Case Examples: Abuse, Neglect, and Misappropriation

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Objectives

- Review elements of a Quality Assurance/Quality Improvement (QA/QI) Program
- Review definitions and requirements of reporting caregiver misconduct
- Use real case examples to test provider procedures and implement improvements to identified weaknesses

Quality Assurance Quality Improvement

- Internal quality assurance and improvement involve continuous activities that promote the model of plan, do, check, and act (PDCA).

- As part of the Bureau of Assisted Living's focus on quality improvement in assisted living, the provider is encouraged to formalize an internal system.

QA/QI Process

PLAN

Have a plan which includes protection of all residents, timely investigation, and reporting of allegations which are proven to have occurred or are likely to have occurred.

DO

Ensure the plan is in place and followed with each allegation.

QA/QI Process

CHECK

Upon completion of an investigation, review the procedure. Identify weakness and failures.

ACT

Problem solve identified system issues and revise procedure/plan as needed.

An internal QA/QI program should contain all of the following:

- Corrective action and system changes to ensure insufficient services are corrected and regulatory compliance is maintained
- Responsible party
- Date of completion for each corrective action
- Collect and analyze data
- Continuous evaluation of assisted living facility systems, processes, and policies

Wisconsin Caregiver Program

Federal Regulations-42 CFR § 483.5
WI Administrative Code Chapter DHS 13

Misconduct Definitions

- Abuse (Verbal, Sexual, Physical, Mental)
- Neglect
- Misappropriation of Resident Property
- Misconduct Definitions

Abuse

- The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish.
- Abuse can be verbal, sexual, physical, and/or mental.

Neglect

The failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

Misappropriation

The deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent.

Wisconsin Caregiver Program: Misconduct Reporting Requirements

- https://www.dhs.wisconsin.gov/publications/p0/p00038.pdf

- If an incident is investigated by Office of Caregiver Quality (OCQ) and found to meet definitions of abuse, the caregiver is placed on the misconduct registry.

Staff Incident Reporting

An entity can learn of an incident from:

- A verbal or written statement
- Discovering an incident after it occurred
- Observing injuries to a client (physical, emotional, or mental)
- Observing misappropriation
- Otherwise becoming aware of an incident

Reporting Requirements

All staff persons must immediately report incidents of suspected caregiver misconduct or injuries of unknown source to a person with supervisory authority in their health care facility. It is then the facility's responsibility to decide how to proceed.

Entity Investigative Responsibilities

Immediately upon learning of the incident, the entity must take necessary steps to protect clients. In addition to DQA requirements, entities are encouraged to notify local law enforcement authorities in any situation where there is a potential criminal violation of the law.

Entity Investigative Responsibilities

All entities regulated by Division of Quality Assurance (DQA) must conduct a thorough investigation and document their findings for all incidents reported to them.

Entity Investigative Responsibilities

Following a thorough investigation, an entity which concludes that the following conditions are true, **must report** the incident.

Entity Investigative Responsibilities

1. Entity has reasonable cause to believe that they have sufficient evidence or that another regulatory authority could obtain the evidence, to show that the alleged incident occurred.

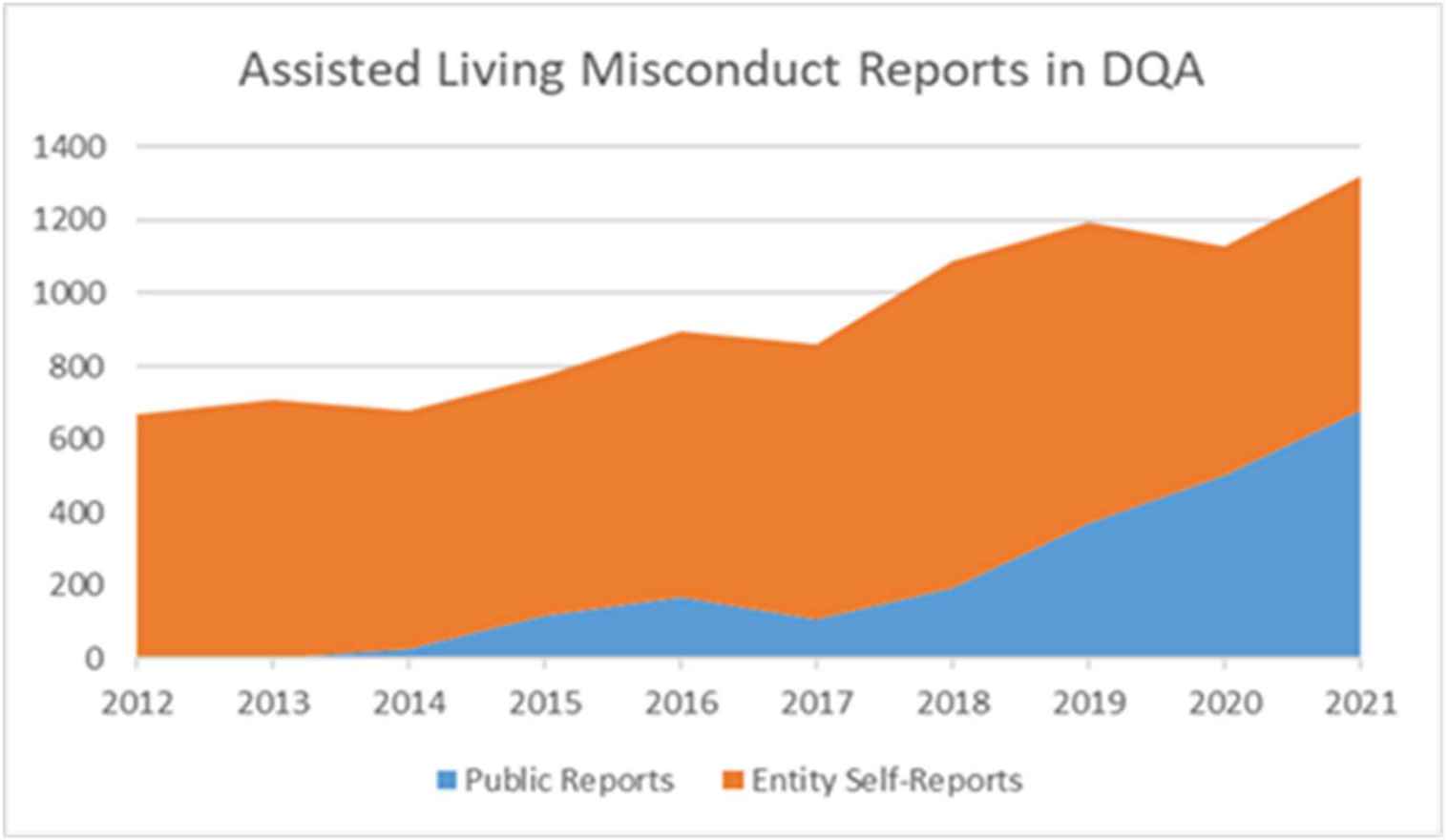
2. Entity has reasonable cause to believe that the incident meets, or could meet, the definition of abuse, neglect, or misappropriation.

Reporting An Incident

- Bureau of Assisted Living (BAL) providers must submit reports to DQA within **7 calendar days** of the incident or of the date that the entity knew, or should have known, of the incident.

- Use **DQA form F-62447**, Misconduct Incident Report, available online. For allegations involving **all staff** (non-credentialed and credentialed), submit the Misconduct Incident Report to DQA.

Numbers of Reported Incidents of Caregiver Misconduct



Develop and Test Procedures to Prevent and Detect Caregiver Misconduct

Plan-Do-Check-Act

Procedures

- Recognizing misconduct: staff training, responsibility
- Reporting: who is to receive initial report, what format should report be
- Immediate protection of residents
- Investigating: statements, evidence collection
- Determining outcome: reporting to Department, Law Enforcement, OCQ, if necessary

Case Example #1 Scenario

Caregiver was video taped by another caregiver hitting a resident on the arm. Three caregivers present did not intervene. The provider did not investigate and did not report the incident to the guardian or the department. The provider did terminate the caregiver 24 hours later, after finishing another 8 hour shift.

Check

- What are the key failures here?
- What is the danger of terminating without investigating and reporting an accused caregiver?

Case Example #2 Scenario

Two caregivers witnessed another caregiver verbally and physically abuse a resident. This incident was not reported to the administrator for 7 days.

Check

- What procedures should have prevented this situation?
- What corrective actions could be made to help ensure this does not happen again?

Case Example #3 Scenario

Police were called to the facility by the resident during the early morning hours after not being able to find staff. After a police search, the only staff on duty was found asleep. The police report noted multiple call lights going off.

Check

- Does this situation meet the definition of caregiver misconduct?

- What system changes can be made to ensure sufficient services and supervision of residents?

Case Example #4

An audio recording by a resident included a verbal exchange of a caregiver and two residents in a facility. Yelling and swearing by the caregiver went on for approximately three minutes. The caregiver was not suspended pending investigation and the event was not reported to OCQ.

Check

- From the information presented, what should be the first steps in the investigation?

- Would this be a reportable incident?

Hint: The Caregiver Program Manual has a Flowchart of Entity Investigation and Reporting Requirements, F-00161A

Resources for Conducting Misconduct Investigations, Staff Training, and Reporting

- DHS caregiver programs
- WI caregiver program manual
- Caregiver misconduct training: Prevention, Investigation and Reporting
- Additional misconduct resources

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