Did you know?

120 complaints involving wireless handheld devices have been reported since 2008.

95 complaints have been reported within the past five years.

17% of the 120 misconduct reports filed have been substantiated since 2008.

8 of the 20 cases substantiated since 2008 have occurred in 2016.

THINGS TO KNOW BEFORE YOU SNAP

Facilities are required to have resident rights posted in a prominent location. Knowing resident rights can help prevent violations from occurring.

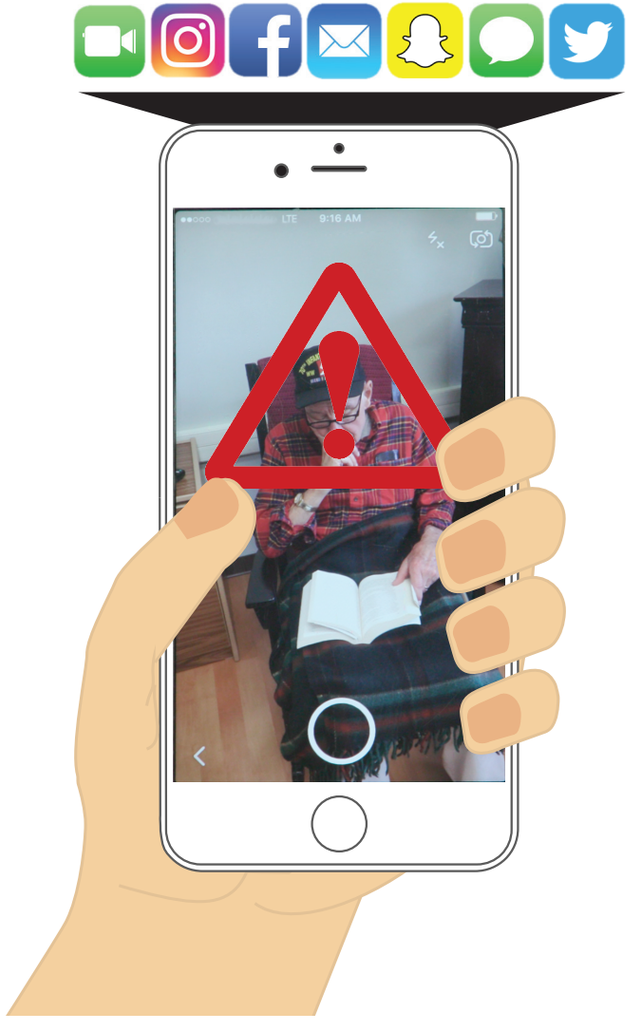
Many facilities have policies regarding the use of handheld devices in the workplace. Know these policies and follow them.

Taking a photo or video of a resident may be a violation of resident rights and considered caregiver misconduct. This action may also result in criminal charges and convictions.

Assume anything put online can be seen by anyone. Even Snapchats that disappear from your phone can be recovered.

WISCONSIN DEPARTMENT *of* HEALTH SERVICES
P-01933 (08/2018)

SNAPPING PICS puts your JOB AT RISK



Handheld Devices and the Potential for Caregiver Misconduct

This brochure is intended to bring awareness to caregivers working in Department of Health Services (DHS) regulated healthcare facilities about the potential for caregiver misconduct and the violation of resident rights through the use of handheld devices. The misuse of handheld devices in healthcare facilities to share personal information, photos, and videos has increased significantly over the past five years.

EXAMPLES OF POTENTIAL CAREGIVER MISCONDUCT OR VIOLATION OF RESIDENT RIGHTS:

1. Posting a photo or video to Facebook that includes personal and identifying characteristics of a resident.
2. Sending or posting a photo on Snapchat or Instagram that include any parts of a resident's body.
3. Having an image or video of a resident on your Snapchat storage or on your camera storage without the resident's written consent or knowledge.
4. Taking a video or photo on your phone of another employee mistreating or degrading a resident and not reporting it to your direct supervisor.

WHAT HAPPENS WHEN AN INCIDENT OCCURS?

After learning of the incident, the facility takes whatever measures are required to ensure the residents are protected from additional misconduct.

The facility will immediately fill out a misconduct incident report, perform an internal investigation into the incident, and may notify police. The facility is required to forward their findings to the Office of Caregiver Quality (OCQ).

If OCQ finds from review of the facility's misconduct report that further investigation is needed, an investigation of caregiver misconduct will be performed.

After completing its investigation, OCQ will prepare a written decision and notify the accused. If it is determined that caregiver misconduct occurred, a substantiated finding under the person's name will be placed on the Wisconsin Caregiver Misconduct Registry.

When placed on the Wisconsin Caregiver Misconduct Registry, you can no longer work as a caregiver in a Department of Health Services regulated healthcare facility in Wisconsin.

Correct Use of Handheld Devices