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RESIDENT SAFETY REVIEW COUNCIL (RSRC) FINAL REPORT

Presented to Elder Abuse Workgroup members on 2/14/2013

House Human Services Committee - 02/25/2013

RSRC Membership

Members	**Bethany Walmsley** (formerly Bethany Higgins), **Chair** Executive Director, Oregon Patient Safety Commission
	Mary Jaeger Long Term Care Ombudsman
	Demi Haffenreffer (consultant) Geriatrician representative
	John Wentworth Oregon District Attorneys Association
	Diane Richardson Oregon Medicare Quality Improvement Organization
	Fred Steele Department of Human Services
Staff Support	**Sydney Edlund**, OPSC Analyst
	Valerie Harmon, OPSC Patient Safety Consultant

Council Charge (HB 4084)

1. Review information and reports from investigations of abuse, performing a root cause analysis of this information to determine whether the occurrences of abuse or alleged abuse should be classified as acts of abuse or as adverse events

Council Charge (HB 4084)

2. Prepare a report on the review and findings of the council, together with recommendations for improvement to the processes of investigation and for corrective actions with respect to occurrences of abuse

Council Review and Analysis

- Monthly council meetings
- Three primary activities
  1. Abuse investigation case review
  2. Panel interviews
  3. State “abuse” definition review
- This approach allowed for a comprehensive assessment of the current system using more than one method for root cause identification

RSRC Timeline

Council Activity	May 2012	June 2012	July 2012	Aug 2012	Sept 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013
Access to Records & Data Review	30th	27th	25th							
Analysis & Results		27th	25th	-	26th					
Panel Interviews and State Definition Review					26th	24th				
Discussion & Recommendations					26th	24th	28th			
Conclusions & Final Report							28th	19th	24th	**14th**

Abuse Investigation Case Review

- Purpose: to determine what portion of investigated abuse cases were *adverse events*
- Closed abuse investigation cases (2011)
- 30% sample from the four long-term care settings
- Sample from only those abuse categories that had the potential to be *adverse events*

Adverse Event Defined

- An adverse event is an event resulting in unintended harm or creating the potential for harm that is related to any aspect of a patient's care (by and act of commission or omission) rather than to the underlying disease or condition of the patient; adverse events may or may not be preventable
- Definition used by the Oregon Patient Safety Commission

Case Review Sample

- 3,460 case investigations in 2011
- Only cases that had the potential to be an *adverse event* were reviewed
- Categories of abuse*
  - Financial exploitation
  - **Neglect**
  - **Physical Abuse**
  - Verbal abuse
  - Abandonment
  - Sexual abuse
- 30% sample (390 cases)

Method to Determine Adverse Events

- Algorithm (Appendix I) applied to each abuse investigation in the sample
- Algorithm is a tool designed by the Commission based on the work of James Reason and his Unsafe Acts Algorithm and other concepts from the Just Culture movement
- The tool assists with sorting out human error versus harm that resulted from the system itself (e.g., determining what events would be unlikely with a more reliable system)

Reviewer Inter-Rater Reliability

- Three reviewers conducted the review
- A method of reaching consensus and agreement was used to resolve any concerns with regard to application of the algorithm
- The reviewers also started the review with independent review of the same cases and made sure the results were consistent before moving forward

Making the Decision

Potential adverse event: Determined to meet the criteria of an adverse event

Not an adverse event: Determined to NOT meet the criteria

Excluded from the algorithm:

- No evidence of an event
- Related to patient/resident underlying medical condition
- Related to patient/resident personal choice
- Potentially criminal act
- Resident-to-resident violence

Case Review Results

- 35% Potential *adverse events*
- 4% Not an *adverse event*
- 61% Excluded from the algorithm

Potential Adverse Event Types

Fall	38%
Medication event	24%
Care delay	11 %
Pressure ulcer	5%
Other *	22%

* 'Other' examples: elopements, dehydration, device events, healthcare-associated infections, etc.

Adverse Events and Abuse

Of the 135 potential adverse event cases:

- 83 cases (61%) were *substantiated wrong doing*
- 49 cases (36%) were *unsubstantiated wrong doing*
- 3 cases (3%) were *inconclusive*

What We Learned

- Adverse events offer the opportunity to understand what occurred and strengthen the system to prevent recurrence
- Potential exists to design the system with this in mind to drive accountability for prevention into the process of abuse investigation

What We Learned

- Data collection for the case review was resource and time intensive for everyone due to the paper process
- Inconsistencies in documentation and the opportunity for error is high
  - Potential for better technology to support the process

Panel Interviews

To appreciate the “on the ground” perception of abuse investigation from multiple perspectives, the council opted to conduct panel interviews with three groups

1. Adult Protective Services (APS) investigators
2. Corrective Action
3. Long-term care providers

Common Themes Identified

- Commonalities were identified across all three groups, which were used to further inform and shape the recommendations for this report
- Despite the different perspectives, these themes represent key areas of opportunity for improvement

Common Themes

- Several barriers to self-reporting
- Technology improvements are needed
- Civil penalty structure could benefit from redesign
- Multiple inconsistencies between interpretation, application, and the definition
- Broad definition of *abuse* is problematic
- *Note:* Table 2 on page 4 of the final report provides additional details for each theme

Oregon Statutory Abuse Definition Review

- Definitions clearly integrate with any conversation related to improving the abuse investigation process
- Other state abuse definitions were reviewed with consideration for four areas:
  1. Who is protected from abuse?
  2. What is investigated?
  3. What is determined?
  4. What is presented to the public and providers?

What We Learned

- A few states have some potentially useful approaches; no one state has the "silver bullet" answer; several states offer ideas that could inform Oregon
- In Oregon, the umbrella term of *abuse* is used to represent all stages of the investigation process
  - Ensuring initial protection
  - Triggering an investigation
  - Making a determination of abuse
  - Public reporting of the determination
- This leads to confusion and can be a problem for transparency and reporting

Tiered Determination System

By breaking down the *abuse* term into several categories and incorporating more clearly labeled determinations:

- Systems can be designed to maintain protection for the citizens of Oregon without having to keep the definition as broad as it currently is
- Good tools can clear up misperceptions, lead to more definition clarity, and result in an improved system

(Will expand on this more in the Recommendation Section)

Key Findings

- Paper is a barrier to a more efficient system
- Subjective language in statutory abuse definitions is problematic on multiple levels
- Process lacks an improvement/prevention focus
- Stigma associated with the term *abuse*, works against accountability and transparency
- Variation in abuse definitions across populations and care-settings impedes reporting; adds to inefficiency

Recommendations

- Worked very hard to preserve the fresh and diverse perspectives of the members to fulfill our charge
- Kept focus on protection for Oregonians
- Two main categories – Process and Definition
  - Process: abuse investigation process
  - Definition: relates to the Oregon definition(s) of abuse
- One set of recommendations without the other is not an effective strategy for change
- Council is very aware that there is current improvement work within Adult Protective Services and recognizes there could be some alignment

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Process – Recommendation 1

IMPROVE INVESTIGATION AND REPORTING TECHNOLOGY

Investigation and Reporting Technology

- Although initial fiscal impact of acquiring a new system must be considered, eliminating rework and creating other efficiencies can help to offset the cost and improve productivity
- An updated system could provide essential data for planning and improvement; ready access to that data would be possible

Investigation and Reporting Technology

Computerize the investigation process

- Fully electronic systems could streamline the process and improve efficiency for investigators
- More modern technology will help with minimizing inconsistencies within the paper records and allow for more real-time data to support appropriate staffing
  - Timely completion of investigations was perceived as an issue across the panel interview groups

Investigation and Reporting Technology

Create an investigation database

- Current database is outdated, not fully functional, and requires rework
- Improve access to aggregate data to identify trends of concern that could be important for follow up and protection of Oregonians
- Allow for ongoing identification of training needs and other support
- Non-protected information could be made available for providers and the public to assist with transparency

Investigation and Reporting Technology

Incorporate analytic tools and processes

- Analytic tools and processes should be built into the technology
- Data collection should be used to inform and prioritize work

Investigation and Reporting Technology

Develop and online tool to determine if an event is reportable as abuse; tool could:

- Give guidance that is of benefit to providers and mandatory reporters
- Provide additional clarity and promote self-reporting and transparency
- Act as a central hub for notifying appropriate agencies and act as a “gatekeeper”

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Process – Recommendation 2

Develop an Abuse Investigation Algorithm

Develop an Abuse Definition Algorithm

- Assist with standardizing the application of abuse definitions
- Create a more consistent and efficient process
- Provide clarity for what is reportable
- Algorithms sort out subjective data and decision points

Develop an Abuse Definition Algorithm

Clearly categorize abuse determinations

- Identify the major decision points and other variables to determine and categorize abuse
- Assist users with distinguishing between sub-categories of abuse
- Series of yes/no questions removes the opportunity for error and standardizes determinations for every user

Develop an Abuse Definition Algorithm

Create objectivity

- Allow for greater objectivity in what can be very emotionally charged situations
- Reduce the burden on investigators and corrective action personnel by aiding with consistent application of definitions
- Potentially improve communication with providers leading to better teamwork and collaboration

Develop an Abuse Definition Algorithm

Include determination of adverse events

- Assist with providing more prevention and improvement focus for abuse reporting
- Identify system-level issues for shared learning and improvement to prevent similar future events
  - Consider triage to Oregon's Patient Safety Reporting Program (PSRP) administered by the Oregon Patient Safety Commission

Develop an Abuse Definition Algorithm

Develop clear definitions of terms used in the abuse definition algorithm

- Ensure consistent application
  - Example: intent, recklessness, or negligence terms defined and used to substantiate abuse (rather than only neglect)
- Identify pattern of events
  - Substantiating abuse could be supported with criteria for a *pattern of events*

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Process – Recommendation 3

MORE COMPREHENSIVE TRAINING AND EDUCATION

Comprehensive Training and Education

- For APS workers, providers, and mandatory reporters
  - Training and education was a prominent theme for improvement
  - Inconsistencies in the investigation process and application of abuse definitions
  - Lack of clarity for providers related to what is reportable and where to report
  - A knowledge gap related to identifying the root cause of an event and system-level improvement
  - Minimal ability to assess ongoing training needs and therefore identify areas where more support is needed

Comprehensive Training and Education

Standardize training and develop ongoing training programs

- Providers and investigators bring varied backgrounds and perspectives to this process leading to differences in beliefs, value systems, and priorities
- More frequent training and routine updates to training programs would support everyone, improve the application of key learning, and promote impartiality and objectivity

Comprehensive Training and Education

Training components

APS service workers, investigators, corrective action, and intake screeners

- Consistent approach for investigation and application of abuse definitions
  - How to use abuse definition algorithm
  - Training to utilize new technology appropriately
- Knowledge sharing for system-level improvement and action plan development
- Effective communication in challenging situations

Comprehensive Training and Education

Training components

Providers

- Clear guidelines for what and where to report
- System-level issues and action plan development
- Abuse prevention strategies

Mandatory Reporters

- Who is a mandatory reporter?
- What is a required report?
- Where does one report?
- How does one report?

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Process – Recommendation 4

EVALUATE AND CONSIDER RESTRUCTURING THE CIVIL PENALTY SYSTEM

Evaluate and Consider Restructuring the Civil Penalty System

Evaluate the current civil penalty system

- Consider if civil penalties adequately reflect the severity of the incident that occurred
- Determine if there is evidence that the penalty had the intended impact (e.g., Is there evidence that this kind of event is no longer occurring or less likely to occur?)

Evaluate and Consider Restructuring the Civil Penalty System

Develop a structure for alternatives to civil penalties

- Alternatives to civil penalties are often proposed by corrective action personnel; however, the system for when and how these alternatives are applied can vary and should be more formalized
- Clearly defined criteria could be supported by improved technology and built into the algorithm proposed

Evaluate and Consider Restructuring the Civil Penalty System

Quality improvement focus

- Any alternatives to civil penalty proposed by corrective action should set expectations for improving quality of care and identification of the root cause of abuse
- Prevention of future abuse should always be the focus

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Process – Recommendation 5

EXPLORE THE IDEA OF A LONG-TERM CARE WORKER REGISTRY

Long-Term Care Worker Registry

Registry could close gaps in the current background check system

- Current system captures substantiation of neglect, physical abuse, and financial exploitation only
- If a worker seeks employment before an investigation is complete or a determination has been made, a perpetrator of abuse could go unrecognized and the ability to jump from facility to facility is possible
- Unique identification numbers could be used to track the long-term care worker and help ensure a known risk to patients is not rehired

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Process – Recommendation 6

ENHANCE SUPPORT FOR MULTIDISCIPLINARY TEAMS

Multidisciplinary Teams

District attorneys in each county are required to coordinate the multidisciplinary teams (MDTs); this includes members from:

- Community mental health
- Developmental disabilities
- DHS
- Local agency on aging
- Law enforcement
- Agencies that advocate on behalf of individuals with disabilities and others with special training in the abuse of adults

Multidisciplinary Teams

Each MDT is to develop a protocol for immediate investigation of abuse, including:

- Victim interviews
- Procedures to assess risks to the adult
- Timelines and procedures for investigations

Multidisciplinary Teams

- Many counties do not have the support or the resources to implement the mandate
  - Budget constraints limit the personnel necessary to prosecute crimes
- Consider modifying the law to allow other agencies to create and chair an MDT
- Sharing resources across counties should also be encouraged

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DEFINITION RECOMMENDATIONS

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Definition – Recommendation 7

ALIGN DEFINITIONS ACROSS SETTINGS AND POPULATIONS

Align Definitions Across Settings and Populations

- Regardless of an individual's age and care setting, consistency to align abuse definitions would reduce confusion among providers, investigators, and other interested parties
- Note: nursing homes also must adhere to federal abuse definitions

Align Definitions Across Settings and Populations

One state that aligns their abuse definitions is Arkansas

- Multiple populations are covered in a single statute
- Abuse is split into two parts:
  1. Long-term care facility residents and state hospital patients
  2. Any person who is not a long-term care facility resident or state hospital patient

Align Definitions Across Settings and Populations

- Other definitions, like *neglect* and *financial exploitation*, have sub-points that apply only to the long-term care setting
- Oregon could use this kind of approach to further streamline and align our abuse definitions, while maintaining specific protections or exceptions for different populations and care settings

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Definition – Recommendation 8

DISTINGUISH BETWEEN APPLICATION VS. DETERMINATION

Application vs. Determination

- In Oregon, *abuse* is defined broadly to ensure all individuals are protected
- Additional clarity for abuse determinations is recommended
- Applying more clearly defined categories to the final determination could improve transparency and understanding for investigators, providers, and the public

Application vs. Determination

Consider a distinct category for *neglect*

- Substantiated *neglect* is a category under the definition of abuse
- Neglect currently acts as a “catch-all” category for investigation
- Council agrees that these cases should be investigated, yet adding *neglect* as a distinct determination category would provide important clarity

Application vs. Determination

Establish a tiered system for abuse determinations (e.g., abuse, maltreatment, adverse event)

- Currently, all determinations are labeled *abuse*
- A tiered system could be used to inform how reckless conduct and intentional harm are managed
- Work will be necessary to sort out any issues created between criminal and APS definitions of abuse to ensure:
  - An escalation of unintended criminal prosecutions is avoided
  - Current levels of cooperation between APS and law enforcement are maintained

Application vs. Determination

Use current research and practice to inform abuse determination definitions

- Opportunity to use patient safety research and evidenced-based literature to inform determinations of abuse
- Goal is prevention and developing a safer culture; this means considering this science as a part of developing any upgrades to determination definitions

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Definition – Recommendation 9

INCREASE CLARITY FOR JURISDICTION AND REPORTS OF POTENTIAL ABUSE

Clarity for Reporting Jurisdiction

Jurisdiction is problematic for individual reporters and the screeners receiving the reports

- Definition variability across care-settings and populations
- Better guidelines are needed for the triage of abuse reports
- Improved clarity within the triage process could support improved communication for all

Clarity for Reporting Jurisdiction

Triage structure should include:

- Central hub for intake of all reports, regardless of the care-setting or population involved
- Online tool with simple, objective questions to direct appropriate triage
  - Connects with Recommendation 1 – helps to determine if an event is reportable
  - Connects with Recommendation 2 – helps to determine what agency the event is reportable to
- Potential to improve communication between agencies (CCMU, law enforcement, ombudsman, etc.)

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Definition – Recommendation 10

CONSIDER SELECT DEFINITION CHANGES

Consider Select Definition Changes

Minimal changes to clarify

- Cleary define language that can be subjectively interpreted
  - Define “willful”
  - Develop a more specific definition of “caregiver”
  - Define “physical injury”
  - Define “by other than accidental means”
  - Define qualifiers (e.g., “significant”) and consider their use

Consider Select Definition Changes

- Separate *emotional abuse* from *verbal abuse*
  - *Verbal abuse* is a form of *emotional abuse*; however, not all *emotional abuse* is *verbal abuse*
- Evaluate the statute and related rule language for *abuse* to identify gaps between them or instances where statute language may be preferred to ensure protection
  - Example: An individual that cannot express pain is currently identified in rule

Setting Priorities for Next Steps

- Smaller work groups to work on four areas of priority:
  1. Develop an abuse definition algorithm
  2. Improve investigation and reporting technology
  3. Definitions
  4. Long-term care worker registry
- Each work group should include DHS representation