SAFETYNETWORKS
Information for Elder Adults-at-Risk and Adults-at-Risk Agencies
AAR Information Memo # 14, June 2011

IN THIS ISSUE

Guidance for County Elder Adults/Adults-at-Risk (EA/AAR) agencies in responding to Misconduct Incident Reports sent by the Wisconsin Department of Health Services/Division of Quality Assurance (DQA)/Office of Caregiver Quality (OCQ).

SUMMARY

County EA/AAR agencies are to respond to Misconduct Incident Reports sent by OCQ that involve either 1) sexual abuse; 2) abuse by someone who is not a caregiver, but is known to the resident/victim; or, 3) resident-to-resident abuse occurring in a nursing home and a determination of imminent harm or immediate danger has been made. Once a report is received, the EA/AAR agency is to determine if any resident/victim services are needed. If yes, an offer of services is to be made. Once the report is handled, a report detailing the response and findings should be entered into the Wisconsin Incident Tracking System (WITS). Misconduct Incident Reports are not to be shared with any agency other than another county EA/AAR agency.

BACKGROUND

DQA/OCQ is responsible for receiving, tracking and investigating complaints of alleged misconduct including abuse or neglect of a resident/victim, or misappropriation of a resident/victim's property that occur in regulated health care facilities. Since 2006 EA/AAR agencies have been receiving copies of Misconduct Incident Reports involving residents/victims of nursing homes from OCQ. EA/AAR agencies have questioned the appropriateness of OCQ referrals of resident-to-resident incidents and have asked for clear direction on how to respond to these reports. This document clarifies which reports will be sent by OCQ to county EA/AAR agencies and methods by which those agencies are to evaluate the referral for proper response.

OFFICE OF CAREGIVER QUALITY AUTHORITY AND PROCESS FOR DETERMINATION OF REFERRAL

OCQ investigates complaints involving noncredentialed caregivers pursuant to Chapter DHS 13 of the Wisconsin Administrative Code.[1] Once a Misconduct Incident Report is received, OCQ determines if the alleged abuser is a noncredentialed caregiver, credentialed staff or if the facility, issue or alleged abuser is regulated by another department or division. Based on its review, OCQ handles the report according to agency protocol, including referring to the Department of Regulation and Licensing and the Department of Justice. In addition, OCQ sends every Misconduct Incident Report received from a nursing home to the appropriate DQA regional office[2] the day it is received.

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[1] http://legis.wisconsin.gov/rsb/code/dhs/dhs013.pdf
[2] http://www.dhs.wisconsin.gov/bqaconsumer/reglmap.htm

According to protocol detailed below, OCQ will also send some of these Misconduct Incident Reports to county EA/AAR agencies.

PROTOCOL AS OF JUNE 2011 FOR OFFICE OF CAREGIVER QUALITY REFERRALS TO ELDER ADULTS/ADULTS-AT- RISK AGENCIES

The criteria that will prompt a referral of a Misconduct Incident Report by OCQ to a county EA/AAR agency are as follows:

1) Alleged abuser is not a caregiver but someone known to the resident/victim such as a family member, visitor or clergy (i.e., someone the resident/victim has an ongoing relationship with and an expectation of trust exists).

Rationale: If the resident/victim lives in a long term care setting such as a nursing home or assisted living facility and is maltreated by a son, daughter, or someone else known to the individual, the dynamics of abuse, neglect or exploitation are similar to a victim residing in a community setting (e.g., one's own home or apartment) and should be addressed comparably. This is also true if the incident occurred outside a facility setting (e.g., resident/victim financially exploited by a family member while on an approved, week-end leave from a nursing home). In such cases, the EA/AAR worker is to take the lead in responding to the possible hurt or harm caused by the alleged abuser. This is because an alleged "external" (non-facility related) abuser has been identified and the abuse the resident/victim has been subjected to does not stem from living in a facility setting.

2) Resident-to-Resident incident report involves a situation of:

A. Any sexual contact or attempted sexual relationship

B. Intentional substantial bodily harm, including:

i. Injury that requires an emergency room visit or hospital stay
ii. Injury that causes a laceration that requires stitches
iii. Any fracture of a bone
iv. Burns
v. Temporary loss of consciousness, sight or hearing
vi. Facial injuries
vii. Loss of a tooth
viii. Dragging
ix. Force feeding

C. Elopement where person suffered substantial harm or remains missing

(Note: Resident-to-resident incident reports that will ***no longer be referred*** to an EA/AAR agency are situations involving physical, verbal or mental abuse that ***fail to meet the level of immediate or imminent danger***.)

Rationale: County EA/AAR agencies should be aware of cases of grievous harm (i.e., when an incident rises to the level of immediate or imminent danger or the resident/victim has experienced substantial physical or psychosocial harm). County EA/AAR agencies should also be made aware of any sexual abuse incident due not only to the potential serious harm the resident/victim was subjected to but also the potential ongoing counseling needs of that resident/victim. Those *potential resident/victim needs* are what should be addressed by the county EA/AAR agency.

To expand, it is not the role of OCQ to focus on the resident/victim. Rather, OCQ findings are focused on the alleged abuser who is a noncredentialed caregiver (i.e., is the alleged abuser culpable – can OCQ hold the alleged abuser accountable either administratively and/or criminally?) DQA's Bureau of Nursing Home Resident Care is focused on the nursing home's response to the alleged abuser – what did the nursing home do to rectify the situation? It is very important that the Misconduct Incident Report be reviewed by the county EA/AAR agency for *potential resident/victim needs*.

METHOD FOR TRANSMITTAL OF OFFICE OF CAREGIVER QUALITY REFERRALS

OCQ will mail a hard copy of the Misconduct Incident Report to the appropriate county EA/AAR agency ***within two (2) working days*** of receiving a report that meets the above criteria. If an EA/AAR agency would prefer instead to receive the report by FAX, please provide OCQ with the agency FAX number as well as a central contact (i.e., name, email, phone number) in case it is needed by staff from OCQ. You may send this information via the following email address: DHSCaregiverIntake@wi.gov.

NOTE: ***Misconduct Incident Reports are not to be shared*** with any agency other than another county EA/AAR agency. Contact Laurie Arkens at 608-264-9876 or via email at Laurie.Arkens@wisconsin.gov if you have questions concerning release of a Misconduct Incident Report.

ROLE OF ELDER ADULTS/ADULTS-AT-RISK AGENCIES IN RESPONDING TO OFFICE OF CAREGIVER QUALITY REFERRALS

When considering your county's response to a Misconduct Incident Report, you should remember that while external agencies may also respond and/or conduct an investigation, their primary emphasis will not be on protective services need identification and service provision. Instead it is the primary role of the EA/AAR agency to focus on the resident/victim and any protective services (resident/victim services) needs that have been identified. By reviewing the Misconduct Incident Report, you will learn the specific factors concerning the allegation: who, what, where, when.

Specifically, pages 3 and 4 of 8 in the Misconduct Incident Report provide the following details:

I. Entity information
II. Summary of Incident
III. Affected Client Information (Resident/Victim Information)
IV. Accused Person (Alleged Abuser) Information

Pages 5, 6 and 7 of 8 in the Misconduct Incident Report provide the following details:

V. Law Enforcement Involvement
VI. Persons with Specific Knowledge of the Incident
VII. Entity's Investigative Records
VIII. Person Preparing the Report
IX. Written Statements from the Entity, Accused Person (Alleged Abuser) and/or Witness

The remaining pages of the Misconduct Incident Report are supplemental (supporting) statements and documents. You may wish to review that material as well.

HOW TO ENTER INTO WITS COUNTY RESPONSE TO MISCONDUCT INCIDENT REPORT

Upon receiving a Misconduct Incident Report from OCQ, a WITS report should be opened by the assigned EA/AAR worker. This is in recognition of the significant time that may be spent reviewing the referral due to the severity of the event that initially triggered the Misconduct Incident Report. Based on this thorough analysis, agency staff should determine what resident/victim services, if any, are needed. Once services are offered and provided (if accepted) and you determine that no further action is necessary, you can close the case in WITS. Substantiation of the case is based on whether the resident/victim was hurt or harmed – not a finding as to culpability of the alleged abuser.

CONTACT INFORMATION

If you have questions about the information presented here or if you need help responding to a report, here are some contacts that can help.

Alice Page, Adults-at-Risk Policy Analyst State Elder Abuse/Adults at Risk Program 608-261-5990 Alice.Page@wisconsin.gov	Laurie Arkens, Director DQA/Office of Caregiver Quality 608-264-9876 Laurie.Arkens@wisconsin.gov

SAFETYNETWORKS #14
APPENDIX A
Statutory References and Related Materials

1. Definition of misappropriation of a client's property and other key terms: http://www.dhs.wisconsin.gov/caregiver/training/pdfcaregvtrng/conFedDef.pdf

2. To see a copy of the Misconduct Incident Report form, click here: http://www.dhs.wisconsin.gov/forms1/F6/F62447.pdf

3. To see a copy of the Misconduct Incident Report Requirements Worksheet (instructions on how to complete the form), click here: http://www.dhs.wisconsin.gov/forms1/F6/F62447.pdf

4. Division of Long Term Care memo that explains the role county designated EA/AAR agencies have in responding to incidents of abuse, neglect, exploitation and self-neglect occurring in entities regulated by the Department of Health Service's OQA: http://www.dhs.wisconsin.gov/dsl_info/InfoMemos/DDES/CY2006/InfoMemo200620.htm

5. Division of Long Term Care memo that includes explanation of the role of county designated EA/AAR agencies in responding to reports of abuse, neglect and exploitation and provides a framework to evaluate risk: http://www.dhs.wisconsin.gov/dsl_info/NumberedMemos/DDES/CY2007/2007-12.htm