Should I be reporting this to someone? Making sense of the Incident Reporting Requirements

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Documents

- DOH DAL 00-04
- CMS S&C Letter 05-09
- DOH DAL 05-10
- DOH Nursing Home Incident Reporting Manual (revised June 14, 2012)
Definitions

- “Accident” refers to any unexpected or unintentional incident, which may result in injury or illness to a resident/registrant.
- An incident is an unplanned, or undesired event
- “Incident” is an occurrence involving a resident/registrant in which mistreatment, neglect, abuse, misappropriation of resident property is alleged or suspected
- “Incident reporting” is performed in health care facilities and programs. An incident report is also known as an accident report. Such reports help in documenting the exact details of unusual events while they are fresh in the minds of those who witnessed the event.

Myth or Reality

- Only nursing homes are covered by the incident reporting requirements; ADHC programs are exempt
- All incidents involving injury should be reported.
- Reporting incidents even when not required will often insulate the program from potential deficiencies
- ADHC programs are frequent reporters of incidents to DOH
- Recent changes to the incident reporting requirements have provided greater clarity
- Abuse and mistreatment for the most part only occur in problem facilities/programs
Abuse among CNAs

- **10% committed physically abusive act(s)**
  - excessive restraint 6%
  - pushing/grabbing/shoving/pinching 3%
  - hitting/slapping 3%
- **40% committed psychologically abusive act(s)**
  - yelling 33%
  - insulting/swearing 9%
  - denying food/privileges as punishment 2%
  - threatening physical violence 2%

Problems often leading to abuse

- High level of job stress/burnout
- Aggressive patient
- Frequent verbal conflict with patients
- Inadequate or lack of education
- Staffing
- Lack of oversight/monitoring by administrative staff
Key Components of Abuse Prohibition

- Prevention
- Screening
- Identification
- Training
- Protection
- Investigation
- Reporting

GAO Study

- Allegations unreported
- Delays in reporting
- Uneven or inadequate investigations
- Lack of modification of care plan
- Failure to conduct a root cause analysis
- Background checks
- Identification of abuse
DOH Investigations

- Individual has a history of incidents but the care plan fails to reflect those occurrences
- Incidents are documented on a care plan without interventions or a plan to prevent recurrence
- Staff is unaware of changes to the plan of care. For example, the CNA card does not match POC
- Care plan is not aligned with resident’s needs. For example, care plan lists an approach of “reminders not to stand” but resident has dementia and cannot remember
- Unrealistic goals and interventions are care planned

Public Health Law 2803-d

- Requires the reporting of abuse, mistreatment or neglect to the Department of Health upon having “reasonable cause” to believe that abuse, neglect or mistreatment has occurred.
Reasonable Cause

- Upon review of the circumstances there is sufficient evidence for a prudent person to believe that physical abuse, mistreatment or neglect has occurred.

Reasonable Cause

- Statement that abuse, neglect, mistreatment took place
- Presence of a condition inconsistent with the course of treatment
- Visual or aural observation of an act
### Key Terms

- **Abuse**—Inappropriate physical contact that harms or is likely to harm. Verbal abuse is the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability.
- **Neglect**—Failure to provide timely, safe, adequate and appropriate services.
- **Mistreatment**—Inappropriate use of medications, isolation or restraints.
- **Misappropriation**—Unauthorized use, removal, destruction of resident property regardless of the monetary value. The misplacement, exploitation, or wrongful use of resident’s belongings or money.
- **Unknown source**—Not witnessed and suspicious.
- **Failure to report**—Unprofessional conduct/fine.

### Who Must Report

Public Health Law Section 2803-d identifies mandatory reporters as those professionals who care for nursing home residents.

- Those who care for residents include health care workers who provide services to nursing home residents in other health care settings and those who provide services under contract.
- Anyone may report alleged abuse, mistreatment, or neglect.
**DAL/DQS: 05-10**

- NYS Public Health Law (PHL) Section 2803-d requires the reporting of abuse, mistreatment or neglect immediately to the Department upon having “reasonable cause” to believe that abuse, neglect, or mistreatment has occurred.
- Department regulations at section 81.1(d) (10NYCRR section 81.1(d)) defines “reasonable cause” to mean that upon a review of the circumstances, there is sufficient evidence for a prudent person to believe that physical abuse, mistreatment or neglect has occurred.

**Circumstances to be reviewed that may lead to a “reasonable cause” conclusion might include, but are not limited to:**
- a statement that physical abuse, mistreatment, or neglect has occurred;
- the presence of a physical condition (e.g. a bruise) which is inconsistent with the history or course of treatment of the resident; or
- a visual or aural observation of an act or condition of abuse, mistreatment or neglect.

Providers should report to the Department alleged violations of abuse, mistreatment, neglect, injuries of unknown origin, or misappropriation of resident property, only if and when the “reasonable cause” threshold has been achieved.
- **This might occur before the provider investigation into the incident has begun or at any time during the investigation.**
- **If the “reasonable cause” threshold has not been achieved, notification to the DOH is not required under the aforementioned federal and state regulations and state law.**
Resident Behavior Facility Practices

- Individual has the right to be free from abuse.
- The facility must ensure that all alleged violations involving mistreatment, neglect, abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator and to other officials in accordance with state law.

What to Investigate?

The following require investigation:
- Accidents
- Injury of unknown origin
- Abuse, mistreatment, neglect
- Misappropriation of property
- Complaints related to care
- Medication errors
Types of Reportable Incidents

Abuse:
- Physical/sexual abuse by staff
- Physical/sexual abuse by resident
- Physical/sexual abuse by family or visitor
- Mistreatment
- Neglect
- Dignity/verbal or mental abuse

Types of Reportable Incidents

Quality of care
- Medication error with harm / drug diversion
- Death related to suicide, restraints, equipment
- CPR issues/Attempted suicide
- Injury of unknown origin
- Burns
- Accidents related to choking
- Accidents related to entrapment
- Individuals found in non-program area (basement, stairwell, etc.)
Types of Reportable Incidents

Care Plan violations (Neglect)
- Failure to follow care plan resulting in injury
- Failure to follow care plan on more than one occasion with or without injury
- Failure to provide timely, consistent safe, adequate and appropriate services (elopement)

Registrant property
- Misappropriation of property

Types of Reportable Incidents

Elopement
- Elopement occurs when a registrant leaves the building undetected or fails to return from a preauthorized leave of absence

Physical Environment
- Fires/smoke
- Faulty equipment
- Physical plant issues
- Power, water, electrical outages or any interruption of service
What is an investigation?

- An investigation is the gathering of evidence and/or data related to an occurrence, or incident.
- The goal is to arrive at a logical conclusion based on the evidence.
- Investigations must begin immediately, upon discovery of an incident.

Purpose of Investigation

- To determine if abuse, mistreatment, neglect or misappropriation occurred.
- To assure compliance with statutes and regulations.
- To improve quality of care.
- To identify flawed practices/policy.
- To identify and correct vulnerabilities.
- To assist with management of risk.
Purpose of Investigation

The investigation should assist in determining if the concern was a result of:

- Individual(s) action (staff member acted on their own, outside of policy)
- Facility/program practice (flawed practice or policy)
- Did abuse, mistreatment, neglect or misappropriation of property occur?
- The investigation should rule out or confirm abuse, mistreatment or neglect through a review of supporting evidence, including interviews and statements that offer valid information, observations and record review
- The outcome is determined by facts, based on the evidence and not an opinion which is subjective

Investigation

- INTERVIEW: Obtaining statement from parties directly involved and others possessing knowledge of relevant information. This may include staff, residents and third party
- OBSERVATION: of the surroundings or scene where the incident is alleged to have occurred. Observation of the general care and condition of the area is very important
- RECORD REVIEW: review of medical records, care plan, any related documents
Investigation Overview

- Protect the individual
- Protect the scene....preserve any physical evidence
- Collect evidence (ask who, what, when, where and how)
- Determine presence of intent by aggressor
- Determine your witnesses
- Conduct interviews
- Documentation (incident reporting form, medical records, interview statements)
- Determine if abuse, neglect or mistreatment has occurred
- Document your conclusions

During the Investigation....

- Assume the abuse occurred and let the investigative process disprove it – (don’t assume it couldn’t happen in your place)
- Any employee under investigation for abuse should be removed from duty while the investigation is in progress to protect others from potential abuse.
Interviews

- Who, what, where, when, why and how?
- Maintain a list of the questions posed to the individuals being interviewed
- Obtain statement from the registrant(s), if they are able to provide a statement about the incident, whenever possible

Interview Tips

- Take notes during the interview
- Provide privacy, minimize distractions; listen carefully and be patient
- What does staff say
- Are you interviewing them or do they fill out a form
- What kind of questions are you asking staff
- Questions should be open ended, designed to elicit descriptions of observations, interventions, or reenactments
Observation

- What did you see
- What did others see
- What does the environment tell you
- Is there evidence that the care plan was followed
- What do you see when you look at or speak to others
- What do you hear when walking through the area
- Do you see evidence of potential abuse or concern

Record Review

- What was required by care plan
- Was it an appropriate individualized plan of care
- What are the resident’s risk factors
- Are the risk factors identified in the Plan of Care
- Was the care plan followed
- What was documented upon discovery of event
- What do nurses’ reports indicate
- Were MD orders followed
- Was the CNA record completed accurately
- Were facility policies and procedures followed
Record Review

- Is there a staff member involved
- What is the staff members performance history
- Has the staff member been counseled for care issues or failure to follow the care plan in the past
- Was care appropriately documented
- Does this indicate that the care plan was followed
- Has the staff member been educated or trained in the area being investigated, and noted in the personnel records

Evidence Gathering

- All evidence used to determine the outcome of the investigation should be relevant to the case
- If the case is related to a medication is a hard copy of the proper Medication Administration Record in the case file
- If the case is related to a care plan violation, is the care plan in the case file
- All materials relevant to the outcome should be included in the file
Conclusion

- What is a thorough investigation
- One that comes to a reasonable conclusion as to how and/or why something occurred. The investigation should rule out or confirm abuse, mistreatment or neglect by review of supporting evidence, including interviews and statements that offer valid information, observations and record review.
- The outcome is determined by fact, based on the evidence and not on opinion.

Conclusion

- Did abuse, mistreatment or neglect occur?
- Is there a policy or practice issue that caused risk?
- Is this an isolated incident or a systemic problem?
- Does the evidence support the outcome?
Final Steps

- Immediately, take corrective action including education
- Identify trends
- Implement and communicate QI interventions for long term prevention of recurrence of the matter
- Periodically review and revise interventions
- Report to appropriate agency as necessary:
  - If abuse, mistreatment, neglect or misappropriation, contact law enforcement
  - If a professional issue, contact State Education or DOH Office of Professional Misconduct (OPMC)
  - If controlled substance issue, contact the DOH Bureau of Narcotic Enforcement (BNE)

What happens when a call comes into the HOTLINE?

- Central Intake (CCIP) takes the information and reviews each complaint carefully.
- A determination is made whether the complaint requires an on site investigation or an off site investigation, or whether the call is simply informational with no action required.
- The information gets entered into the federal computer program for complaint tracking.
Investigations

- Commenced “Immediately”
- Evidence reviewed
- Conclusion
- Any changes implemented

The Investigation

- The date and time the incident was discovered;
- Who discovered the incident;
- How the incident was discovered;
- A description of the registrant and any pertinent information regarding their condition (medical, psychological, behavioral, etc.) noted prior to discovery of the incident;
- A description of the registrant and the area where the incident occurred;
- An interview log that includes:
  - Names of staff interviewed along with their signed and dated statements;
  - Staff who the facility decided not to interview, and why it was decided not to interview these staff;
  - A list of the questions posed to the staff interviewed;
  - A statement from the registrant, if they are able to provide a statement about the incident;
  - Statements from other registrants, volunteers, visitors any other individual who may have been in the area the incident took place and may have been a witness to the incident.
Root Cause Analysis

- Potential Contributing factors
  - Procedure/Policy based on Regulation
  - Knowledge of Regulation
  - Staff education
  - IDT Responsibility
  - Communication
  - Normalizing Behaviors: accepting the unacceptable
  - Quality Assessment/Assurance Process

Incident

CF and AH are at the program and get into an argument that quickly escalates into a shoving match. Staff intervene and restore order. Although the pushing and shoving according to witnesses was described as “intense” neither registrant is hurt. Is this incident an incident that should be reported to DOH?
Definition of Abuse

- **NYS** - Inappropriate physical contact with a resident of a residential health care facility, while the resident is under the supervision of the facility, which harms or is likely to harm the resident. Inappropriate physical contact includes, but is not limited to, striking, pinching, kicking, shoving, bumping, and sexual molestation.

- **Federal** - The *willful* infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.

Incident

Registrants ZC and LL are both cognitively impaired. ZC is at the noon meal with LL. ZC becomes angry with LL who is yelling out that he wants to be taken to the bathroom. ZC throws a cup of soda at LL getting his sweater and shirt wet. LL becomes angry at ZC and has to be escorted from the dining area. The staff is surprised at this situation since both registrants have had no issues with one another in the past and have been generally pleasant and cooperative.
Incident

RR was found outside the program having eloped. RR was new to the program having been admitted three weeks ago. There were several instances where he wandered over to the door and hallway and was easily directed back, but this was the first time that he had ever left the program. He was immediately placed on 15 minute checks.

Incident

- BT has a history of elopement and wandering. At 10 AM a staff member observes him going out the front door of the program and other staff members in response to the activated alarm come to the lobby. The registrant is followed outside by the staff member who observed the registrant exit and about 20 feet from the front door stops the registrant and escorts him back to the program.
Definitions

- Unsafe wandering—wandering that is disruptive to other individuals or places the wandering registrant or others at risk for harm.
- Elopement—when an individual successfully leaves the program area undetected and unsupervised and enters into harm’s way.

Incident

When it comes time to transport registrants home for the day no one can find LL. The program sets into place its missing registrant policy and procedure and notifies the police. After several hours LL is located at his home. Upon interview of LL by program staff, LL states that it was taking longer than necessary to get going at the conclusion of the program, he became impatient and got a ride home from someone he stopped in the street. He is unharmed. Is this a reportable incident?
Incident

KT is sitting in a chair in the program area and as is his usual pattern stretches his legs out far in front of him. LY has some vision limitations and does not notice KT. In trying to get by she trips over KT legs and falls. She is in significant pain and an ambulance is called. Later you learn that LY sustained a fractured hip and will be hospitalized. Is this incident reportable to DOH?

Incident

CJ reports that one of the aides threatened her, saying she was going to get her “kicked out” of the program. CJ has a psychiatric history and has made similar allegations in the past that were later found out to have been fabricated. What course of action should be taken here and is this reportable to DOH?
Verbal Abuse

- The use of oral, written or gestured language that willfully includes disparaging terms to registrants or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability

Incident

Program aide WW reports to you that she saw another aide LL, slap registrant RW in the face with an open hand. Is this reportable?
Incident

During a routine review of medications it is noted that there are missing medication (Oxycontin) for registrant AB. In your check of the administration records you find all the medications have been signed for appropriately. You interview AB and she thinks that she has gotten all her medications each day she was at program. What should you do?

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