

# *No Safe Place to Call Home* *DRI's October 29, 2018 Report on the Cycle of Abuse, Neglect, and Injury at the Southwest Idaho Treatment Center*

## FINDINGS

### **POLICIES**

A facility that equips its staff with comprehensive, detailed policies that prioritize resident health & safety will likely have staff who are well-informed of their respective duties & obligations to provide residents with the best care possible. For those facilities whose policies lack thoroughness & a clear commitment to the care & treatment of its residents, the opposite is true.

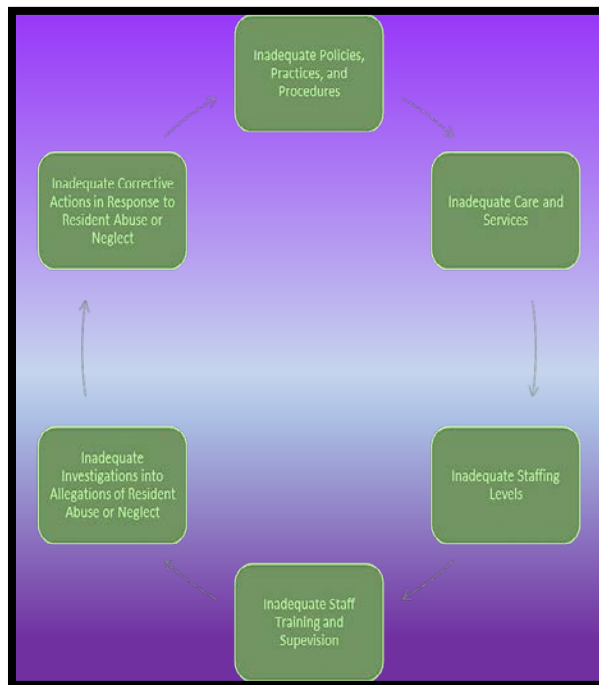
### **ACTIVE TREATMENT**

Without the provision of a "continuous and active treatment program," residents at SWITC may never have the opportunity to acquire the skills necessary to function with as much self-determination and independence as possible.

### **STAFF NUMBERS**

Not having enough staff places everyone in the facility at risk of a chaotic environment, client-to-client abuse, self-abuse by clients, clients sitting unengaged for long periods of time with little to no staff presence, clients not given the opportunity to assist in activities of daily living, reparation), or programs not being carried out due to inadequate on-duty staffing.

## **CYCLE OF ABUSE & NEGLECT**



- **Inadequate Policies, Practices & Procedures**
- **Inadequate Care & Services**
- **Inadequate Staffing Levels**
- **Inadequate Staff Training & Supervision**
- **Inadequate Investigations into Allegations of Resident Abuse or Neglect**
- **Inadequate Corrective Actions in Response to Resident Abuse or Neglect**

### **RECOMMENDATIONS:**

**Contract with an independent consultant to:**

- review all facility policies, practices, & procedures to ensure resident care, treatment, & safety are clearly identified as the faculty's top priority;**
- develop & train all staff including direct care staff, supervisors, professional staff, & Administration on the provision of active treatment to ensure residents receive the specialized treatment they are entitled & required by law to receive;**
- develop & train on a Quality Assurance monitoring & tracking system to identify patterns & trends in abuse, neglect, &**

**mistreatment investigations & responses incorporating incidents recorded in Significant Event Reports (SERs) to ensure resident safety;**

- assist with developing & implementing a program to eliminate the use of non-approved restraint methods & eliminate the use of restraint entirely;**
- evaluate the performance of SWITC staff supervisors, professional staff, & Administration as well as their contribution to the current cycle of abuse & neglect.**

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### TRAINING

Substandard staff training places residents at risk of serious injury or death through the use of unapproved restraint methods or failure to follow treatment plans which leave residents without medical care or required supervision.

### INVESTIGATIONS

Investigations into abuse/neglect allegations must be thorough and if not, patterns & trends go unidentified and unaddressed, findings are unreliable & conclusions & responses are inadequate allowing for acts of abuse or neglect to continue in perpetuity.

### FACILITY RESPONSE

Recommended changes were inconsistent, not fully implemented, or insufficient, did not hold supervisors accountable & failed to even acknowledge the affects abuse or neglect has on residents, thus SWITC missed the opportunity to ensure its residents feel safe & respected their own home.

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THE REPORT AT:

**[disabilityrightsidaho.org/switc-report/](http://disabilityrightsidaho.org/switc-report/)**

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