidelines.

Definition of Abuse

"Abuse", as used in these guidelines, refers to any sexual abuse; physical abuse, abandonment; neglect; financial exploitation; domestic abuse; confinement, restraint, and/or isolation without legal authority; forcible administration or misuse of medication; stalking; emotional abuse, disrespectful, or demeaning statements or behavior towards consumers; harassment; intimidation; or illegal activity that victimizes a consumer. (Handbook 2 – Statutes and Administrative Code which define abuse –
s. 55.01; s. HFS 13.03; s. 940.30; s. 940.32; HFS 83.21)

Mandatory (Required) Reporting

Agencies shall report to the DCACS Abuse and Neglect Contact all suspected or known abuse towards any adult with developmental disabilities for whom the agency provides services using DCACS funding. A verbal report shall be made within 24 hours or on the next business day after the abuse is noticed. A written report shall be submitted to the Abuse and Neglect Contact at DCACS within 2 weeks, and shall include any reports obtained from law enforcement. Agencies must use the County Critical Incident Report to document each allegation of abuse. (Handbook 1, 3, 4 – Schedule A; Abuse and Neglect Contact;
Critical Incident Report Form)

Employees of each agency shall develop internal systems for reporting and documenting abuse. Every employee of the agency is required to report incidents of abuse or neglect. The employee shall be able to report suspected or known abuse/neglect without fear of reprisal, even when the suspected abuser is a fellow employee. Minimally this will include immediately notifying the agency Fact-

Finder (see below) of suspected abuse and designating who will call the DCACS Abuse and Neglect Contact.
Agencies are strongly encouraged to provide appropriate legal and disciplinary consequences to employees who abuse consumers.

Compliance with DCACS contract requirements does not necessarily mean agencies have complied with all other laws and mandated reporting requirements to other Wisconsin entities, such as to the Department of Health and Family Services.

Fact-Finders

Agencies shall assign at least two employees or persons under contract with the agency who will be responsible for internal fact-finding when abuse is suspected towards any consumer who receives DCACS funding and who is supported by that agency. At least one Fact-Finder shall be available to the agency at any given time. The Fact-Finders must have clear authority to ask questions and receive answers from other employees, to interview people privately, to view records, to take charge of evidence before law enforcement arrives, to take action necessary for the safety of the consumer, and to take action necessary for an effective fact-finding response. Ideally, a Fact-Finder will be a long-term employee who possesses an understanding of how abuse occurs and is prevented.

In many cases, no fact-finding will be necessary as it will be apparent abuse has occurred or the consumer has reported abuse or law enforcement has been contacted.

Agency Fact-Finders or their designees shall report suspected abuse to the Abuse and Neglect Contact within 24 hours, even if fact-finding is not completed.

Fact-finding should be done by the agency where the abuse occurred, the agency which is most directly involved or, if the abuse occurred in a setting other than a residential or vocational agency, by the agency which first recognizes the abuse. Residential, vocational, and support broker agencies will need to communicate and share information with one another to decide who will do the fact-finding and to accomplish effective fact-finding.

The DCACS Abuse and Neglect Contact may choose to conduct the fact-finding or an agency director may request that the Abuse and Neglect Contact conduct the fact-finding when:

- There is a conflict of interest
- The alleged abuser is a guardian, parent, or other family member

The DCACS Abuse and Neglect Contact and/or Legal Advocate for People with Developmental Disabilities are available to consult on fact-finding issues. (Handbook 3)

Agencies shall cooperate with and provide information to the DCACS Abuse and Neglect Contact as requested.

All Fact-Finders shall attend meetings and training provided by DCACS on best practices for agency internal fact-finding. This training will include information on interviewing, documentation, understanding behavior, sexual abuse and assault,

domestic violence, bruises and other physical injuries, evidence, report writing, reporting requirements, and the role of law enforcement. Fact-Finders are not criminal investigators, but are expected to know how to gather enough information to make immediate safety decisions on behalf of the consumer and when to involve state licensing personnel and law enforcement. (Agencies may borrow videotapes of the training and handouts from Maya Fairchild or Christine White. Handbook 3)

Personnel Considerations for Agencies

Employment application process

Agency directors are strongly encouraged to familiarize themselves with Wisconsin employment law and attend training on this topic. (Handbook 5 – Overview of Wisconsin Employment Law)

- **References must be thoroughly checked on all applicants considered for hire.**
- **Any applicant considered for employment must complete a Background Information Disclosure (BID) form and the agency or other employer must keep these BID forms on file**. (Handbook 6 – BID instructions and form). Probationary employment may begin after a satisfactory BID is received, but it is strongly recommended that consumers not be left alone with a new employee until the background check is completed.
- The Employee Directory is a listing of all persons who quit or are terminated from employment with residential, vocational, and broker agencies under contract with DCACS. A mere listing in the Directory does not signify that an applicant has either a positive or negative work record, rather it is a source for determining the applicant's work history and references. (Handbook 1 – Schedule A)

  Agencies shall register all employees who have quit or been terminated by e-mailing or calling the Employee Directory (cline.nan@co.dane.wi.us, or 242-6470) and shall provide the following information:
  1. **Employee name**
  2. **Date of birth**
  3. **Employer name**
  4. **Dates of employment**

  Agencies considering an applicant for hire shall contact the Employee Directory to see if the applicant is listed. If the applicant is in the Directory, the hiring agency shall call all previous agencies under contract with DCACS with which the applicant has worked. Agencies shall respond within 48 hours to inquiring agencies currently under contract with DCACS, providing any and all pertinent information (allowable under labor law) that will assist in a hiring decision. A sample form "Re-Employment Questionnaire" is included in the Handbook. (Handbook 7 – Re-Employment Questionnaire)

Background check requirements

Criminal background checks must be completed on any person who:

- **Is considered for employment using DCACS funding, including those hired through Self-Directed Services**

- **Is over 18 and is living with employees of the agency who live in the same residence as the consumer.**

Resources for completing background checks

- **Check http://www.doj.state.wi.us/dles/cib/crimback.asp for more information on background checks.**

- **Agencies must submit a Wisconsin Criminal History Record Request to the Department of Justice (DOJ) on all prospective employees. The box entitled "Caregiver – General" must be checked to obtain full information for a caregiver background check.** Agencies are strongly encouraged to have background checks done every four years on all current employees. (Handbook 8 –WI Criminal History Record Request instructions and form)

- When the DOJ check is completed, the agency will receive a letter from DOJ, **which shall be kept on file.**

- An applicant's misstatements on his or her application would normally be sufficient reason for the applicant not to be hired.

- Agencies are strongly encouraged to use the Wisconsin Circuit Court Automation Program (CCAP) website as an adjunct to background checks: http://ccap.courts.state.wi.us/. (Check "Case Search" and type in the first and last name.) This web site will access Criminal Summary Reports for most Wisconsin counties. Note whether the applicant was actually convicted of the charges. This check alone does not satisfy the background checks requirement nor does it contain details about the circumstances of a case. A search on CCAP that fails to find a record does not mean that the applicant does not have a record.

- Agencies are strongly encouraged to check the Wisconsin Caregiver Misconduct Registry website at http://www.dhfs.state.wi.us/caregiver/misconduct.HTM

- Agencies are strongly encouraged to submit a Drivers Record Information Request on applicants being considered for positions that require transporting a consumer. http://www.dot.wisconsin.gov/drivers/forms/mv2896.pdf

- Agencies are strongly encouraged to call the Wisconsin Sex Offender Registry Information access line at 1-800-398-2403. Agencies must have the applicant's full name, exact birth date and either the social security number or driver's license number. This is a 24-hour automated system, which will give information on certain offenders since December 25, 1993. The Sex Offender website can also be used knowing only the first and last name of a person. http://offender.doc.state.wi.us/public/ (Handbook 9 – Wisconsin Sex Offender Registry Information)

- Agencies are strongly encouraged to check an applicant's military records, if applicable. All persons no longer active in the Armed Forces receive DD214's upon discharge. The DD214 provides information concerning the person's military discharge status. Anything other than "honorable" may indicate a concern needing

further exploration. The Wisconsin Department of Veteran's Affairs, which can be reached at (608) 266-1311, may help veterans obtain new copies of their DD214 and help employers understand the DD214.

- **Agencies shall make a good faith effort to obtain out-of-state conviction records for employees who resided out of state at any time during the three years preceding the date of the search.** Information on this can be obtained at **http://www.doj.state.wi.us/dles/cib/sclist.asp**

- **Agencies shall not employ any person as a caregiver or who is expected to have regular, direct contact with a consumer, whose criminal behavior or past work performance is substantially related to the care of the consumer and indicates the person would be a danger to or would negatively affect the consumer's well-being.**

- **Agencies shall include in their personnel policies a provision which would require all employed staff, contracted persons, or persons residing with employees who live at the same residence with consumers to notify the agency director or designee within one week when that person has been charged with or has been convicted of any crime.**

- **Agencies shall not permit any child under the age of 18 to be in a caregiver role of a developmentally disabled person, including children living in the home of the caregiver.** Exceptions may be supervised volunteer or student intern programs.

Monitoring Personnel

- Supervisors in residential agencies are strongly encouraged to frequently visit the homes they support and to maintain an open dialogue with caregivers about the caregivers' concerns and supervisor's observations.

- When a live-in direct support staff is discharged due to suspected abuse, residential agencies are strongly encouraged to have a supervisor accompany the discharged employee back into the home to remove his or her belongings and that the removal of belongings is done immediately. Locks may need to be changed.

- Agencies are strongly encouraged to have procedures to ensure that discharged employees do not remove any property, but their own belongings, from the premise.

Required Training

Agencies shall offer the following training as soon as feasible after hiring employees who will have any direct contact with consumers:

- **Orientation to the agency's own abuse and neglect policies and protocol for reporting abuse within the agency**
- **Recognizing abuse and neglect, including signs of physical and sexual abuse** (Handbook 10 –Recognizing Sexual or Physical Abuse in People with DD)

- **Reporting abuse to Fact-Finders and law enforcement, and mandatory (required) reporting to DCACS**
- **Consequences for not following agency policies and procedures**
- **Awareness of laws related to people with developmental disabilities and abuse** (Handbook 11 - s. 940.285; s. 940.295)
- **Recognizing subtle forms of abuse, disrespect, and power and control by agency staff** (Handbook 12, 13 –subtle forms of abuse; power & control/equality wheel)

Recommended abuse prevention training for all agencies:

- Managing Threatening Confrontations (Handbook 14 – course descriptions)
- Power and Control; Learning to Use it Respectfully (Handbook 14)

Guardianship

The role of the guardian is to protect the ward's interests and the guardian is accountable to the court for his or her actions in fulfilling this role. Agencies are also responsible for protecting the consumer, whether or not the consumer is under guardianship. Agencies may take necessary actions, distinct from the authority of the guardian, to protect the consumer from harm. Consumers under guardianship may also take necessary actions, to the extent they are capable, to protect themselves, just as could any citizen.

Exceptions of reporting abuse to a guardian are if the guardian is suspected of the abuse, is protecting or is in collusion with the abuser, or is acting in conflict with his or her role of protecting the consumer. **Otherwise, when a consumer under guardianship has been the victim of abuse or criminal activity, agencies must involve the guardian as follows:**

- **Notify the guardian as soon as feasible after potential abuse is discovered**
- **Provide the guardian with complete information to enable the guardian to make informed decisions on behalf of the consumer**
- **Advise the guardian as soon as feasible whenever law enforcement has been notified**
- **Encourage the guardian to be involved in planning for the consumer's safety and well-being**
- **Permit the guardian to take necessary additional steps necessary to protect the consumer**

If the guardian is suspected of the abuse, has an apparent conflict of interest related to the abuse, is failing to take necessary steps to protect the consumer, cannot be reached or is unresponsive in regards to the abuse, agencies shall document this and verbally report it to the DCACS Abuse and Neglect Contact and Adult Protective Services (242-6479), if the consumer is under Protective Placement, or the Probate Court (266-4331) as soon as feasible. (Frequently Asked Questions about Guardianship http://arcdanecounty.org/FAQ.html)

Notifying Law Enforcement

Agency staff shall contact law enforcement immediately if a crime has been committed and the consumer is in immediate need of protection.
(Handbook 15 – s. 940.34)

Agency staff has the authority to contact law enforcement when such enforcement is reasonably necessary to provide protection or prevent revictimization of a consumer.

If a crime has been committed against a consumer, but he or she is safe from harm, agency staff should make reasonable efforts, considering the consumer's abilities, to determine if he or she wishes to contact law enforcement. The guardian of a consumer should be included in this decision.

Agency staff is strongly encouraged to assist and support consumers in their efforts to contact law enforcement for self-protection or for other protective legal measures. (Handbook 16 – s. 940.44; s. 940.45)

The agency Fact-Finder shall be called immediately whenever law enforcement is contacted for a consumer who is a victim of crime.

Agencies shall notify the consumer's guardian as soon as feasible whenever law enforcement is contacted.

Agencies are strongly encouraged to call and page the Legal Advocate for People with Developmental Disabilities when law enforcement is contacted for consumers who are victims of crime. (Handbook 3,17 – Legal Advocate information)

When contacting law enforcement, agency staff is strongly encouraged to be professional and mindful of confidentiality issues. Sharing information directly related to the crime, the safety of the consumer, and how the victim communicates is generally important to share with law enforcement. Because most information about a consumer is confidential, the agency director should be consulted before agency staff share information about the consumer's diagnosis, IQ, behavioral concerns, veracity, or other like information about the consumer.

After a report has been made to law enforcement, it is neither the consumer's nor the agency's decision to bring criminal charges. A victim of crime may share his/her wishes regarding charges with the District Attorney's (DA) office. Charging a crime is at the sole discretion of the DA.

Agencies shall not retaliate against employees who make good faith reports of suspected abuse to law enforcement, DCACS, Wisconsin Coalition for Advocacy, or the Department of Health and Family Services, which includes the Bureau of Aging and Long Term Care Resources and the Bureau of Quality Assurance.

If a decision is made not to contact law enforcement regarding a sexual assault, the agency is strongly encouraged to preserve relevant available information regarding the suspected abuse and document the decision not to contact law enforcement.

Sexual Contact

There shall be no sexual contact under any circumstances between an agency employee and any consumer while the employee is in a position funded by DCACS.

Sexual Assault

Wisconsin Statute 940.225 defines sexual assault. The definition of 2nd degree sexual assault may pertain to some people with developmental disabilities.
(Handbook 18 - s. 940.225).

Immediately after a sexual assault:

- **Agency staff shall check the consumer for injuries and attend to his or her physical and psychological safety. The environment shall be made safe. In circumstances where this is not feasible, agency staff shall move the consumer to a safe environment.** Agency staff is strongly encouraged to contact the Legal Advocate for People with Developmental Disabilities or a Rape Crisis Center legal advocate as soon as feasible. A legal advocate can accompany the consumer to a physical exam and be there for law enforcement questioning. (Handbook 19 – Rape Crisis Center)

- **Agencies must make a sexual assault examination available to consumers after a sexual assault where there is penetration of some sort or evidence on the body of the consumer. The sexual assault examination shall be documented.** Agency staff is strongly encouraged to take the consumer for a sexual assault exam by a Sexual Assault Nurse Examiner (SANE) at Meriter Hospital Emergency Room as soon as feasible within 96 hours. These nurses are specially trained to examine females and males for signs of sexual assault and can take forensic evidence at the same time. Consumers with Medical Assistance and those who are uninsured may use the SANE services. SANE exams are not recommended when sexual touching happened over clothes or it is clear that there was no penetration, injury or physical evidence. In addition to a SANE exam or if the assault happened more than 96 hours prior, agency staff is strongly encouraged to take the consumer to his or her doctor to be examined for injuries, pregnancy, Sexually Transmitted Diseases, or other concerns. (Handbook 20 - SANE Program)

- A spare set of clothing and shoes should be taken to the exam, as the clothing may be taken by law enforcement for evidence. A consumer who has been sexually assaulted and wishes to have forensic evidence taken at the time of the exam should be advised to avoid urinating, douching, taking a shower or cleaning her/himself in any way, brushing teeth, drinking fluids or rinsing the mouth, or changing clothes before the exam. Physical evidence, such as bed sheets, clothing, towels, washcloths, rugs or anything at the scene of the sexual assault should not be touched before law enforcement arrives.

Physical Abuse

Agencies shall have policies prohibiting agency staff behavior which is injurious to consumers including, but not limited to, punching; hitting; slapping; pinching; arm-twisting; inflicting bruises, welts, punctures, swelling, scratches, and fractures; burning, use of unauthorized restraints; pushing; kicking; dragging;

spitting; or otherwise causing bodily harm to consumers. Agencies shall provide training to agency staff regarding these policies. (Handbook 21 – s. 940.19)

Immediately after physical abuse is noticed, agency staff shall check the consumer for injuries and attend to his or her physical and psychological safety. The environment shall be made safe. In cases where this is not feasible, agency staff shall move the consumer to a safe environment. Agencies must make medical attention available to the consumer immediately after physical abuse is known or suspected. The medical examination shall be documented.

Agencies shall document all bruises and injuries, regardless of their origin, as soon as such bruising or injuries are observed.

Abandonment

Agencies shall have policies prohibiting abandonment, which occurs when a consumer is intentionally left by agency staff without supervision under any circumstance that a consumer requires supervision for his or her safety. Agencies shall provide training to agency staff regarding these policies.

Each consumer shall have a plan for self-supervision ranging from zero to twenty-four hours. The plan shall be reviewed at least annually. Agencies shall develop policies that address emergency back up plans for staff and regular check-in plans for consumers who are unable to obtain help when direct service workers have not arrived.

Financial/Material Exploitation

Agencies shall have clear policies regarding the handling of consumers' funds. Policies shall include prohibition against taking a consumer's money or items belonging to the consumer for any unauthorized reason. This includes, but is not limited to, stealing money or personal items; borrowing money or personal items; rearranging money in an account; transferring money to a caregiver's account; using the consumer's resources, such as telephone, computer and television, in such a way that incurs extra expense for the consumer; buying groceries or other items for the caregiver using the consumer's money. Agencies shall provide training to agency staff regarding these policies. (Handbook 22 – s. 943.20; s. 943.38; s. 943.39; explanation of Financial Abuse Specialist Team)

Medication Abuse

Agencies shall have clear policies regarding the handling of consumers' medications. Policies shall include prohibitions against any intentional mismanagement of a consumer's medication by agency staff. This includes, but is not limited to, stealing medication for personal use; chemical restraint for staff convenience; misrepresenting consumer needs for medication in order to obtain prescriptions for personal use; and giving medication to the individual supported without necessary or medical justification. Agencies shall provide training to agency staff regarding these policies.
(Handbook 23 – Medication Administration Guidelines)

Neglect

Agencies shall have policies prohibiting behavior by agency staff which, because of the failure to provide adequate food, shelter, clothing, medical care or dental care, creates a significant danger to the physical or mental health of a consumer. Agencies shall provide training to agency staff regarding these policies.
(Handbook 8 – s. 940.295)

Domestic Abuse

In Wisconsin Statute section 968.075(a), domestic abuse applies to spouses or former spouses, an adult with whom the person resides or formerly resided, or an adult with whom the person has a child in common. A live-in direct support staff person who physically or sexually abuses a consumer in his or her care may be charged under domestic abuse statutes, in addition to other statutes which may apply.
(Handbook 24 - s. 968.075)

Law enforcement officers are mandated to arrest the primary physical aggressor in a domestic abuse incident if they determine that a person is committing or has committed domestic abuse, and that the person's actions constitute the commission of a crime. The victim may not have input regarding whether or not to bring charges against an abuser. (Handbook 24, 25 –s. 968.075; Domestic Mandatory Arrest)

There are various types of restraining orders and injunctions available through civil court. For purposes of a domestic restraining order, domestic abuse must be committed "by an adult family member or adult household member against another adult family member or adult household member, by an adult caregiver against an adult who is under the caregiver's care, by an adult against his or her adult former spouse, by an adult against an adult with whom the individual has or had a dating relationship, or by an adult against an adult with whom the person has a child in common". A consumer or his or her guardian may choose to obtain a restraining order as a way to safeguard the consumer in a domestic abuse situation. The Legal Advocate for People with Developmental Disabilities or a legal advocate from Domestic Abuse Intervention Services can assist with restraining orders and/or other domestic abuse issues.
(Handbook 26, 27 – s. 813.12, domestic restraining orders and injunctions; s. 813.125, harassment restraining orders and injunctions; Domestic Abuse Intervention Services)

Some agency staff relationships with consumers contain subtle forms of power and control similar to those found in domestic abuse relationships. Agencies are strongly encouraged to develop policy with consequences to address disrespect, emotional abuse, and harassment of consumers. (Handbook 12, 13 –subtle forms of abuse, power & control/equality wheel)

Medical Emergencies

Agencies are strongly encouraged to develop plans for consumers regarding foreseeable emergencies. Residential agency staff is strongly encouraged to keep all

medications and essential medical and emergency information in an easily accessible place for Emergency Medical Technicians (EMTs) to see. Consumers who do not live with direct service workers should be encouraged to keep emergency and medical information, or the location of such information, where it can be easily spotted by an EMT, such as on the outside of the refrigerator.

Agency staff have the authority to contact emergency medical services if a consumer is in immediate need of medical attention.

Agency staff shall notify the agency Fact-Finder as soon as feasible regarding any medical emergency that is related to abuse or illegal activity.

Deaths

Law enforcement may conduct a death investigation when a citizen dies in a setting other than a hospital or licensed nursing or hospice facility. Exceptions may be when a consumer dies under the care of a hospice program or death was expected. The coroner may be called to the scene and agency staff may be questioned about events leading up to the death. (Handbook 28 – s. 979.01)

Agency staff shall notify the agency Fact–Finder and the coroner or law enforcement as soon as feasible upon the unexpected death of a consumer in a setting other than a hospital or licensed nursing facility.

Agencies shall call the Abuse and Neglect Contact at DCACS within 24 hours or on the next business day of any death. This includes unexpected deaths in a hospital or licensed nursing facility. A County Critical Incident Report must be filled out and submitted to the Abuse and Neglect Contact within 2 weeks. (Handbook 4)

Agencies are strongly encouraged to provide opportunities for grief counseling for consumers when the death of someone close to them has occurred.

Safety Planning and Follow-Up

Agencies are strongly encouraged to work with consumers to develop safety plans, which should be reviewed every six months and following an allegation of abuse.

Planning for safety may include:

- Teaching consumers how to use a house key
- Teaching consumers protective behaviors
- Encouraging consumers to report abuse
- Evaluating the isolation of a living situation
- Encouraging consumers to carry current identification or to develop “safety cards” containing:
    - Consumer’s name, address, and phone number
    - Agency contact person, phone and pager numbers
    - Guardian name and phone number

- Teaching consumers to show safety cards or identification to law enforcement or medical personnel when assistance is needed

Victims of abuse need immediate support and may need this support for many months. Agencies are strongly encouraged to obtain support for victims of abuse through resources such as the Rape Crisis Center, Domestic Abuse Intervention Services, psychotherapy, the Legal Advocate for People with Developmental Disabilities, and/or ongoing counseling through the agency. (Handbook 3, 19, 27– Legal Advocate, Rape Crisis Center, Domestic Abuse Intervention Services)

Agencies are strongly encouraged to develop sexuality policies, which at minimum should include providing sexuality education to consumers, helping consumers understand consent in sexual relationships, and teaching consumers correct language or alternative forms of communication for sexual concepts.
(Handbook 29 - sexuality policies)

Residential agencies are strongly encouraged to assess staff and housemate compatibility with consumers to ensure the home environment meets the consumers' safety requirements.

When agencies identify gaps in the safety of consumers they support, they are strongly encouraged to bring the issue to the Dane County Quality Assurance Board for multidisciplinary team solutions. (Handbook 30 - Quality Assurance Board)

Agencies are strongly encouraged to review all Support Plans of consumers every six months.

Agencies are strongly encouraged to review their agency abuse and neglect policies and procedures yearly, and following an allegation of abuse, to improve safety for consumers.

Critical Incident Review: When is a Critical Incident Report Required?

If you have any questions or are unsure about whether to report, call Maya Fairchild at 242-6466.
Read the State memo for more detailed definitions

If this happens, the answer is…

- Abuse or Neglect, physical, verbal, mental, financial, sexual? YES, always
- Death, by any cause? YES
- Emergency Medical Treatment? YES
- Fires, Acts of Nature: Resulting in property destruction or injury? YES
- Hospitalization, not routine? YES
- Hospitalization, routine? Complete a report once, note the frequency, note in the person's plan
- Medical Errors, threat to health or life? YES
- Medical Errors, frequent occurrences? YES
- Medical Errors, not a threat to health? NO
- Missing Person, routine elopement and plan is in place? NO
- Missing Person, non routine or person missing for more than usual? YES
- Police Contact, routine, part of a plan, reviewed by the Restrictive Measures Committee? NO
- Police Contact, not routine, or routine but results in arrest or injury? YES
- Suicide Attempts, Suspected or Confirmed? YES
- Unsafe or Unsanitary Conditions, anywhere person receives services? YES
- Violation of Rights, Restrictive Measures, routine use, part of a plan, reviewed by Restrictive Measures Committee? NO
- Violation of Rights, Restrictive Measures, emergency use, not reviewed by Restrictive Measures Committee? YES

STATE OF WISCONSIN
Department of Health and Family Services
Division of Supportive Living

DSL Memo Series 2003 - 02
January 8, 2003
Re: RESPONDING TO AND REPORTING CRITICAL INCIDENTS IN CIP 1A/B, CSLA AND BRAIN INJURY WAIVERS

cc: [illegible]
Theresa Sanders
Dan Rossiter

To: Area Administrators/Assistant Area Administrators
Bureau Directors
County Departments of Community Programs Directors
County Departments of Developmental Disabilities Services Directors
County Departments of Human Services Directors
County Departments of Social Services Directors
Licensing Chiefs/Section Chiefs
Tribal Chairpersons/Human Services Facilitators

From: Sinikka McCabe
Administrator

The assurance of health, safety and welfare of program participants is a condition of approval of all Medicaid (MA) Waivers by the federal Centers for Medicare and Medicaid Services (CMS). County agencies are required to address this pursuant to conditions in the state/county contract and the Medicaid Waivers Manual. One of the ways both counties and the Department assure health, safety and welfare in MA Waivers administered by the Bureau of Developmental Disabilities Services (BDDS) is by reporting, monitoring and resolving critical incidents. Since 1997, Chapter 9, section 9.06 of the MA Waivers Manual has included an explicit requirement for counties to report critical incidents involving individuals served on waivers administered by BDDS to the regionally based Community Integration Specialist (CIS). A standard definition of these events or prescribed reporting format was not included in the Manual. This has made it difficult to document the frequency and nature of all critical incidents. CMS in their recent review of the Brain Injury Waiver program recommended standardization of the reporting process in the format supplied in this memo. This DSL memo contains a definition of critical incidents and establishes a prescribed format for counties to use in reporting these incidents.

The definitions used come from either statutes or administrative rules. The reporting format in this memo has been in use for a number of years with state staff completing the critical incident report based on verbal and written communications with county staff. The original internal BDDS system was developed with informal advice from a number of counties that already had incident management systems in place. In fact, Winnebago County's system was used as the model for the system described below.

CRITICAL INCIDENTS DEFINED

A "critical incident" is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well being of a waiver participant. The critical incidents covered by this memo that must be reported include:

- Any abuse or neglect of the participant inflicted by others;
- Any misappropriation of the person's funds or property;

Document Summary

This memo defines the content and format for critical incident reporting in BDDS-administered MA Waivers. It communicates the Division's policy requiring County Agencies to report critical incidents, defines these incidents and describes the way counties make these reports. This policy will come into effect 30 days after the date of this memo but will apply to all 2003 incidents.

- A violation of the persons rights under S. 51.61 WI Stats. And Chapter HFS 94;
- All unexpected, untimely and urgent emergency hospital admissions including any that are or may be the result of substandard care; this excludes urgent care clinic visits for acute physical health issues;
- Errors in medical or medication management that result or could result in significant adverse medical reactions or behavioral responses indicating a threat to the person's health;
- The initiation of an investigation by law enforcement authorities of an event or allegation that involves a waiver participant either as a perpetrator or victim that may lead to criminal charges;
- Any death of a waiver participant including those by natural causes. (This does not replace any other death reporting requirements);
- All suspected or confirmed suicide attempts by a waiver participant;
- A fire in the home or facility in which the participant lives or where the participant was receiving services if the fire required the response of a fire department and created a significant risk to the participant's health or safety;
- Significant damage to property including but not limited to the property of the waiver participant, service providers, to the participant's residence, place of employment or other place the participant frequents if such property damage poses or posed a threat to the person's health, safety or welfare. Includes damages that are the result of acts of nature such as storms.
- Unsafe or unsanitary environmental conditions in a person's home or place where the individual receives services;
- Use of isolation, seclusion, or restraint (physical or chemical) by a service provider in violation of S. 51.61 WI Stats. , HFS 94.10 without county and the Department's prior approval;
- Unanticipated absence of the participant including any unauthorized leaving by the participant such as wandering or intentionally leaving which suggest that the participant is at risk of harm.

***County staff should take special note that reporting critical incidents on this system does not eliminate any other reporting requirements. All other required reporting procedures such as child abuse or caregiver reporting or notifying BQA of possible code violations and the timelines of these other required reporting systems remain in force and are not replaced or superseded by this process.**

APPLICATION
The subjects to whom this memo applies are Medicaid Waiver participants with a developmental disability or acquired brain injury who participate in one of the MA Waivers administered by the Bureau of Developmental Disabilities Services (BDDS). Responsibility for responding to such incidents is with the county agency operating the Medicaid Waiver. Counties are encouraged to make the responsibility for reporting and the procedures recommended in the attached instructions a condition of their contracts or agreements with all service providers.

THE CRITICAL INCIDENT REPORTING AND RESPONSE PROCESS
Counties are expected to have an effective response process in which county staff or their agents address and resolve the situations and implement systems to decrease the likelihood of a recurrence. The report documents the occurrence of the incident and describes the county's response by their staff or contract agencies. Reports must contain accurate and timely information. BDDS will use the Critical Incident Reports to identify statewide or regional trends, which will then allow the development of interventions to decrease the likelihood of reoccurrence.

The critical incident response process begins with local staff learning of the situation. They determine what has occurred and determine the response needed. Critical incidents that have been confirmed to have occurred or exist as well as alleged critical incidents that have not yet been determined to be founded or unfounded should be reported. If the reported critical incident is determined to be unfounded the report will be withdrawn. The response by county staff is intended to remove the waiver participant from danger and resolve the situation to remove the risk. The event and the response are to be reported

to the assigned CIS for the county within five days of learning of the event. Often these reports initially are done by phone and might result in a collaborative effort by state and local staff. Such efforts often attempt to constructively resolve problem situations. State CIS serve as consultants, often serve a liaison function with other units in the Department such as the Bureau of Quality Assurance (BQA) or may get involved by assisting with increased on-site monitoring of some situations. Critical incident follow up may be completed in as short of time as a day or may involve a number of corrective actions that may occur over a longer period of time. The incident investigation may also lead to follow up monitoring by both county and state staff and plans of correction for the county or the provider involved.

THE CRITICAL INCIDENT REPORT (CIR)

Reportable incidents must be reported using the prescribed format provided in this memo. The attached Critical Incident Report must be sent to the Bureau of Developmental Disabilities Services' Central Office within five working days of the county learning of the situation. For active and urgent situations, County staff should also report the incident by phone to their assigned CIS. (Phone numbers are in the Medicaid Waivers Manual, Appendix L.) County staff may also make other arrangements with the CIS concerning the due date for submission of the form. Additional reporting concerning the progress and disposition of the event that occurs after initial reports shall be done in a timely way. All CIRs must include information necessary for BDDS to close the incident record.

Reports shall be mailed or faxed to:

Critical Incident Report Contact
Waiver Program Assistant
Bureau of Development Disabilities Services
P. O. Box 7851
Madison, WI 53708

FAX (608) 261-6752

County staff are strongly encouraged to report serious and active incidents to their CIS by phone immediately on learning of the situation. Department staff must often respond to inquiries from police, legislators, advocacy organizations, the press and others. Accurate and up to date information helps us assure these groups that events are being handled appropriately. In serious and active situations, make sure you talk to someone from BDDS in person and not just leave a message on someone's voice mail. The first point of contact is the county assigned CIS. If the CIS is not available, please call the central phone number at BDDS 608-266-0805 and ask to speak with a manager.

The paper form is attached to this memo. In the future, the form will be available in a format that counties can use with word processing programs. It is also our intent to expand the use of data collected on this form to further analyze the nature and extent of CIRs to identify patterns. Specifically, we hope to identify trends and clusters of critical incidents including providers with persistent incidents to make adjustments and improvements as needed. The results of such efforts will be shared with counties to assist future state and local quality improvement efforts. It is our hope and belief that this process will improve the quality of care in our Medicaid Waiver programs.

IMPLEMENTATION

Counties are required to implement the requirements of this memo as quickly as possible. Counties have a 90-day implementation period from the date of this memo to work out the procedures and inform affected providers and staff. All critical incidents that occur on or after January 1, 2003 shall be reported. This will permit the department to have and analyze a full years worth of data. Since critical incident reporting was previously required by Chapter 9 of the Medicaid Waivers Manual, and this new requirement including the form and instructions will be added to Chapter 9 of the revised Manual.

We ask and thank you for your cooperation in this effort.

REGIONAL OFFICE CONTACT: Community Integration Specialist

CENTRAL OFFICE CONTACT: Ken Golden
DSL/BDDS
(608) 266-1520

MEMO WEB SITE: http://www.dhfs.state.wi.us/partners/local.htm

L/#memo/DSL/BDDS_critical incidents.doc

Instructions for Completing Critical Incident Reports

I. Overview

The Department of Health and Family Services is required by the Centers of Medicare and Medicaid (CMS) to insure the health, safety and welfare of Home and Community-based waiver participants. The Department shares this responsibility with County agencies in the State-County Contract by requiring County compliance with the Medicaid Waivers Manual. Chapter IX of this Manual requires each County agency administering any of the waivers to have an adequate system to ensure waiver participants are adequately protected form physical, verbal and sexual abuse. Maltreatment, neglect, financial exploitation and violations of their rights under law. Chapter 9 also requires counties to have an effective response system when Incidents of this kind arise. The Manual also specifies Critical Incident Reporting requirements for counties. The Manual requires County agency staff to report Critical Incidents as defined here. Please refer to the Medicaid Waiver Manual, Chapter IX: Assuring Health, Safety and Welfare, for detailed information.

II. Timelines

The County must report all Critical Incidents to the assigned CIS within 30 days of the Incident. **If a CI has the potential of becoming a high profile situation, the County is asked to immediately contact the assigned CIS or the Bureau of Developmental Disabilities at (608) 266-0805 to alert them and seek any assistance that may be needed.**

Completion of the BDDS Critical Incident Report does not meet any other requirements for reporting events, deaths or misconduct to other state or County agencies. Please visit the Department web site for additional information regarding reporting requirements at www.dhfs.state.wi.us.

III. Procedures:

The following is a recommended sequence of procedures county staff and the service providers involved may wish to follow in responding to reportable critical incidents.

1. Immediately upon learning of an allegation of a critical incident, the service provider should determine if the allegation is credible. If there is reasonable cause to believe that the report may be accurate, the service provider should proceed with the next steps listed here.

2. The service provider's first responsibility is to take necessary actions to protect waiver participants from the potential of harm. In doing this, they should preserve possible evidence for an investigation if one is to be conducted.

3. The provider must notify the case manager/service/support coordinator or designated county staff of the allegation and results of any action taken. Agencies are expected to notify local law enforcement authorities in any situation where there is a potential violation of criminal law.

4. The county case manager/ Service/support coordinator should notify the guardian is about the situation/ incident.

5. **If an incident has the potential of becoming a high profile situation, county agency staff are asked to immediately contact their assigned CIS or the Bureau of Developmental Disabilities at (608) 266-0805 to alert them and seek any**

assistance that may be needed. Knowledge of such situations by department staff often helps alleviate concerns that may come from legislators or the media about the adequacy of responses that might arise if the department is not so informed.

6. The county staff or their agents/contractors who are involved should promptly determine if the critical incident occurred and if the person's with on-site responsibility have taken the necessary steps to ensure participant health, safety and welfare as required by the waiver. County staff should also determine if the service provider's procedures and responses were adequate. The county must take action to ensure that any remedial action needed is taken.

7. If county staff determine that the situation or event occurred, they should next determine if a longer term, a substantive response or change is warranted. County staff should take all actions necessary to make the changes needed including substitution of provider, termination of contracts, etc. These may occur after the initial CIR but shall be reported in updates to the initial CIR.

8. The CIR is intended to summarize the details of the incident, the county's review and participant outcomes. Each such incident should also be viewed as a test of the adequacy of the county's response system. County staff shall send the completed Critical incident form (DSL 2558) to their assigned CIS. Reports shall be within 30 days of the incident unless other arrangements have been made with the CIS. For active situations, Counties are encouraged to submit the report earlier.

9. If a county is unable to gain access to certain findings or records within the 30 day time frame due to concurrent investigations or other extenuating circumstances beyond their control, the county should send in all available information with a notation that the initial report is not complete. County staff should indicate when the rest of the report is anticipated if that is known or can be predicted.

10. County agencies are responsible for "closing" all critical incident reports. Closing here means submitting a report and any necessary updates so that all pertinent information about the event and the response are included in the report. Follow up visits or future targeted reviews are usually not expected to be part of the report unless they occur within a short time frame.

11. The DSL/BDDS staff will review all CIRs. This review is intended to determine:
    - if participant's health, safety and welfare are now adequately protected;
    - that the response to the situation and event was reasonable and appropriate;
    - that the county's procedures and system for responding to such incidents were adequate;
    - that the participant's service plan is adequate;
    - that where relevant, steps to prevent similar incidents were taken;
    - that all service providers or staff involved in the incident appear to be adequately trained or that additional training needed is to be provided pursuant to the report;

12. County staff should take special note that all other required reporting procedures such as Child abuse reporting and the timelines of other required reports remain in force and are not replaced or superseded by this process.

III. Definition of Critical Incidents and Key Terms

1. **Critical Incidents** are events or situations that pose an immediate and/or serious risk to the physical or mental health, safety, or well being of a waiver participant. A Critical Incident may also involve the misappropriation of a waiver participant's property or a violation of the person's rights. Waiver participants covered by this include people with a developmental disability or acquired brain injury who participate in one of the Medicaid Waivers administered by the Bureau of Developmental Disabilities Services (BDDS). Critical Incidents that are alleged to have occurred as well as the results of internal investigations are to be reported. If the reported Critical Incident is determined to be unfounded, the report should still be submitted.

2. **Abuse** means any of the following:
   a. An act, omission or course of conduct by another that is inflicted intentionally or recklessly and that does at least one of the following:
      (1) Results in bodily harm or great bodily harm to the individual.
      (2) Intimidates, humiliates, threatens, frightens or otherwise harasses the individual.
   b. The forcible administration of medication with the knowledge that no lawful authority exists.

   Examples of abuse include:
   - mental/emotional abuse - threats of harm, name calling, blaming, ignoring, threatening to withhold personal property or denying client rights or use of tonal inflection that intimidates, humiliates, threatens, frightens or otherwise harasses the individual
   - physical abuse - hitting, slapping, pinching, or grabbing a person that causes pain or injury
   - physical abuse - use of a mechanical or chemical restraint, isolation or seclusion without prior Departmental approval
   - physical abuse - restricting the use of a mobility device or intentionally failing to provide necessary assistance for activities of daily living
   - sexual abuse - inappropriate physical contact, exposure to unwanted sexually explicit material or verbal harassment of a sexual nature
3. **Community setting** means a public location that is not under an agency's control such as a park, roadway, shopping center, YMCA or other public accommodation.
4. **Death-accidental** means an unanticipated death that is the consequence of a specific negative and unintentional event such as a medical error, motor vehicle accident, airway obstruction by a foreign object or food or ingestion of a toxic substance. An accidental death is <u>not</u> abuse or neglect.
5. **Death-anticipated** means a death that was medically predicted to occur within six months if only routine and comfort interventions was provided. Anticipated deaths do not include the death of a person with a life-long disability that has been reasonably stable.
6. **Death-related to psychotropics** means death that was contributed to by the use or withholding of a psychotropic medication, or adverse reactions to a psychotropic medication.
7. **Death-related to restraints** means the person was either in restraints, seclusion, or isolation at the time of death or the death was directly related to the proper or improper use of restraints, seclusion, or isolation.
8. **Death-related to suicide** means the participant intentionally placed himself or herself in harm with a reasonable belief that it would result in their death.

9. **Death-unanticipated** means a death that was not predicted or anticipated within 6 months, or caused by an accident. An unanticipated death may be the result of abuse, neglect, an emergency medical condition, high-risk medical procedure, or sudden decline from of a pre-existing medical condition. Deaths due to ruptured bowel, cardiac arrest, pneumonia, sepsis, seizure, or stroke are examples of unanticipated deaths. If the death was related to abuse or neglect, this must be documented in the CIR.

10. **Hospitalization-emergency** means unscheduled medical treatment needed for the sudden and unexpected onset of a medical situation that, if immediate medical attention was not received, could result in death or serious injury to the person.
    Examples of emergency hospitalization include:
    - admission for heart attack, stroke, severe shortness of breath,
    - assessment following a significant trauma event
    - significant loss of blood
    - burns or frostbite over a large portion of the body

11. **Hospitalization-mental health/behavioral** means an emergency or pre-scheduled overnight admission for assessment or management of an unstable mental condition or high-risk behaviors that require management by a physician.
    Examples of mental health/behavioral hospitalization include:
    - emergency detention for mental health symptoms or behaviors
    - deterioration of behavior that requires inpatient assessment
    - admission to an inpatient psychiatric unit for urgent medication adjustment

12. **Isolation** means any process by which a person is physically or socially set apart by staff from others but does not include separation for the purpose of controlling contagious disease.

13. **Law authority contact** means a participant is the subject of an investigation by law enforcement or the victim of an event that is reported to law enforcement.
    Examples of law authority contacts that <u>are</u> a critical incident include:
    - motor vehicle accidents or driver violations that pose a safety risk to a participant **and** the participant is a passenger in the vehicle at the time of the accident or violation **or** is struck by a moving vehicle
    - physical detention by law authorities of a participant for disruptive behaviors, possible or actual legal action or parole revocation
    - investigation of possible criminal activity where a participant is the victim or alleged perpetrator of a crime such as sexual abuse or assault

    Examples of law authority contacts that <u>are not</u> a critical incident include:
    - parking tickets, minor "fender-benders", moving violations that did not pose a risk of harm to a participant

14. **Mechanical support** means an apparatus that is used to properly align a person's body or to help a person maintain his/her balance, or to promote mobility. (Use of a gait belt to provide support during mobility activities is a mechanical support.)

15. **Medical restraint** means an apparatus or procedure that restricts the free movement of a person during a medical procedure or prior to or subsequent to such a procedure to prevent harm to the individual or aid in recovery or when used to protect an individual during the time a medical condition exists.

16. **Neglect means** an act, omission or course of conduct that, because of the failure to provide adequate food, shelter, clothing, medical care or dental care, creates a significant danger to the physical or mental health of an individual.
    Examples of neglect include:
    - environmental – failure to maintain a building, furniture and associated spaces in a clean, well ventilated, and safe condition
    - environmental – failure to provide adequate sensory and mental stimulation appropriate the participant's needs
    - failure to follow plan/poor care - failure to provide support services to an individual according to the care plan or policies and procedures or in such a limited manner that the person's safety or health is compromised
    - medical - failure to provide medication as ordered, prompt and adequate physical care, seek appropriate medical treatment or report change in a participant's condition in a timely manner
    - nutritional - failure to provide adequate and appropriate food, water or other dietary services to meet the needs of the person

17. **Physical restraint** means a manual hold by a support worker or use of an apparatus other than a medical restraint or mechanical support, that interferes with the free movement of a person's limbs or body which the person is unable to remove easily.
    Examples of physical restraint include:
    - a locked room
    - a device or garment that interferes with an individual's freedom of movement and that the individual is unable to remove easily.
    - restraint by a facility staff member of a resident by use of physical force
    - disabling or interfering with a participant's use of a mobility device
    - withholding assistance to a dependent person for the purpose of interfering with the person's free movement

18. **Provider** means any person or agency that is paid by waiver, County, private or public funds for providing a service to the person.

19. **Psychotropic medication** means an antipsychotic, antidepressant, lithium carbonate or a tranquilizer.

20. **Response summary** means actions taken by the person/guardian, County or providers in response to the event or allegation.

21. **Seclusion** means physical or social separation from others by provider not including separation to prevent the spread of a communicable disease or cool down periods in an unlocked room as long as the person's presence in the room is voluntary.

22. **Service provider,** in this context, means a person who is providing paid or unpaid service or support pursuant to the person's individualized service plan. Service providers may be the person in contact with the waiver participant or someone who supervises the people in direct contact with the participant.

23. **Suicide** means the act of taking one's own life voluntarily and intentionally.

24. **Unanticipated absence** means a participant's whereabouts is unknown and he or she is considered missing.

COUNTY CRITICAL INCIDENT REPORT

Instructions: This form must be completed in its entirety. Additional information may be attached to supplement information provided on the report form. FAX this form to the Bureau of Developmental Disabilities Services (BDDS) Critical Incident Contact in Central Office assigned to this individual within 30 days of the incident. Additional material that is not available due to reasons beyond the county's control may be sent under cover letter at a later date. Personally identifiable information on this form is collected for the purpose of improving quality of services and will only be used for that purpose.

1. Date Form Completed (mm/dd/yyyy)

2. Name – Primary Community Integration Specialist

3. Report Type (Check all appropriate)
☐ Original ☐ Update ☐ Correction ☐ Review Closed

4. Date Critical Incident Review Closed (mm/dd/yyyy)

PERSON COMPLETING FORM INFORMATION

5. Name – Last | Name – First

Title

6. Name – Agency

7. Telephone Number

CASE MANAGER INFORMATION (If different from above)

8. Name – Last | Name – First

9. Telephone Number

10. Case Manager ID Number

PARTICIPANT INFORMATION

11. Name – Last | Name – First | MI

12. Birthdate (mm/dd/yyyy)

13. Gender
☐ Male ☐ Female

14. Medicaid Number

15. Telephone Number – Residential

16. Program
☐ BIW ☐ CIP 1A ☐ CIP 1B ☐ CSLA ☐ Other

EVENT

17. Date of Event (mm/dd/yyyy)

18. Location Event Occurred (Street, City, State, Zip Code)

19. Type of Setting

Residence
☐ Participant's private home or apartment
☐ Adult family home (1-2 beds)
☐ Adult family home (3-4 beds)
☐ CBRF
☐ Children's foster home

Other
☐ Work/day program
☐ Community work site
☐ Community setting; e.g., park, store, etc.
☐ Transport
☐ Another person's residence
☐ Other – Specify: ____

20. Allegation of caregiver misconduct?
☐ Yes ☐ No

21. Name – Provider Agency

22. Address – Provider Agency (Street, City, State, Zip Code)

INITIAL REPORT

23. Provide a brief description of initial event or allegation. Send additional documentation only if necessary.

24. How did the reporter learn of this event?

If hospitalization or medical treatment was needed, complete the following.

25. Date of Treatment (mm/dd/yyyy)	26. Name – Institution Where Treatment was Obtained

27. Reason for admission/treatment

28. Outcome of treatment

If the participant died, complete the following:

29. Date of Death (mm/dd/yyyy)	30. Official cause of death as reported on the death certificate

31. Check applicable event type(s) / allegations below. Check "Alleged Only" if there is doubt that the event occurred.

Event Type/Allegation	Alleged Only
Abuse	
☐ Mental/emotional	☐
☐ Physical	☐
☐ Sexual	☐
☐ Verbal	☐
Death	
☐ Accidental	☐
☐ Anticipated	☐
☐ Related to psychotropic medication*	☐
☐ Related to restraint*	☐
☐ Related to suicide*	☐
☐ Unanticipated medical	☐
Hospitalization	
☐ Emergency medical	☐
☐ Mental health/behavior	☐
Law Authority Contact	
☐ Commission of crime	☐
☐ Victim of crime	☐
Misappropriation	
☐ Person's funds	☐
☐ Person's property	☐

Note: * Deaths related to above factors in certain facilities must be reported to the Department/DSL Death Review Committee within 24 hours.

Event Type / Allegation	Alleged Only
Neglect	
☐ Environmental	☐
☐ Fail to follow plan/poor care	☐
☐ Medical/failure to seek	☐
☐ Nutrition	☐
☐ Self neglect	☐
☐ Unanticipated absence of provider	☐
Residence Damage	
☐ Fire	☐
☐ Other	☐
☐ Weather	☐
Other	
☐ Serious illness/injury/accident	☐
☐ Significant behavior that placed others at risk	☐
☐ Suicide attempt	☐
☐ Other rights violations	☐
☐ Unanticipated absence of participant	☐

32. Contact checklist. Check all persons/agencies contact by county, provider and person/guardian. Fill in the first date contacted in regard to this event. * Contacts may be required depending upon circumstances.

☐ A. **Adult Protective Services**
Name-Agency | Date-First Contact (mm/dd/yyyy)
Name-Contact Person | Telephone Number-Agency

☐ B. **BDDS/Community Integration Specialist (CIS) (Required)**
Name | Date-First Contact (mm/dd/yyyy)

☐ C. **Caregivers Investigation*** (608) 261-7561 | Date-First Contact (mm/dd/yyyy)

☐ D. **Child Abuse**
Name-Agency | Date-First Contact (mm/dd/yyyy)

☐ E. **County Case Manager**
Name-Contact Person | Date-First Contact (mm/dd/yyyy)

☐ F. **Elder Abuse**
Name-Agency | Date-First Contact (mm/dd/yyyy)

☐ G. **Guardian** (Required)
Name | Date-First Contact (mm/dd/yyyy)

☐ H. **Law Enforcement Agency**
Name-Agency | Date-First Contact (mm/dd/yyyy)

☐ I. **Licensing ***
☐ **Adult** Name-Agency | Date-First Contact (mm/dd/yyyy)
☐ **Children's** Name-Agency | Date-First Contact (mm/dd/yyyy)

☐ J. **Other Providers If additional space is needed, attach separate sheet**
Name-Agency | Date-First Contact (mm/dd/yyyy)
Name-Agency | Date-First Contact (mm/dd/yyyy)

☐ K. **Physician** | Date-First Contact (mm/dd/yyyy)

☐ L. **Area Administration**
Name | Date-First Contact (mm/dd/yyyy)

☐ M. **Residential Support Provider** | Date-First Contact (mm/dd/yyyy)

☐ N. **Residential Support Provider** | Date-First Contact (mm/dd/yyyy)

☐ O. **Wisconsin Coalition for Advocacy** | Date-First Contact (mm/dd/yyyy)
Telephone Number – Madison (608) 267-0214
Telephone Number – Milwaukee (414) 342-8700

33. Response Summary. Check all that apply; send updates as needed.
☐ **Nothing Changed**

Case Management
☐ Additional services added to plan
☐ Higher level monitoring
☐ Terminated waiver participation
☐ Changed – New case manager is: ______________________

Day/Work Provider
☐ Same agency – staff changed
☐ Same agency – staff training provided
☐ Same agency – staff added
☐ Changed – New provider is: ______________________

Guardian
☐ Changed – New guardian is: ______________________
Telephone number: ______________________

Residential Provider
☐ Same agency – staff changed
☐ Same agency – staff training provided
☐ Same agency – staff added
☐ Changed – New provider is: ______________________

☐ **HFS 94 grievance filed**

☐ **Other –** Specify: ______________________

34. Narrative CI outcome

35. In the internal reviews of this event, were there any recommendations offered to improve the quality of care for other waiver participants or changes in policy/procedure? If so, summarize what the recommendations/changes are and the plans for implementing them.

FOR BDDS USE ONLY

36. Name - Participant	37. Medicaid Number	
38. Name – Staff Member Who Completed This Form	39. Event Date	40. Review Date

41. Check applicable event type(s)/allegations below. Check "Alleged Only" if there is doubt that the event occurred.

Event Type/Allegation	Alleged Only
Abuse	
☐ Mental/emotional	☐
☐ Physical	☐
☐ Sexual	☐
☐ Verbal	☐
Death	
☐ Accidental	☐
☐ Anticipated	☐
☐ Related to psychotropic medication*	☐
☐ Related to restraint*	☐
☐ Related to suicide*	☐
☐ Unanticipated medical	☐
Note: * Deaths related to above factors in certain facilities must be reported to the Department/DSL Death Review Committee within 24 hours.	
Hospitalization	
☐ Emergency medical	☐
☐ Mental health/behavior	☐
Law Authority Contact	
☐ Commission of crime	☐
☐ Victim of crime	☐
Misappropriation	
☐ Person's funds	☐
☐ Person's property	☐

Event Type / Allegation	Alleged Only
Neglect	
☐ Environmental	☐
☐ Fail to follow plan/poor care	☐
☐ Medical/failure to seek	☐
☐ Nutrition	☐
☐ Self neglect	☐
☐ Unanticipated absence of provider	☐
Residence Damage	
☐ Fire	☐
☐ Other	☐
☐ Weather	☐
Other	
☐ Serious illness/injury/accident	☐
☐ Significant behavior that placed others at risk	☐
☐ Suicide attempt	☐
☐ Other rights violations	☐
☐ Unanticipated absence of participant	☐

42. BDDS Response Summary. Check all that apply and the date completed.

		Date Completed			Date Completed
☐	None	______			______
☐	Informal follow-up	______	☐	Caregiver referral	______
☐	Behavior consult	______	☐	Formal POC issued	______
☐	Provide training	______	☐	Formal POC issued	______
☐	Additional field visit	______	☐	ISP revision	______
☐	Licensing referral		☐	CI review closed	

43. Provide any additional information about the event you need to add to the record.

44. Review Planning

		Date Due
☐	Plan of correction	______
☐	Targeted review	

45. ☐ Yes ☐ No Are there attachments in the paper file?

Case Manager's Referral Form to Adult Protective Services For Guardianship and Protective Placement

Attached is the referral form to the Adult Protective Services unit of Dane County Department of Human Services to request that an individual be appointed a Guardian and/or be protectively placed. **Please note the attached medical evaluation, which must be completed by the client's medical doctor, psychiatrist or licensed psychologist.**

This form can also be used for a person currently under guardianship where there are issues surrounding the guardianship you would like addressed.

Please make a copy of the referral and send the original to Adult Protective Services.

Attachments

Community Referral Form for Guardianship And Protective Placement

Complete the attached forms to make a referral for Guardianship of the Person, Guardianship of the Estate and/or Protective Placement to Dane County Adult Protective Services (APS). These forms include a two-page referral form and a six-page statutorily required Examining Physician or Psychologist Report. Determination of incompetence is dependent upon a medical report of a physician, psychiatrist or psychologist. In a short written narrative, please state why a guardian of the person and/or estate is needed plus what less restrictive actions have been taken to permit this person to care for themselves without a guardian or protective placement. If Protective Placement is also being requested, explain the reason it is necessary. If there are questions, please call 242-6200 and ask for Adult Protective Services.

Person Making Referral

Name/Relationship ______________________________

Agency ______________________________

Address ______________________________

City/State/Zip ______________________________

Phone ______________________________

E-mail ______________________________

Information About Person Being Referred

Client Name ______________________________
(First, Middle, Last)

Address ______________________________

City/State/Zip ______________________________

Home Phone ______________________________

Date of Birth ______________________________

Monthly Income from Social Security ______________________

Monthly Income from SSI ______________________

Monthly Income from VA ______________________

Monthly Gross Earnings ______________________

Any Other Income and Source ______________________

Assets, for example: money in bank, client account, etc. ______________________

Guardian Information

Proposed Guardian		Proposed Standby Guardian	
Name		Name	
Address		Address	
City/St/Zip		City/St/Zip	
Phone Number(s):		Phone Number(s):	

Persons to Notify

For Guardianship appointments, family members must be sent notice of this hearing. Please use this space to list family members and their addresses. Start with the individual who would be seen as the next of kin for this person. For example: their spouse, children, mother, or father. If the person does not have a spouse or children and their parents are deceased, then list their siblings. Also, if this person has Advanced Directives such as Power of Attorney for Health Care or Durable Power of Attorney for Finances, please attach a copy. If the person has a Payee, please list.

Name	Relationship	Address	Phone # :

MAIL THIS REFERRAL FORM WITH NARRATIVE and COMPLETED ORIGINAL MEDICAL EVALUATION TO:

Adult Protective Services
Dane County Department of Human Services
1202 Northport Drive, Madison WI 53704

STATE OF WISCONSIN, CIRCUIT COURT, DANE ____________ COUNTY

For Official Use

IN THE MATTER OF

☐ **Amended**

____

Examining Physician's or Psychologist's Report

____
Date of Birth

Case No. ____________________

TO THE COURT:

I am a ☐ physician. ☐ psychologist.

This report is made to the court as required when it is proposed to appoint a guardian for an individual on the ground that the individual allegedly has incompetency. This report contains my professional opinion regarding the presence and likely duration of any medical or other condition causing the proposed ward to have incapacity.

I certify that I have, by personal examination and inquiry, satisfied myself as to the condition of competency of this individual and the result of my evaluation and inquiry will be found in my answers to the following questions, which answers are true to the best of my knowledge. All opinions are provided to a reasonable degree of professional certainty. Questions requiring an opinion for which I cannot provide an answer to a reasonable degree of professional certainty are left blank.

____
Signature of Examiner

____
Name printed or typed

____
Address

____

____
Date

NOTICE OF RIGHTS

Prior to examination of this individual for whom guardianship is proposed on the ground that the individual allegedly has incompetency, was the individual informed that:

1. Statements made by the individual may be used as a basis for a finding of incompetency? ☐ Yes ☐ No

2. The individual has a right to refuse to participate in the examination, absent a court order, or speak to you?

☐ Yes ☐ No

3. You are required to report to the court even if the individual does not speak to you? ☐ Yes ☐ No

PERSONAL AND FAMILY HISTORY

Date of Birth: ___________________ Age: ____________ Sex: ☐ Female ☐ Male
Marital Status: ____
Children: ____
Occupation and Employment: ____
Veteran: ☐ Yes ☐ No

EXAMINATION

Date of Examination: ______________________
Place of Examination: ______________________
Time spent with individual: ______________________

1. Please give a summary of background/historical information obtained from the individual and/or collateral source:

____
____
____
____
____

2. Did you consult any collateral information in conjunction with your evaluation? ☐ Yes ☐ No
Explain: ______________________
____

3. During the examination, did you note a disturbance of this individual's:

a.	Orientation?	☐ Yes	☐ No	______________________
b.	Speech?	☐ Yes	☐ No	______________________
c.	Motor Behavior?	☐ Yes	☐ No	______________________
d.	Thought Processes?	☐ Yes	☐ No	______________________
e.	Affect?	☐ Yes	☐ No	______________________
f.	Memory?	☐ Yes	☐ No	______________________
g.	Concentration and Comprehension?	☐ Yes	☐ No	______________________
h.	Judgment?	☐ Yes	☐ No	______________________

4. Describe any abnormalities identified in question number 3:

____
____

5. Based on your evaluation, were you able to reach a conclusion as to this individual's ability to distinguish time and place? ☐
Yes ☐ No
Explain: ______________________

6. Were the individual's responses coherent and logical? ☐ Yes ☐ No
Explain:______________________
____

7. Could you determine the individual's general level of intelligence and fund of knowledge? ☐ Yes
☐ No
Explain: ______________________
____

8. Describe any physical illness of the individual and the prognosis: ______________________

____
____

9. Describe any mental disability, alcoholism or other drug dependency of the individual and the prognosis: ____
____

10. Is this individual presently under medication? ☐ Yes ☐ No

A. If yes, what is the medication and dosage? ___________________________

B. Does the medication affect the individual such that it interferes with your ability to evaluate the individual's mental functioning, including evaluative and decision-making capacities? ☐ Yes ☐ No

11. Is it your opinion that the individual's physical or psychological health would be adversely affected by the individual's attendance in court? ☐ Yes ☐ No

Explain: ___________________________

12. Using the following definitions, Is it your opinion that that this individual has an impairment of the individual's functional capacity as a result of:

A. developmental disability? ☐ Yes ☐ No

B. serious and persistent mental illness? ☐ Yes ☐ No

C. degenerative brain disorder? ☐ Yes ☐ No

D. other like incapacities? ☐ Yes ☐ No

DEFINITIONS:

Impairment:

Developmental disability, serious and persistent mental illness, degenerative brain disorder, or other like incapacities.

Incapacity:

Inability to effectively receive and evaluate information or to make or communicate a decision with respect to the exercise of a right or power.

Developmental Disability:

A disability attributable to mental retardation, cerebral palsy, epilepsy, autism or another neurological condition closely related to mental retardation or requiring treatment similar to that required for mentally retarded individuals, which has continued or can be expected to continue indefinitely, substantially impairs the individual from adequately providing for his or her own care or custody and constitutes a substantial handicap to the afflicted individual.

Serious and Persistent Mental Illness:

A mental illness that is severe in degree and persistent in duration, that causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, that may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support that may be of lifelong duration. Serious and persistent mental illness includes schizophrenia as well as a wide spectrum of psychotic and other severely disabling psychiatric diagnostic categories, but does not include degenerative brain disorder or a primary diagnosis of a developmental disability or of alcohol or drug dependence.

Degenerative Brain Disorder:

This form shall not be modified. It may be supplemented with additional material.

The loss or dysfunction of an individual's brain cells to the extent that he or she is substantially impaired in his or her ability to provide adequately for his or her own care or custody or to manage her or her property or financial affairs.

Other Like Incapacities:
Those conditions incurred at any age that are the result of accident, organic brain damage, mental or physical disability, or continued consumption or absorption of substances, and that substantially impairs an individual from providing for his or her own care or custody.

13. Is it your opinion that because of an impairment as distinguished from mere old age, eccentricity, poor judgment or physical disability, the individual is unable effectively to receive and evaluate information or to make or communicate decisions to such an extent that the individual is unable to meet the essential requirements for his or her physical health or safety? ☐ Yes ☐ No
Explain: ____

14. Is it your opinion that this individual has an understanding and appreciation of the nature and consequences of any inability the individual may have to meet the essential requirements for his or her physical health or safety? ☐ Yes ☐ No
Explain: ____
____

15. Is it your opinion that as a result of an impairment, as distinguished from mere old age, eccentricity, poor judgment or physical disability, the individual is unable effectively to receive and evaluate information or to make or communicate decisions related to management of his or her property or financial affairs to such an extent that:
(a) property of the individual will be dissipated in whole or in part? ☐ Yes ☐ No
(b) the individual is unable to provide for his or her support? ☐ Yes ☐ No
(c) the individual is unable to prevent financial exploitation? ☐ Yes ☐ No
Explain: ____
____

16. Is it your opinion that this individual has an understanding and appreciation of the nature and consequences of any inability the individual may have to manage his or her finances and property? ☐ Yes ☐ No
Explain: ____
____

17. If it is your opinion that the individual has an impairment, is it your opinion that the effect on the individual's evaluative capacity is likely to be temporary or long-term? ☐ temporary ☐ long-term.
Is it your opinion that the effect may be ameliorated by appropriate treatment? ☐ Yes ☐ No
Explain: ____
____

18. If it is your opinion that the individual has an impairment, is it your opinion that that the individual's need for assistance in decision making or communication is unable to be met effectively and less restrictively than guardianship, through appropriate and reasonably available training, education, support services, health care, assistive devices, or other means that the individual will accept? ☐ Yes ☐ No
Explain: ____
____

19. Is it your opinion that the individual has the evaluative capacity to engage in any advanced planning for health care and financial decision making that would avoid guardianship including executing a power of attorney for health care, financial durable power of attorney, a trust, or a jointly held account? ☐ Yes ☐ No

Explain: ____

____

20. Indicate any of the following rights which the individual in your opinion has incapacity to exercise:

- ☐ execute a will.
- ☐ serve on a jury.
- ☐ register to vote or vote in an election.

This form shall not be modified. It may be supplemented with additional material.

21. Indicate any of the following rights which the individual in your opinion either:
A. has incapacity to exercise; or
B. has limited incapacity to exercise and **may exercise with consent of a guardian**:

1) consent to marriage;
☐ A. has incapacity. ☐ B. has limited incapacity but may exercise with consent of guardian.

2) apply for an operator's license, a hunting, fishing or other license issued under ch. 29, or a credential as defined in §440.01(2), Wisconsin Statutes **_________**;
☐ A. has incapacity. ☐ B. has limited incapacity but may exercise with consent of guardian.

3) consent to sterilization;
☐ A. has incapacity. ☐ B. has limited incapacity but may exercise with consent of guardian.

4) consent to organ, tissue, or bone marrow donation;
☐ A. has incapacity. ☐ B. has limited incapacity but may exercise with consent of guardian.

22. Indicate any of the following powers for which the individual in your opinion either:
A. lacks evaluative capacity to exercise the power; or
B. **has limited capacity to exercise the power** to the extent that the individual is able effectively to receive and evaluate information and communicate decisions (**describe extent of capacity**):

1) power to consent to medical examination and treatment, and consent to voluntary medication, including psychotropic medication that is in the individual's best interests, if the guardian has first made a good-faith attempt to discuss with the individual the individual's voluntary receipt of the psychotropic medication and the individual does not protest;
☐ A. lacks capacity. ☐ B. has limited capacity (describe) ___________________________

2) power to authorize individual's participation in an accredited or certified research project if the research project might help the individual, or others if minimal risk of harm;
☐ A. lacks capacity. ☐ B. has limited capacity (describe) ___________________________

3) power to authorize individual's participation in research that might not help the individual but might help others if greater than minimal risk of harm to the individual but evidence indicates individual would have elected to participate;
☐ **A. lacks capacity.**

☐ **B. has limited capacity (describe)** ________________
____
____

4) power to consent to experimental treatment in the individual's best interests;
☐ A. lacks capacity. ☐ B. has limited capacity (describe) ___________________________

5) power to consent to receipt by individual of social and supported living services;
☐ A. lacks capacity. ☐ B. has limited capacity (describe) ____________________________

6) power to consent to release of confidential records other than court, treatment, and patient health care records and redisclosure as appropriate;
☐ A. lacks capacity. ☐ B. has limited capacity (describe) ____________________________

7) power to make decisions related to mobility and travel;

☐ **A. lacks capacity.**

☐ **B. has limited capacity (describe)** ____________________

8) power to choose providers of medical, social, and supported living services;

☐ **A. lacks capacity.**

☐ **B. has limited capacity (describe)** ____________________

9) power to make decisions regarding educational and vocational placement and support services or employment;

☐ **A. lacks capacity.**

☐ **B. has limited capacity (describe)** ____________________

10) power to make decisions regarding initiating a petition for termination of marriage;

☐ **A. lacks capacity.**

☐ **B. has limited capacity (describe)** ________________
____
____

11) power to receive all notices on behalf of individual;

☐ **A. lacks capacity.**

☐ **B. has limited capacity (describe)** ________________
____
____

12) power to act in all proceedings as an advocate of the individual, except the power to enter into a contract that binds the individual or the individual's property or to represent the individual in any legal proceedings pertaining to the property, unless the guardian of the person is also the guardian of the estate;
☐ A. lacks capacity. ☐ B. has limited capacity (describe) _________________________

13) power to apply for protective placement or for commitment;

☐ **A. lacks capacity.**

☐ **B. has limited capacity (describe)** ________________
____
____

14) power to have custody of the individual, if an adult, or power to have care, custody, and control of the individual, if a minor;
☐ **A. lacks capacity.** ☐ **B. has limited capacity (describe)** _____________

15) other specific powers: ____ ☐ **See attached**

☐ **A. lacks capacity.**
☐ **B. has limited capacity (describe)** ______________________

23. Indicate your opinion of the individual's evaluative capacity to manage his or her financial affairs and property:
☐ A. the individual lacks evaluative capacity to manage his or her financial affairs and property; or
☐ B. the individual has limited capacity to make decisions to the extent that the individual is able effectively to receive and evaluate information and communicate decisions to manage his or her financial affairs and property. Describe capacity ____

24. Is it your opinion to a reasonable degree of professional certainty that this individual lacks evaluative capacity to make decisions about which the individual is unable effectively to receive and evaluate information and communicate decisions due to an impairment, and that this individual is an appropriate subject for the court to appoint a guardian? ☐ Yes ☐ No
Explain:____
____
____
____

SUMMARY OF REPORT

1. Would this individual's physical or psychological health be adversely affected by the individual's attendance in court at the court hearing? ☐ Yes ☐ No

2. Is it your opinion to a reasonable degree of professional certainty that this individual is incompetent and needs a guardian? ☐ Yes ☐ No

KATHLEEN FALK
DANE COUNTY EXECUTIVE

Dane County Department of Human Services
Division of Adult Community Services

Interim Director – Charity Eleson
Division Administrator - Fran Genter

Quality Assurance Board

The Quality Assurance Board was established in December 1998 to build and strengthen relationships among people with developmental disabilities, their families and friends, individuals who are paid to support them and other citizens of our communities. With a membership* including parents, self-advocates, advocates and county and state staff who support people with disabilities, the Quality Assurance Board has assumed a number of significant roles. These include:

- Reviewing, analyzing and providing feedback on the manner in which providers, support brokers and county staff respond to identified problems with services;
- Identifying and publicizing patterns and trends which enhance or impede the quality of life experienced by the people we serve;
- Overseeing the new system of continuous quality review and improvement of the support and services people are receiving individually and collectively;
- Developing and reviewing outcomes from satisfaction surveys and focus groups on particular issues; and
- Assisting in the resolution of individual conflicts by offering an informal opportunity for mediation.

> The quality assurance and improvement system does not of itself create good personal assistance for those who need it. It does not of itself create more caring and competent communities. It is a part of our larger system, and it both contributes to and relies upon continuous learning by all of us together.

Anyone who is receiving or providing services or is a family member or an advocate is welcome to come to talk to the Board to report concerns/issues or what is going well in their lives. For more information, call Maya Fairchild at 242-6466.

1202 Northport Drive, Madison, Wisconsin 53704 • (608) 242-6200 TTY (608) 242-6279 FAX (608) 242-6531

Adults At Risk Reporting Law

In the mid-1980's, the Wisconsin Legislature passed a law establishing the Elder Abuse & Neglect (EA&N) voluntary reporting system for those age 60 and over. However, there has been no similar reporting system for people age 18 - 59.

Based on law passed this spring, effective December 1, 2006, counties are required to respond to Adults at Risk referrals. As this is an unfunded mandate, the ACS Division will be implementing this without new resources.

The law defines an adult at risk as "any adult who has a physical or mental condition that substantially impairs his or her ability to care for his or her needs who has experienced, is currently experiencing, or is at risk of experiencing abuse, neglect, self neglect or financial exploitation".

Abuse includes physical abuse, emotional abuse, sexual abuse, treatment without consent and unreasonable confinement or restraint.

Reporting is mandated for certain professionals in some situations. Mandated reporting now applies to both EA&N and Adults at Risk. Mandatory reporters are: a) an employee of any entity that is licensed, certified or approved by or registered with WDHFS; b) a health care provider defined in s.155.01(7); and c) a social worker, professional counselor, or marriage or family therapist certified under ch.457.

Reporting is mandated when a mandated reporter sees the elder person or the adult at risk in the course of the reporter's professional duties and one of the following is true: a) the person at risk has requested the person to make the report; or b) there is reasonable cause to believe that the person at risk is at imminent risk of serious bodily harm, death, sexual assault, or significant property loss and is unable to make an informed judgment about whether to report the risk; or c) other elders or adults at risk are at risk of serious bodily harm, death, sexual assault, or significant property loss inflicted by the suspected perpetrator.

The Elder Abuse Helpline (261-9933) has been expanded to be the receiving/screening point for Adults at Risk referrals and has been renamed the Elder Abuse/Adults at Risk Helpline. The Helpline is operated out of SMO-A by the Area Agency on Aging of Dane County. However, any required investigations will be done by staff from other parts of the ACS Division, and not by EA&N staff.

Support Brokers representing consumers with developmental disabilities on their caseload, should continue to use the Fact-Finders Protocol as illustrated earlier in this Section. However, since Support Brokers are mandatory reporters under this law they should follow this policy for elders and other adults at risk.