Investigating Elder Abuse and Neglect in LTC Facilities

Kansas Health Care Association

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Abuse or Neglect in LTC:

- No other issue
  - Causes more concern
  - Creates more controversy
  - Creates greater media scrutiny
  - Requires greater priority
How critical is abuse/neglect today?

- Data from the National Center on Elder Abuse shows that 10% of the Elderly suffer from abuse once a year.
- An earlier National Center study revealed that 90% of the abusers are family members.
- Data from a 2010 NY Study shows 41 out of 1000 elderly surveyed suffered major financial exploitation.
- 2013 Administration for Community Living Report (cited by OIG), also finds 10% (approximately 5 million) Elders (65 and older) are abused, neglected or exploited annually.
Federal Abuse Reporting Requirements

- Elder Justice Act: Reporting the Suspicion of a Crime
  - MCR/MCD LTC Facilities
  - “Covered Individuals” have to report
  - Serious bodily injury – 2 hours
  - Other abusive acts – 24 hours
  - LTC Facilities must have Policies and Procedures
Federal regulation – F223

- **Abuse** means willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. (includes deprivation by a caretaker/staff of goods or services that are necessary to attain or maintain physical, mental, psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish).

- **Verbal abuse** means use of oral, written or gestured language that willfully includes disparaging/derogatory terms regardless of ability to comprehend or disability
State Abuse Reporting Requirements

- Licensed health care professionals who have **REASONABLE CAUSE** to believe that a resident is being
  - or has been abused, neglected or exploited
  - or is in a condition which is the result of such abuse/neglect/exploitation
  - or is in need of protective services

**SHALL REPORT IMMEDIATELY** to KDADS, DEPT. OF SOCIAL/REHABILITATION SERVICES, DEPT. OF HEALTH AND ENVIRONMENT
Threshold for “suspected” abuse or neglect that requires reporting

- Kansas Article 14, 39-1402– “reasonable cause”

WOULD AN OBJECTIVE PERSON IN THE SAME POSITION HAVE A FACTUAL BASIS UPON WHICH TO SUSPECT ABUSE OR NEGLECT OR FINANCIAL EXPLOITATION?
Key to Reporting: Know what to look for

Staff knowledge & understanding of what constitutes abuse and neglect

What are elements of abuse

What are elements of neglect
Abuse includes:

- Any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to a resident
- Infliction of physical or mental injury
- Any sexual act when a resident does not consent or when known resident incapable of resisting/consenting due to mental deficiency/disease or fear of retribution or hardship
- Unreasonable use of physical restraint, isolation or medication that harms or is likely to harm a resident or as punishment or staff convenience or substitute for treatment
- Threat or menacing conduct toward resident that results or might reasonably be expected to result in fear/emotional distress (psychological abuse)
- Fiduciary abuse
- Omission/deprivation by staff of goods/services necessary to avoid harm or illness
Has abuse occurred?

- An 84 yo female resident tells a CNA when getting ready for a bath that “a man came into my room last night and touched me”
- Aide took EOS report from male aide night before and he reported that resident had increased urinary incontinence and to monitor during day shift for possible UTI
- Aide asks resident who touched her but resident cannot recall or explain or tell aide where she was touched
- Aide tells charge nurse about resident’s statement and resident tells nurse was touched on breast and genital area but can’t remember who touched her or when

IS THERE A REASONABLE SUSPICION OF ABUSE?
Critical Step of Preliminary Determination of Potential Abuse

- Assess accuracy and credibility of report
- What actually happened, what was said or done
- What is background and experience of staff members
- What is normal demeanor/behavior of resident
- Any prior history by resident of same type of report
- Are prior reports documented/care planned?
- Are family members available to help with communication

CANNOT DISMISS MERELY BECAUSE OF DEMENTIA OR INABILITY TO RECALL DETAILS
Time is of the essence to make preliminary determination

- How you conduct preliminary determination of whether abuse (or neglect) occurred will impact:
  - Accuracy of report of potential adverse event
  - Type of protective measures to put into place
  - Effectiveness of protective measures
  - Effectiveness of prevention measures
  - Err on side of safety (overprotect rather than underprotect)
Neglect includes:

- Failure or omission by staff with a duty to provide goods and services which are reasonably necessary to ensure safety and well-being and to avoid harm or illness.
Has neglect occurred?

- Female resident requires 2 persons for mechanical lift transfer but only 1 person does transfer from wheelchair to bed (breach of standard of care)
- Resident slips out of sling when lift is over the bed, resident falls onto bed
- No serious injury but resident has bruises and is complaining of soreness and more pain than normal
- Staff person explains 2nd aide not available and resident demanded to be transferred “now” due to increasing pain from sitting in wheelchair
Distinguishing bruises of known vs unknown origin under F225

- Source of bruise/injury was not observed by anyone
- Source of /bruise injury could not be explained by resident
  AND
- Injury is suspicious because of extent of bruising/injury
  OR
- Location of injury (not generally vulnerable to trauma)
  OR
- Number of bruises/injury observed at same point in time
  OR
- Frequency of bruises/injuries over time
Key to determining whether bruise of unknown origin is reportable

- Characteristics of bruise and/or injury (new or old or healing)
- Any evidence of other bruises of known source?
- Evaluating possible causes of bruise/injury (root cause analysis)
- What is resident’s history of bruising/minor injuries?
- If not observed, what have staff reported in past for resident’s activities that pose a high risk for bruising/injury?
- Is resident at risk for bruising/injury due to medical condition or activities?
- Is risk for bruising/injury care planned with interventions?
Keys in Early Detection of Abuse

STAFF RISKS

FAMILY RISKS

ENVIRONMENTAL RISKS

RESIDENT RISKS

DETECTION & PREVENTION
KEY: Identify Resident Risk Factors

- Behaviors (verbal and physical)
- Medications (antipsychotics or need for)
- Degree of physical impairment - physical functioning problems (personal hygiene or incontinence) increases risk for verbal abuse
- Cognitive Deficits increase both physical & verbal abuse
- Prior occupation (law enforcement, military, etc.)
- Prior criminal history (any convictions or arrests, pending warrants (conducting criminal background checks))
- Prior admissions (other facilities & institutions)
Identifying Caregiver/Staff Risk Factors

– Poor knowledge of behavior management
– Poor management of personal stress
– Abusive personality style/history
– Cultural acceptance of punishment
Identifying Administrative Risk Factors

- Resident/staff interaction not monitored
- Under-recognition of staff “burn out”
- History of “abuse” deficiencies
- Staffing shortages/high turnover
- Culture/management
Steps to Ensure Investigation of Abuse or Neglect is Thorough
Preliminary Determination Checklist

- Suspected or confirmed abuse or neglect?
- What type of abuse? (physical, verbal, or neglect?)
- Is incident/act reportable?
- Are you able to intervene early?
- Does resident require an exam, monitoring, safeguarding?
- What protective measures are needed for resident/others?
- Does an employee(s) require suspension pending investigation?  PROTECTION COMPONENT
- Does any ‘evidence’ need to be preserved at the scene?
- Do any documents need to be preserved (locked)?
Is this an Adverse Incident Requiring Immediate Reporting?

- Death – criminal act, suicide, medication overdose or other un-natural cause
- Physical Abuse – any allegation of intentionally or recklessly causing physical harm to a resident
- Inappropriate sexual contact – any allegation of intentional touching of a sexual nature without consent or is incapable of consenting or declining consent due to mental deficiency/disease or fear of retribution
- Misuse of medication – incorrect administration or mismanagement of meds which resulted in or could result in serious injury or illness
Which Agencies Require a Report?

- Law Enforcement (Elder Justice Act)
- KDADS
- Adult Protective Services Agencies
- Licensing Boards
- Coroner (unexplained or unattended death or suspicious circumstances)
What measures are needed to protect residents?

- As soon as you make a preliminary determination or have a reasonable suspicion that abuse or neglect has occurred
  (may not know all facts or details yet)

CRITICAL TO THEN ASK

What actions are necessary to protect safety of resident (victim) and other residents (or staff) from continuing/recurring abuse/neglect?
Options for Protective Measures

- If **reasonably suspect** a staff member acted in a manner toward a resident that could constitute abuse or neglect, suspension pending investigation essential
- If **no reasonable suspicion** of specific staff member:
  - unable to identify specific staff member but report raises a reasonable suspicion of abuse/neglect by a staff member, isolate to time/shift/unit as much as possible and then look at need to suspend all
  - consider reassigning staff with increased supervision or moving resident or instituting 1:1 monitoring 24/7
Choosing an Internal Investigator:

- Experience with investigations
- Thoroughness and promptness
- Background should fit the alleged event
- Known to staff and respected
- Impartiality – not a ‘judge or jury’ but objective
- Good interpersonal skills
- Oversight and direction
Secure/Safeguard all Records

- Medical chart
- Incident report
- Applicable policies/procedures
- Possible witness statements or summaries of interviews
- Records from outside providers
- Financial records
- Facility business records
- Staff member employment/personnel files
Create an Investigative File

- Start a timeline to record chronology of events
- List of potential interviewees
  - staff members
  - residents and family members
  - independent medical/other providers
- List of key documents/records
- Create log of persons to be notified
- Securing access to authorized persons only
- Outline action plan for investigation
Formulating an Investigative Plan

- Develop approach for investigating from “outside in”
- Focus on concept of “corroboration”
- Decide on approach for memorializing witnesses observations & accounts
  (actual witness statements OR note taking of interviewees)
- Reporting & gathering findings
- Analyzing critical facts (root cause analysis)
- Develop final product (oral or written report)
Interviewing Third Parties & Other Witnesses

- Identify other witnesses with material knowledge
- Schedule interviews on a time table and in order to further investigation
- Conduct interviews (vs. emails) to provide optimal information
- Disclose “practical” confidentiality conditions
- Follow-up with interviewees (on critical facts & outcome)
- Obtain any written statement(s) as needed (or summarize notes from interview)
Preparing to Interview Primary Witnesses

- Select neutral site, depending on circumstances
- Conduct in person – assess demeanor & credibility
- Select & organize documents for interviews
- Determine interviewers for each witness
  - whether team approach is optimal or necessary
  - who has the best rapport with staff members or residents
- Identify role for multiple interviewers (who will ask questions or take notes)
- Identify critical facts or issues and purpose for each
Conducting Interviews

- Identify issues and purpose of interview
- Establish credibility (conducting objective investigation to determine what happened)
- Use direct questions (what happened?)
- Avoid loaded or accusatory or leading questions
- Listen to answers/responses
- Clarify any inconsistencies in explanation
- Summarize witness explanation or statement to confirm understanding
- Pausing and use of silence

DO NOT DISCUSS FINDINGS OR CONCLUSIONS
Post Interview Follow-Up

- Complete contemporaneous witness & document summaries
- Include comments on credibility & accuracy
- Be persistent to close ‘loose ends’
- Manage escalation of seriousness of investigation
- Consult with QA, Risk Management or Legal prn to formulate findings
- Formulate findings & conclusions
- DO NOT DISCUSS CONCLUSIONS, FINDINGS OR RECOMMENDATIONS OUTSIDE OF QA CONTROL GROUP
Reporting Investigative Findings

- Findings are part of the QA or Self Evaluative process
- Oral report to QA (noted in QA committee minutes)
- Written report (to any governmental agencies)
  - Identify the matter being investigated
  - Identify the issue/negative outcome involved
  - Report facts that were established & corroborated
  - List all sources of information
  - Identify all actions taken including how residents protected
  - Identify matters or facts not established or verified
  - List all agencies that received reports & status
Closing the Investigation

- Complete and organize all notes, key documents, interviews and summaries, any gathered evidence
- Meet with staff and residents for necessary follow-up and any training
- Meet with resident/victim and family members for proper disclosure of investigative findings
- QA control group to assess how to handle follow-up with governmental agencies on external investigations and actions
- Refer all inquiries to QA control group
Questions?