Review, Findings, and Recommendations of the

Resident Safety Review Council

A Short-Term Legislative Workgroup Report
as Directed in House Bill 4084

Respectfully Submitted to the Elder Abuse Workgroup

February 2013

Page intentionally left blank

Contributors

Resident Safety Review Council Members

Bethany A. Walmsley
Oregon Patient Safety Commission, Council Chair

Mary Jaeger
Long-Term Care Ombudsman

Demi Haffenreffer
Geriatrician

John Wentworth
Oregon District Attorneys Association

Diane Richardson
Oregon's Medicare Quality Improvement Organization (Acumentra Health)

Fred Steele
Department of Human Services

Staff Support

Sydney Edlund
Oregon Patient Safety Commission, Data Analyst

Valerie Harmon
Oregon Patient Safety Commission, Patient Safety Consultant

Table of Contents

Executive Summary

Background

On March 1, 2012, the Oregon Legislature passed House Bill 4084, which created a short-term workgroup – the Resident Safety Review Council (to be referred to as the *council* for purposes of this report). The council would consist of six members with the Oregon Patient Safety Commission to chair and provide staff support to the council. House Bill 4084 was the outcome of another Legislative workgroup – the Elder Abuse Workgroup – charged with defining elder abuse and rethinking the process for prevention, investigation, and appropriate reporting of elder abuse (House Bill 2325).

The council, which convened in May of 2012, was tasked with examining the relationship between adverse events and instances of alleged abuse. Specifically, House Bill 4084 directed the council to:

> First, 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.
>
> Second, 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. The report may include recommendations for legislation, to the committees of the Legislative Assembly related to the care, protection and provision of services to elderly persons over 65 years of age and residents of long-term care facilities.

The results of a closed abuse record review, along with additional information gathering and subsequent analysis, have informed the recommendations the council has developed for this report.

Review and Analysis

Three primary information gathering activities informed the council's work:

1. A case review of 2011 abuse investigations
2. Panel interviews with representatives of key stakeholder groups
3. A review of Oregon statutory abuse definitions with comparison to other states

The review process identified potential areas of opportunity, or key findings that, if addressed, have the potential to streamline the investigation process. Of note, the review focused on uncovering the root causes that were contributing to inconsistencies and inefficiencies prevalent in the current system.

Recommendations

Recommendations were developed to address areas of opportunity identified through the council's review and analysis process. The recommendations have been categorized as one of the following:

- Process Recommendations – those relating to the abuse investigation process

- Definition Recommendations – those relating to the definition(s) of abuse

Recommendations focus on system-level improvements that have the potential to reduce inefficiency and variability as well as provide necessary clarity and transparency to the abuse investigation process. The council is aware that Adult Protective Services is currently working on improvement efforts within their organization and some of those efforts may closely align with recommendations being proposed by the council.

Review Process and Key Findings

The council conducted a comprehensive review and information synthesis, as directed in House Bill 4084, examining the relationship between adverse events and instances of alleged abuse and identifying opportunities for improvement in the current abuse investigation process. The review was comprised of three core activities and their subsequent analysis:

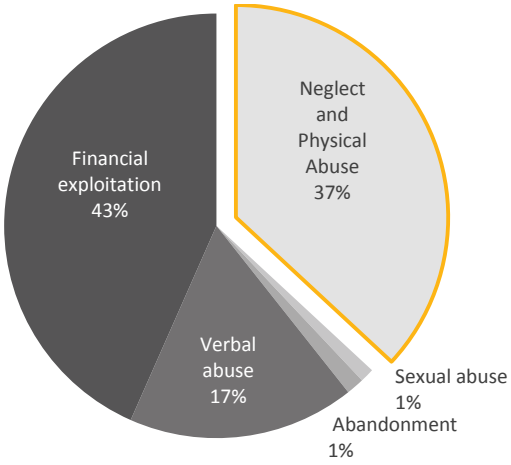
1. 2011 Abuse Investigation Case Review
2. Panel Interviews with Key Stakeholders
3. Oregon Statutory Abuse Definition Review

The following provides an overview of each activity and what was learned that informed the council's recommendations.

2011 Abuse Investigation Case Review

Methods

A case review was completed on a 30% sample of abuse investigations from 2011 across all long-term care settings (i.e., nursing home, assisted living facility, residential care facility, and adult foster home) to determine if an investigated event had the potential to be an adverse event. The sample was drawn only from abuse type categories that had the potential to be adverse events (i.e., *neglect* and *physical abuse*, see Figure 1) and was based on abuse type category proportions and definitions from the *Adult Protective Services (APS) Community and Facility Annual Report, 2010* applied to the total number of 2011 abuse investigation reports (3,460) (see Table 1, page 2 for definitions).



For the purposes of the case review, the reviewers applied the definition of adverse event used by the Oregon Patient Safety Commission: "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 an act of commission or omission) rather than to the underlying disease or condition of the patient; adverse events may or may not be preventable."

To determine whether or not an event had the potential to be an adverse event, an algorithm was applied to each abuse investigation in the sample. The algorithm, which was based on the work of James Reason and his *Unsafe Acts Algorithm* as well as concepts from the Just Culture movement, is available in

Appendix I.[1, 2,3] The questions in the algorithm helped determine the intent of the individual(s) involved and the likelihood that system-level factors contributed to or caused the event.

Table 1. Abuse Investigation Report Review Inclusions

Type of Abuse	Inclusion in Sample	Explanation of Inclusions
Neglect	Included	Neglect is "the failure to provide basic necessary care or services when such failure may lead to harm or risk of serious harm," which meets the adverse event criteria of being related to an aspect of a patient's medical care, and therefore has the potential to be an adverse event.
Physical abuse	Included	Physical abuse is "the use of physical force that may result in bodily injury, physical pain or impairment," which meets the adverse event criteria of being related to an aspect of a patient's medical care, and therefore has the potential to be an adverse event.
Financial exploitation	Excluded	Financial exploitation is "illegal or improper use of an adult's resources (including medications) through deceit, theft, coercion, fraud, undue influence or other means," which does not meet the adverse event criteria of being related to an aspect of a patient's medical care, and therefore *could not* be an adverse event.
Abandonment	Excluded	Abandonment is "a caregiver's desertion places the adult in serious risk of harm," which does not meet the adverse event criteria of being related to an aspect of a patient's medical care, and therefore *could not* be an adverse event.
Sexual abuse	Excluded	Sexual abuse is "non-consensual sexual contact, sexual harassment, inappropriate sexual comments and threats; these activities are considered non-consensual if the person does not make, or is incapable of making, an informed choice," which does not meet the adverse event criteria of being related to an aspect of a patient's medical care, and therefore *could not* be an adverse event.
Verbal abuse	Excluded	Verbal abuse is "the infliction of anguish, distress or intimidation through verbal threats," which does not meet the adverse event criteria of being related to an aspect of a patient's medical care, and therefore *could not* be an adverse

[1] James T. Reason, PhD, is one of the founding fathers of patient safety. His principal research area has been human error and the way people and organizational processes contribute to the breakdown of complex, well-defended systems such as commercial aviation, nuclear power generation, process plants, railways, marine operations, financial services, and healthcare institutions. His error classification and models of system breakdown are widely used in these domains, particularly by accident investigators.

[2] The Unsafe Acts Algorithm is a mechanism to assess individual versus system accountability, developed by James Reason (1997, Managing the Risks of Organizational Accidents), and is a practical method of ensuring a just assessment of individual acts.

[3] A just culture is one that recognizes that competent professionals make mistakes and acknowledges that even competent professionals will develop unhealthy norms (e.g., shortcuts, routine rule violations), but has zero tolerance for reckless behavior. Additional information on just culture as it relates to patient safety is described in *Patient Safety and the "Just Culture": A Primer for Health Care Executives* available at http://www.psnet.ahrq.gov/resource.aspx?resourceID=1582.

event.

Definitions from the Adult Protective Services (APS) Community and Facility Annual Report 2010. Compiled by Aging and People with Disabilities (APD). The full legal definitions of abuse can be found at ORS 124.050 & 441.630.

Learning

The case review identified approximately 35% of the sample that had the potential to be adverse events. While not currently integrated into the investigation process, adverse events offer an opportunity to better understand why the event occurred in order to strengthen systems and prevent future occurrences.

In addition, the data collection process for the case review presented challenges related to manually collecting data from paper documentation. First, the process was time-intensive, taking approximately 100 person-hours to complete (this does not include the Department of Human Services employee time to sort and de-identify the documents necessary to prepare for the review). Second, the lack of a standardized information collection system (e.g., no standard selection options for investigators) and the paper process contributed to inconsistencies between the investigation records. The opportunity for documentation error was high, which limited the level of analysis possible.

Additional information from the case review process is available in *Appendix II*. *Case Review Results: 2011 Long-Term Care Abuse Allegation Investigations.*

Panel Interviews with Key Stakeholders

Methods

To further contextualize and inform the data collected in the case review process, panel interviews were conducted with three key groups:

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

The goal of the panel interviews was to leverage each member's unique perspective to help identify practical challenges in the current investigation process as well as opportunities for improvement. Common themes identified from the panel interview process were used to inform the council's discussion related to potential recommendations.

Learning

While each of the stakeholder panels represented different perspectives in the investigation process, many common themes were identified across the groups (see Table 2). Please note these themes are a reflection of information shared by the panel interview participants and are not representative of the perspective of the council. The themes were intended to identify commonalities across the panel interviews that would inform the council's review and recommendations.

Table 2. Common Themes Across the Panel Interviews

Barriers to Self-Reporting	• Fear of litigation among providers • Stigma attached to the term *abuse* • Variation and lack of clarity around definitions, jurisdictions, interpretations • Perceived contentious relationships between providers and investigators – Perceived assumption of guilt, from the providers perspective, prior to an investigation
Technology Improvements/Limitations	• Current system is limited, time consuming, inefficient – More efficient system means more time to investigate – Better database means better understanding (for APS, providers, public) • Current investigation process invites a irremovable level of subjectivity that could be improved with technological standardizations
Civil Penalties	• The goal (prevention) is not supported by the means (civil penalties) – Too small to be motivating – Too punitive to foster transparency and accountability • Corrective action needs more flexibility to encourage improvement
Inconsistency	• The standards for substantiation are different for investigators (preponderance of evidence) and corrective action (clear and convincing evidence) • Multiple statutes and definitions lead to a lack of clarity about in whose jurisdiction a particular investigation should be • Multiple statutes and definitions lead to a lack of clarity about what is reportable • Multiple definitions that vary by population and care setting lead to inconsistent interpretation – Training on these definitions may vary between investigators, screeners, and corrective action – Frequency of training and knowledge audits may be inadequate
Definitions	• Public perception of the word *abuse* leads to stigma • Works against transparency and accountability because the application of the word *abuse* does not feel like an accurate representation for all the situations in which it is used • The right people are being protected, the right things are being investigated– it is a problem of how substantiated cases are labeled

Oregon Statutory Abuse Definition Review

Methods

The statutory abuse definition review consisted of current Oregon statutes related to elder abuse as directed in House Bill 4084 (ORS 124.050 and ORS 441.630), and, for context, also included other Oregon abuse statutes that could impact individuals in Oregon's long-term care settings (i.e., ORS 430.735). In addition, the discussion was informed by a nationwide state abuse statute review conducted by the Oregon Patient Safety Commission (see *Appendix III* for a summary of the review). Several states' statutes were brought forward for discussion based on elements that had alignment with the council's preliminary recommendations. Those states were Minnesota, Arkansas, and Wisconsin.

While certain components of those statutes were used to inform the discussion about Oregon's statute, none of the council's recommendations suggest using any one of the aforementioned state statues in their entirety (see Table 3 for details).

Oregon's elder abuse definitions were reviewed with consideration for the four areas in which the definitions are frequently applied. The word *abuse* has different implications in each area which were considered when reviewing the definitions.

- **Who is protected from abuse** – By location (e.g., nursing homes, community-based care settings), by person (e.g. elderly person, person with a developmental disability)
- **What is investigated** – By outcome (i.e., harm), by act (i.e., omission or commission)
  Note: Currently, all investigations are of potential abuse and include physical harm, neglect, financial exploitation, and verbal harm.
- **What is determined** – *Substantiated abuse* can include neglect, financial exploitation, and verbal harm, much of which may not be included in a lay understanding of the word *abuse*
- **What is presented to the public/providers** – Determinations need to be meaningful publicly as well as administratively

Learning

Based on the above considerations, some of the challenges with the current system, which were reinforced during the panel interviews (see Table 2, page 4), appear to stem from the umbrella application of the term *abuse*. That is, the same term, *abuse*, is used to represent events of all types and at all stages of the investigation process; i.e., from ensuring protection and triggering an investigation to making an abuse determination and publicly reporting determinations. This contributes to confusion surrounding what abuse is and a lack of transparency.

Looking at what other states are doing, two strategies were identified that had the potential to improve clarity and transparency in Oregon. First, is the concept of a tiered determination system and second, more clearly labeling abuse categories. Using the two strategies in conjunction, a tiered system could be established that did not limit protections by maintaining the use of an umbrella term, such as *maltreatment* (or another term) associated with less stigma than *abuse*, to trigger investigations and incorporating more clearly labeled determination categories (e.g., physical abuse, financial exploitations, neglect, etc.), as opposed to categorizing everything as *abuse*. Coupling the change in an umbrella term with more clearly labeled determinations would be crucial in avoiding the likelihood that a new term (e.g., *maltreatment*) would simply become associated with the same stigma as *abuse*. Additionally, a tiered system should include a means to clearly categorize abuse determinations (e.g., an algorithm) to aid investigators in consistent application of definitions. For more discussion, see the *Recommendations* section starting on page nine.

While several other states' offered strategies as to how Oregon could improve the process and structure of abuse definitions, no state offered a model that could transfer seamlessly. By incorporating some of the positive aspects from other states, Oregon can strengthen its abuse definitions, which could lead to more clarity for the investigation process, for consumers, and for the public in general.

Table 3. State Abuse Statute Review: Highlights from Minnesota, Arkansas, and Wisconsin

Please note that the information presented in this table was used to inform the council's discussion. Conclusions made by the council can be found in the Recommendations section starting on page eight.

Minnesota	• Uses *maltreatment* as an umbrella term to define what is investigated – Includes *abuse*, *neglect*, and *financial exploitation* • Clearly defines what is—and what isn't—reportable, investigated, substantiated – Definitions can be turned into a series of yes/no questions to provide guidance for a proposed algorithm (see *Recommendation 2*) – Defines "accident" and "therapeutic conduct" • Clearly defines the potential final determination categories – Substantiated – Inconclusive – False report – No determination will be made • Does not use the term *unsubstantiated*—uses "No determination will be made" instead, which does not imply that the only thing holding back a substantiation is a lack of a preponderance of evidence • Creates a statutory incentive for reporting potential neglect AND doing quality improvement work. For example, if a facility causes harm in the course of therapeutic treatment yet: 1) provides timely care and does no permanent or serious harm; 2) the event is not part of a pattern of events; 3) immediately reports the event; 4) implements changes to prevent future occurrence; and 5) adequately documents those changes, the facility has the opportunity to be released from the label of "substantiated maltreatment." • Only substantiates the umbrella term rather than the specific type of occurrence that was investigated, even though those are very clearly defined
Arkansas	• Uses *maltreatment* as an umbrella term to define what is investigated – Includes *abuse*, *exploitation*, *neglect*, *physical abuse*, and *sexual abuse* • Covers multiple populations in a single statute with clear organization – The definition of *abuse* is split into part (A), pertaining to long-term care facility residents and state hospital patients, and part (B), pertaining to any person who is not a long-term care facility resident or state hospital patient – Other definitions, like *neglect* and *exploitation*, have additional sub-points that specifically apply only to the long-term care setting
Wisconsin	• Implementation of an online incident reporting tool (the WITS system) (http://www.dhs.wisconsin.gov/aps/wits/index.htm) • Detailed and publically available manual for providers and the public explaining the statute in easy to understand, plain language (http://www.dhs.wisconsin.gov/aps/training/Chapter55/chapter55manual.pdf)

Key Findings

The council's comprehensive review process resulted in key findings that informed the final recommendations.

Paper is a Barrier to a More Efficient System

The current paper-heavy investigation process is inefficient and fosters inconsistency. This impacts the investigation system in a variety of ways:

- It creates a burden on investigators and other APS staff
- Data integrity is questionable due to inconsistencies and lack of timeliness and frequency of aggregation (i.e., compiled manually, annually) making auditing, analysis, and trending difficult if not impossible
- There is no ability to evaluate investigations to identify needs and provide targeted support
- It does not support an efficient means of tracking referrals or coordinating services
- Comparing data across care-settings is difficult due to collection variation by setting

Subjective Language is Problematic

Subjective language in statutory abuse definitions contributes to confusion and inconsistent application on multiple levels (e.g., language varies between investigators, corrective action, care-settings, districts, and providers).

- Data integrity is compromised due to inconsistent application, making it difficult to analyze
- Contributes to confusion and frustration among providers who may have a different interpretation (e.g., definitions include terms that are themselves undefined), additional confusion results when a determination changes from the investigator to corrective action
- Creates misunderstanding for the public as standards of evidence are different between investigators and corrective action
- Subjective language may contribute to an imbalanced application of civil penalty to providers

The Process Lacks an Improvement/Prevention Focus

The goal of the investigation process—i.e., providing protection for all patients/residents—could be realized through a process that supports system-level action plans and efforts to prevent the occurrence of future events.

- The current structure of the investigation and corrective action process is not prevention focused or based on current evidence-based methodology
- Improved support services and resources for providers when problems are identified that are not abuse, but in fact adverse events, could lead to cultural changes that support ongoing quality improvement

The Stigma of Abuse is Counterproductive

The stigma associated with the term *abuse*, and its use as an umbrella term, works against transparency and accountability as the application of the term may not accurately reflect what actually occurred.

- With the same term used to represent such a wide variety of events/acts, the public cannot have an accurate perception of what occurred, nor is it accurately reflected within publicly reported data, particularly given the lay association of the term *abuse* with intentional, malicious harm
- Perceived stigma of word *abuse* limits self-reporting because providers do not want to be labeled as "abusers," which:
  - Provides a disincentive for thorough investigations to identify root causes of events, thus removing the opportunity to learn and improve
  - Decreases the likelihood that preventative solutions/improvements will be implemented
  - Perpetuates problems that arise from work-arounds devised by individuals to deal with system-level problems
  - Encourages providers to stop investigating at the first sign that an event might be an accident (which would not be reportable, although differences in interpretation were noted during the panel interview process)

Variation in Abuse Definitions Impedes Reporting

Inconsistency in abuse definitions across populations and care-settings contributes to a lack of clarity around what and where to report.

- Lack of clarity around jurisdiction leads to inefficiencies and frustration

Recommendations

Through the council's in-depth review process, two overarching principles were identified. These principles represent the foundation upon which all recommendations were built.

> **Principle 1** – Any proposed recommendations should incorporate both the investigation process and the statutory abuse definitions; only focusing on one or the other will not be adequate.
>
> **Principle 2** – Maintaining the protections currently provided in statute, in terms of what is investigated and who is protected, is crucial.

The following sections offer a summary of the Resident Safety Review Council's recommendations for consideration by the Elder Abuse Workgroup. The recommendations address areas of opportunity identified through the council's review and analysis process, identified in this document as *Key Findings*. The recommendations have been categorized as either Process Recommendations– those relating to the investigation process– or Definition Recommendations– those relating to the definition(s) of *abuse*.

I. Process Recommendations

1. Improve investigation and reporting technology
2. Develop an abuse definition algorithm
3. Provide more comprehensive training for adult protective services workers, providers, and mandatory reporters
4. Evaluate and consider restructuring the civil penalty system to ensure it has the intended impact – prevention and improvement
5. Explore the idea of a long-term care worker registry
6. Enhance support for multidisciplinary teams (MDTs)

II. Definition Recommendations

7. Align definitions across settings and populations
8. Explore the option of a distinction between how the definition of abuse is applied to investigations versus determination
9. Increase clarity around jurisdiction for reports of potential abuse
10. Consider select definition changes

The council is aware that Adult Protective Services is currently working on improvement efforts within their organization. Some of those efforts may closely align with one or more of the recommendations being proposed by the council. Incidentally, funding and a structure to support the implementation of recommendations will need to be considered through the legislative process.

I. Process Recommendations

Recommendation 1

Improve Investigation and Reporting Technology

A recurring theme throughout the review process was the inefficiency and inconsistency in both the investigation and reporting systems that could be attributed to inadequate technology resources. While organizations that make investments in technology to support their work are faced with the initial fiscal impact, with appropriate planning, the investment can be offset with efficiencies and cost savings gained from eliminating rework and redundancy. In addition to improving efficiency, an updated system could provide important data that can be used for planning and improvements.

Computerize the Investigation Process

The current paper-heavy investigation process contributes to inconsistency in the investigation process and creates undue burden on investigators. The current process may also be a factor in the perception of the panel interview groups that timeliness of investigations is an issue. Transitioning to a fully electronic system could streamline the process and improve investigator efficiency, giving them the ability to complete investigations in a consistent and timely manner.

While data was not available to support investigation timeliness, given the inability to consistently track this information in the paper-based investigations provided to our reviewers, it was reinforced by each panel interview group. If data could be analyzed through a fully electronic system, there would be a better understanding of the staffing needed to support the investigation case load in each region. Having the appropriate information to assess staffing levels would support timely completion of investigations and reduce unnecessary burden on individual investigators.

Create an Investigation Database

Based on the experience of the council, information from investigations is accessible only through manual review of paper copies. Creating a database fed directly by computerized investigations would not only streamline the current investigative process, but would improve Adult Protective Services' ability to identify trends and produce aggregate summary reports. Currently, data collection is a multi-step process for investigators who collect information and later enter select information into a database. Personal accounts provided by investigators during the panel interviews revealed that the database is outdated, not fully functional, and often requires investigators to redo work that is frequently lost by the database.

A functional database has the potential to be used to inform and prioritize improvements in quality of care and services or to track investigators and substantiation records which could help identify training support needs. In addition, a database could be used to make non-protected information accessible to multiple parties (such as providers and the public) and would be a benefit to transparency.

Incorporate Analytic Tools and Processes

An investigation database must incorporate analytic tools and processes into the data collection systems to ensure data is used to inform and prioritize work. This should include establishing pre-defined schedules to produce some kind of analytic product(s) that could be used both internally and externally.

Develop an Online Tool to Determine If an Event is Reportable

An online tool could offer guidance to providers and mandatory reporters to determine what is and is not reportable, thus increasing self-reporting by removing subjective application of the definitions from the process. Additionally, if this tool were automated, it could serve as a central hub for notification of appropriate agencies.

Recommendation 2

Develop an Abuse Definition Algorithm

The problem associated with the inconsistent application or interpretation of the current abuse definitions is two-fold: 1) providers are unclear about what is reportable and 2) Adult Protective Services investigators' and corrective actions' application of the definitions is variable. An algorithm would serve to improve and standardize how decisions are made in the application of abuse definitions, thus creating a more efficient and consistent process.

Clearly Categorize Abuse Determinations

Development of an algorithm would help identify the major decision points/variables necessary to make an abuse determination and categorize abuse by type. Through a series of yes/no questions, abuse determinations could be clearly categorized. The algorithm should help users distinguish between finer abuse determination categories (e.g., *abuse*, *neglect*, *maltreatment*, or *adverse event*).

Create Objectivity

Maintaining objectivity can be particularly challenging in the often emotionally-charged situations that surround abuse investigations. An algorithm would make the process more objective, reducing the burden on investigators and corrective action to apply definitions consistently over time. This has the added benefit of enhancing data integrity and has the potential to improve communication and collaborative relationships with providers.

Include Determination of Adverse Events

Allowing providers the ability to report all events, even those that may not be required under the abuse definition, can aid in the identification of system-level issues, one-time events, events that are part of a pattern, and improvement opportunities. This is a gap in the current system. Inclusion of adverse events offers an opportunity to learn from events to improve systems of care, an opportunity which may not be clear without an adverse event determination. Please refer to *Appendix IV* for a sample illustration of what this could look like. Considerations for adverse events determinations should include:

- Referrals to triage adverse events to the Oregon Patient Safety Commission's (OPSC) Patient Safety Reporting Program (PSRP) which would be a natural fit to fill this gap
- Referrals should apply to all settings – currently, only nursing homes participate in the Commission's Patient Safety Reporting Program supported by a fee structure as outlined in OAR 325-020-0010
- Care must be taken to avoid an unfunded mandate for handling referrals from facilities that are not currently supported by the Commission's programs, and for the additional support required to encourage appropriate root cause analysis and other system-level quality improvement strategies

Develop Clear Definitions of Terms Used in the Abuse Definition Algorithm

Clear definitions of any terms used in the algorithm will help ensure consistent application and minimize subjectivity. For example, if *intent*, *recklessness*, or *negligence* were a distinguishing element in the substantiation of abuse (rather than neglect), the element's application would need to be clearly defined. Or, if a pattern of events at a facility played a role in the determination of substantiated maltreatment, explicitly defining what met the criteria for a *pattern of events* would be necessary. Each definition should be evaluated for consistent and objective application.

Recommendation 3

Provide More Comprehensive Training for Adult Protective Services Workers, Providers, and Mandatory Reporters[4]

Training was a recurring theme throughout the council's review process and has contributed to many identified needs. Examples include, but are not limited to:

- Inconsistencies in the investigation process and application of abuse definitions
- Providers are unclear about what is reportable and where to report
- Inability to support system-level improvement and prevention due to lack of knowledge (e.g., related to evidence-based improvement science and appropriate resources) that could improve care for Oregonians
- Inability to target appropriate training needs due to a paper-heavy investigation process where data is not easily accessible

Standardized Training

Due to a variety of backgrounds and experience, each provider and investigator bring their own perspective to the investigation process, which can lead to a difference in value systems, beliefs, and priorities. In addition, the varying backgrounds of investigators (e.g., social workers versus law enforcement) can impact how individual investigators approach the investigation process. Increased standardization and more frequent training in all arenas would help further define roles and responsibilities. Improved training would increase impartiality and improve the application of key learning to the investigation process.

Develop Ongoing Training Programs

Training programs must be ongoing to support routine evaluation of competencies. A method for testing competency should be incorporated into all training programs. A preference for online training that can be accessed at any time, by anyone, is recommended.

[4] There are categories of professionals and public officials who must report suspected abuse. Mandatory reporter is defined in ORS 124.050(9). Mandatory reporters include: Naturopathic, osteopathic, podiatric, chiropractic or general physician or surgeon (including an intern or resident); licensed practical nurse, registered nurse, nurse's aide, caregiver, home health aide or employee of an in-home health service; employee of DHS or OHA, county health department, community mental health, developmental disabilities program or an area agency on aging (AAA); peace officer; member of the clergy; psychologist, licensed clinical social worker, licensed professional counselor, licensed clinical social worker or licensed marriage and family therapist; physical therapist, speech therapist, occupational therapist, audiologist or speech language pathologist; information and referral or outreach worker; senior center employee; firefighter or emergency medical technician; adult foster home licensee or an employee of the licensee; or any public official that comes in contact with older adults in the performance of the official's duties. All of the aforementioned, plus legal counsel, guardians and family members are mandatory reporters for any resident in a nursing facility.

Training Components

At a minimum, training should include the components identified in Table 4.

Table 4. Training Components by Group

APS Service Workers, Investigators, corrective action, intake screeners[5]	• Consistent approach to conducting investigations and application of abuse definitions
	  – Guidance and instruction for how to use the algorithm proposed in *Recommendation 2*
	  – Use of proposed technology enhancements that support consistency
	• How to identify system-level issues and implement action plans to prevent recurrence of similar events and strengthen systems (e.g., root cause analysis)
	• Evidenced-based training and support to maintain objectivity and communicate effectively in emotionally charged situations

Providers	• Clear guidelines on what to report and where to report • How to identify system-level issues and implement action plans to prevent recurrence of similar events and strengthen systems (e.g., root cause analysis) • Abuse prevention strategies and how to address issues that contribute to/cause abuse (including burnout, staffing, etc.) • Development of behavioral management programs
Mandatory Reporters	• Who is a mandatory reporter • What is a required report • Where one reports • How one reports

Recommendation 4

Evaluate and Consider Restructuring the Civil Penalty System to Ensure it has the Intended Impact – Prevention and Improvement

Evaluate the Current Civil Penalty System

Based on anecdotal evidence, the civil penalties in the current system are not representative of the "crimes" or "actions" they are intended to address. Reevaluating the structure for making civil penalty determinations to inform how to best address this discrepancy would be valuable. The council recommends an evaluation of the civil penalty system for a future workgroup activity to 1) consider if civil penalties adequately reflect the severity of the incident that occurred and 2) determine if there is evidence that they have the intended impact (i.e., long-term quality improvement or prevention efforts for facilities). Any structured system to support facilities with quality improvement and prevention efforts should consider corrective action to facilitate this work.

Develop a Structure for Alternatives to Civil Penalties

While it is not uncommon for corrective action to propose alternatives to civil penalties, the structure for when and how these alternate approaches are applied can vary from person to person and should be more formalized through the proposed technological improvements. Alternative options could be

[5] Intake screeners receive the same training as investigators and have been included in this recommendation.

established based on the results of the abuse definition algorithm proposed in *Recommendation 2* and could be informed by trends from investigations. Additionally, providing clearly defined criteria for use of different approaches would ensure consistent application.

Quality Improvement Focus

Options of alternate approaches that are available to corrective action should be reflective of improving quality of care and identifying the root cause(s) of abuse. They should encourage improvement and prevention whenever possible.

Recommendation 5

Explore the Idea of a Long-Term Care Worker Registry

Currently, little ability exists to protect individuals in long-term care settings from workers who have been found to be responsible for abuse in another facility. While there is a system of background checks, there are notable gaps. For example, the background check system only captures substantiations of *neglect*, *physical abuse*, and *financial exploitation*. The system does not include substantiations for other types of abuse. Additionally, long-term care workers involved in abuse situations who seek employment at another facility before an investigation is complete or a determination has been made (where they may be found to be a perpetrator of abuse), will fall through the cracks.

Establishing a registry of individuals could help prevent future occurrences of abuse from individuals known to have been responsible for abuse (i.e., for those abuse types not captured by the current background check system) and prevent them from jumping from facility to facility for employment when they are already a known risk to long-term care patients/residents. The Oregon Home Care Commission Registry & Referral System could serve as a potential model.

Assign Long-Term Care Worker ID Numbers

A registry would provide a unique identification (ID) for anyone who provides care in a long-term care facility and would allow providers access to information to make informed hiring decisions. This would help providers avoid potentially hiring someone that has a history of unsafe practice or other behaviors.

Recommendation 6

Enhance Support for Multidisciplinary Teams (MDTs)

Under Oregon law, the district attorney in each county is required to develop a multidisciplinary team to include personnel from the community mental health program, the developmental disabilities program, the Department of Human Services, the local area agency on aging, law enforcement, and an agency that advocates on behalf of individuals with disabilities and others specially trained in the abuse of adults. Each team is to develop a written protocol for the immediate investigation of abuse of adults, interviewing of victims, procedures to be followed to assess risks to the adult, and timelines and procedures for the investigations.

Unfortunately, many counties do not currently have the resources needed to implement this mandate. Budgetary constraints leave some district attorneys' offices without sufficient personnel to prosecute crimes in their jurisdiction, let alone create a protocol and staff frequent meetings of a multidisciplinary team. Altering the law to allow other interested agencies the opportunity to create and chair a

multidisciplinary team may allow for the creation and maintenance of a team where one does not exist or fails to meet its potential. Additionally, counties should be encouraged to seek assistance from other Oregon counties with the resources available to more easily maintain a multidisciplinary team.

II. Definition Recommendations

It is important to note that while the focus of the council's work was on elder abuse, there are other abuse definitions that may need attention (e.g., those that apply to persons with a developmental disability; the mental health community; persons with a physical disability; people in community-based care who do not meet the definition of *elderly person*, including assisted living facilities, residential care facilities, nursing homes and adult foster homes). Additionally, the statutory definitions of *abuse* reflect the statute's intent to provide immediate protection for vulnerable adults. They were not written with accountability for long-term quality improvement in mind, although they are currently being used in both arenas.

Recommendation 7

Align Definitions Across Settings and Populations

Currently, definitions vary depending on an individual's age and setting. Creating some consistency to better align those definitions would reduce confusion among providers, investigators, and other interested parties about what is and is not abuse in a given setting and/or for a given population. When considering this recommendation, keep in mind that nursing homes also adhere to federal abuse definitions.

An example of a state that has alignment in its definitions is Arkansas. In Arkansas, multiple populations are covered in a single statute that is clearly organized. The definition of *abuse* is split into two parts:

1. Pertaining to long-term care facility residents and state hospital patients
2. Pertaining to any person who is not a long-term care facility resident or state hospital patient

Other definitions, like *neglect* and *exploitation*, have additional sub-points that specifically apply only to the long-term care setting. This type of structure has the potential to streamline Oregon's definitions, while maintaining specific protections/exceptions for different populations or settings.

Recommendation 8

Explore the Option of a Distinction between How the Definition of Abuse is Applied to Investigations Versus Determination

In an effort to ensure protections for all individuals and ensure nothing falls through the cracks, the definitions of *abuse* have been created to be intentionally broad; however, the council sees an opportunity to provide additional clarity for abuse determinations (related to *Recommendation 2*, subhead: *Clearly Categorize Abuse Determinations*).

Improve Labeling of Abuse Determinations

Currently, *abuse* is used as an umbrella term. When a finding of abuse is made, there is no indication about what specific type of abuse occurred. More explicit labeling would clearly specify the type of abuse which could:

- Allow the Department of Human Services (DHS) to better support quality improvement and therefore prevent future abuse
  - DHS could respond with more targeted tools based on the more nuanced definitions
- Encourage self-reporting by removing some of the perceived stigma
- Provide more clarity and transparency to the public
- Potentially reduce turn-over in facilities by reducing the perceived need to assign blame to an individual and respond punitively (e.g., terminate or reprimand "at fault" employees)

Looking at Arkansas' statute, *maltreatment* is used as an umbrella term to define what is investigated. Falling under m*altreatment* are more clearly labeled categories of *abuse*, *exploitation*, *neglect*, *physical abuse*, and *sexual abuse*. In Oregon, applying clearly defined categories to the final determination could improve transparency and understanding for investigators, providers, and the public.

Consider a Distinct Determination Category for Neglect

Substantiated *neglect* is a broad category under the definition of *abuse*. Currently, *neglect* operates as a "catch-all" category that increases the number of things that can be investigated but also accounts for a significant number of substantiations that may not fit the lay understanding of abuse.

While the council agrees that all instances of what is currently defined as *abuse* should be investigated, they agree with the interview panels that the inclusion of *neglect* in the determination of abuse is problematic and a distinct determination category would provide needed clarity.

Establish a Tiered System for Abuse Determination

In the current system, all determinations fall under the umbrella of *abuse*. Consider implementation of a tiered system for determinations, in conjunction with improved labeling as mentioned above. This type of a tiered system could be used to inform how corrective action applies alternative approaches to civil penalties (see *Recommendation 4* for additional detail).

Categories could include *adverse event* as the lowest tier, *maltreatment* as a second tier, and finally *abuse* as the highest tier. This approach could contribute to a rise in the level of criminal prosecution as necessary for categorization as *abuse*, which would require reckless conduct and/or intentional harm. Future workgroups would need to evaluate how to maintain the current levels of cooperation between APS and law enforcement, and to clarify the impact of any potential changes. Any gaps between the criminal definition of abuse and the APS definition of abuse would need to be appropriately investigated, maintaining protection for Oregonians.

Use Current Research and Practice to Inform Abuse Determination Definitions

Development of any abuse determination definitions should include consideration for what other states may be doing along with current evidence-based research related to human error and disciplinary systems (e.g., just-culture, safety culture, learning systems). With evidence that many reported cases of potential abuse may in fact be adverse events, there is cause for using this type of research to inform how determinations are defined. The determination and ultimately the response to adverse events will impact whether or not the overall system of safety can be improved.

Recommendation 9

Increase Clarity around Jurisdiction for Reports of Potential Abuse

The confusion around jurisdiction is problematic both for the individual trying to report and for the screener receiving incoming reports. This confusion is, in part, fueled by the variability in definitions across care-settings and populations, but is also impacted by the lack of clear guidelines for the triage of events.

Increased clarity could be achieved through a structured system for event triage that is driven by clear guidelines and tracking/notification systems. A system to structure the triage process should include:

- A centralized hub for intake of all reports, regardless of care-setting or population involved (e.g., over the age of 65, disabled)
- An online algorithm tool with simple, objective questions to direct appropriate triage. The use of simple, objective questions increases consistency across those who apply the questions to individual events. A triage system could be incorporated into an online tool to determine if an event is reportable (see *Recommendation 1*) and where it should be reported using an algorithm format (see *Recommendation 2*). Such a system would clearly determine who has jurisdiction and when a case should be referred to law enforcement, the long-term care ombudsman, the Client Care Monitoring Unit, or any other agency or department determined to be appropriate.

This type of a triage system supports improved lines of communication between Adult Protective Services, law enforcement, long term-care ombudsman, and the various district attorney offices in Oregon.

Recommendation 10

Consider Select Definition Changes

While the council is recommending changes to how definitions are used in practice, the changes to the definitions themselves are minimal in order to maintain protections provided under the current definitions. Additional clarity and elimination of some of the subjectivity has the potential to address some of the key findings if coupled with indicated Process Recommendations. Consideration for the following changes is recommended:

- Clearly define language that can be subjectively interpreted to ensure consistent application
  - Define “willful”
  - Develop a more specific definition of “caregiver”
  - Define “physical injury”
  - Define “by other than accidental means”
  - Consider the use of and define all qualifiers (e.g., “significant”)
- Separate *emotional abuse* from *verbal abuse*, where it is currently found—while verbal abuse is a form of emotional abuse, not all emotional abuse is verbal abuse
- Inclusion of language similar to OAR 411-020-002 (1)(a)(C) in statute would more clearly protect those who cannot express pain

Next Steps

The recommendations put forward by the Resident Safety Review Council have the potential to make a significant impact to the abuse investigation process in the state of Oregon. The council does caution that these recommendations require thoughtful planning for development and implementation that is beyond the scope of this workgroup. While the review and subsequent analysis shed light on many potential areas of opportunity, from the council's perspective, there are priority areas that have the potential to make the greatest impact. These priority areas are seen as an opportunity for Oregon to be a leader and reinforce the commitment to protecting our most vulnerable adults.

Moving forward, small workgroups should be established to focus specifically on each of the priority areas. Commitment to thoughtful and deliberate planning will be necessary to develop and implement effective, sustainable improvements.

Finally, each workgroup must be staffed with the appropriate expertise to effectively inform and contribute to the specific priority area. At a minimum, each group should include Adult Protective Services personnel in a co-chair role to ensure that implementation realities are factored into the overall work plans. There may be an opportunity to draw from the current Elder Abuse Workgroup membership to fill some of the roles necessary for the proposed priority area workgroups.

Priority Areas to Focus Additional Workgroup Efforts

Develop an Abuse Definition Algorithm – The algorithm should clearly categorize abuse determinations, create objectivity, and include the determination of adverse events.

Improve Investigation and Reporting Technology – Improvements should include a computerized investigation process, creation of an investigation database incorporating analytic tools and processes, and the development of an online tool for reporting events that enables users to determine if an event is reportable.

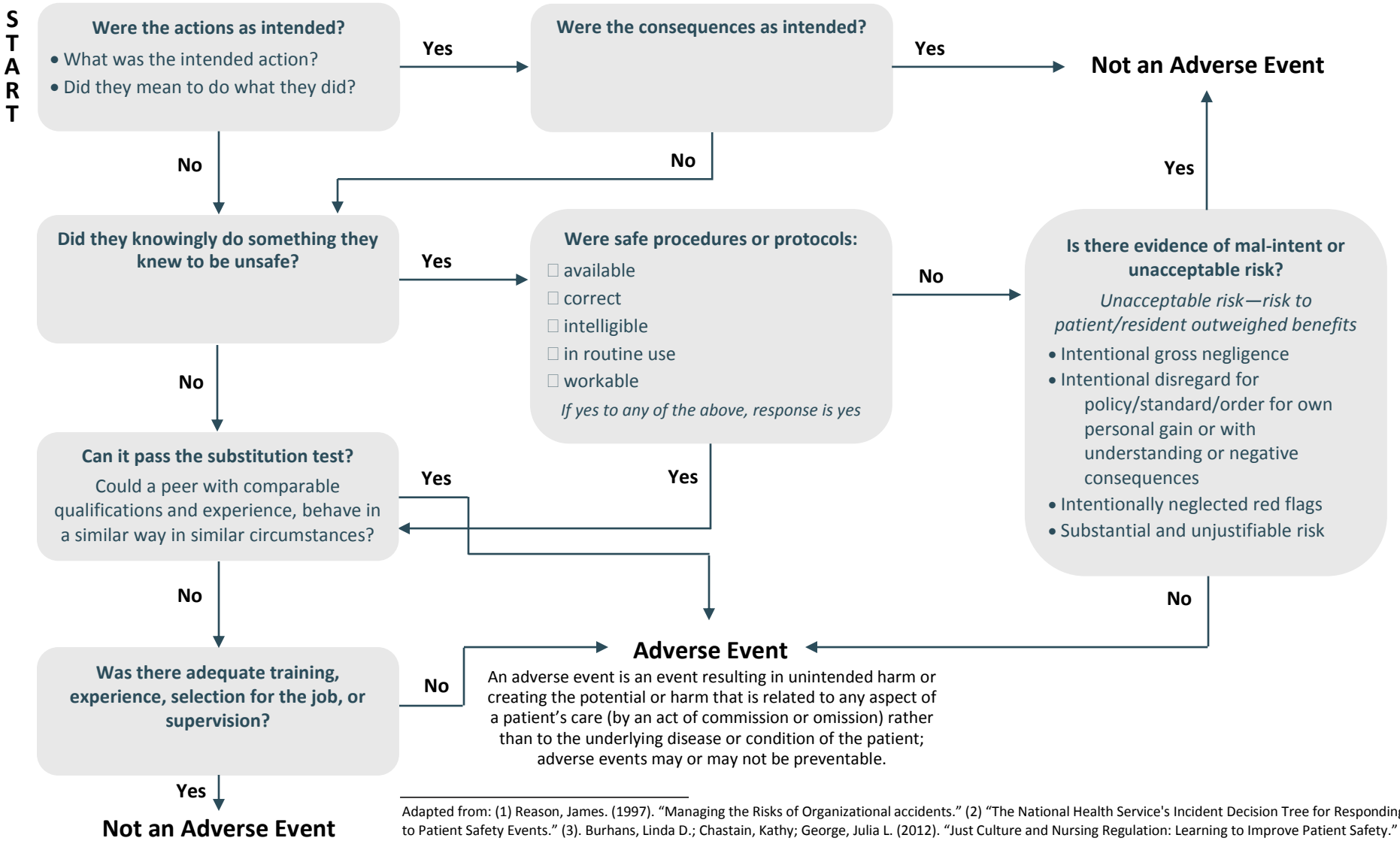
Definitions – Consideration for aligning definitions across populations and care settings, and developing appropriate categories for substantiated abuse, are of the highest priority. In addition, a deeper analysis of all state abuse definitions at both the statutory and administrative rule level is advisable. The council made great strides in factoring in some best-practice ideas to improve Oregon's definitions using the information found within other state abuse statutes. The time necessary to also thoroughly review administrative rules as well was not possible.

Long-Term Care Worker Registry – A registry would allow providers access to information for hiring decisions to avoid potentially hiring someone that has a history of unsafe practice.

Appendix I

Resident Safety Review Council Adverse Event Algorithm

Note: This document was developed by the Oregon Patient Safety Commission for use in the identification of adverse events by Oregon's Resident Safety Review Council and is not intended to be used by other organizations or outside providers for any purpose.

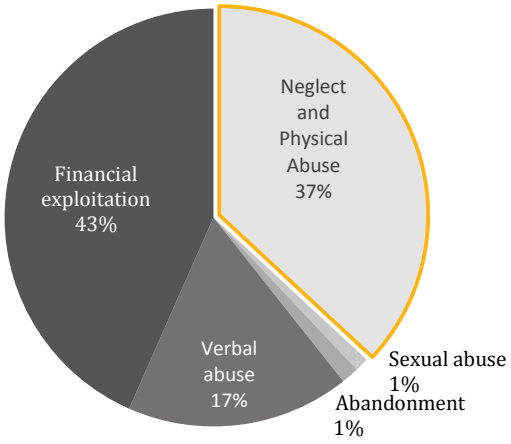


Adapted from: (1) Reason, James. (1997). "Managing the Risks of Organizational accidents." (2) "The National Health Service's Incident Decision Tree for Responding to Patient Safety Events." (3). Burhans, Linda D.; Chastain, Kathy; George, Julia L. (2012). "Just Culture and Nursing Regulation: Learning to Improve Patient Safety."

Appendix II

Case Review Results: 2011 Long-Term Care Abuse Allegation Investigations

Sampling Strategy for Investigations by Abuse Type (2011, n=3,460)



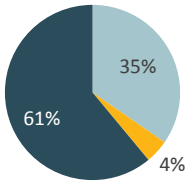
A case review was completed on a 30% sample of abuse investigations from 2011 across all long-term care settings (i.e., nursing home, assisted living facility, residential care facility, and adult foster home) to determine if an event had the potential to be an adverse event. The sample was drawn only from abuse type categories that had the potential to be adverse events (i.e., *neglect* and *physical abuse*) and was based on abuse type proportions from the *Adult Protective Services (APS) Community and Facility Annual Report, 2010* applied to the total number of 2011 abuse investigation reports (3,460).

*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 an act of commission or omission) rather than to the underlying disease or condition of the patient; adverse events may or may not be preventable.*

Abuse Allegation Investigation Case Review, All Care Settings (2011, n=390)

Potential adverse event	an event that was determined to meet the criteria of an adverse event
Not an adverse event	an event that was determined not to meet the criteria of an adverse event
Excluded from the algorithm	an event where there was no evidence of an event, was related to the patient's/resident's underlying medical condition, was related to hygiene or the patient's/resident's personal choices, potentially criminal acts, and resident-to-resident violence

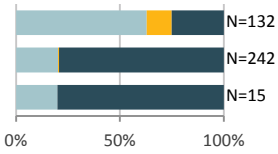
Potential Adverse Events



The *Adverse Event Algorithm* was applied to investigations to determine whether or not an event met the criteria of an adverse event. The questions in the algorithm help determine the intent of the individual(s) involved and the likelihood that system-level factors contributed to or caused the event. Further discussion provided on the following page in *Potential Adverse Events, Further Discussion*.

Determination

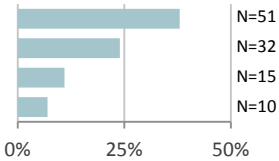
Substantiated
Unsubstantiated
Inconclusive



Reviewers recorded the determination of wrong-doing from the investigations reviewed. Due to inconsistent documentation, determination of abuse was not recorded. The majority of the cases reviewed (242/390) were unsubstantiated. In 132 cases wrong-doing was substantiated. Fifteen cases were inconclusive and in one case the record did not document the determination.

Event Types

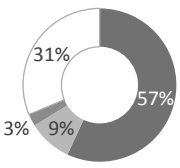
Fall
Medication event
Care delay
Pressure ulcer



The Oregon Patient Safety Commission's adverse event reporting program defines 20 event types for nursing home participants. These event types were used to categorize investigations that were determined to be potential adverse events. Falls, medication events, and care delays were the most common event types in this data, but we also saw pressure ulcers, elopements, device events, a choking event, a dehydration event, and a healthcare-associated infection.

Ages

All over 65
All under 65
Mixed ages
Unavailable



Some of the investigations reviewed involved multiple patients/residents of different ages. Age categories reflect if all patients/residents involved were over 65, all were under 65, if there was a mix of ages (both over and under 65), or if the patient/resident ages were unavailable. The total number of patients/residents involved in each event was not captured.

Potential Adverse Events, Further Discussion

Potential adverse event: The *Adverse Event Algorithm* determined that 135 investigations could be adverse events. Eighty-three of the 135 were cases of substantiated wrong doing, 49 were cases of unsubstantiated wrong doing, and in three cases the investigation was inconclusive.

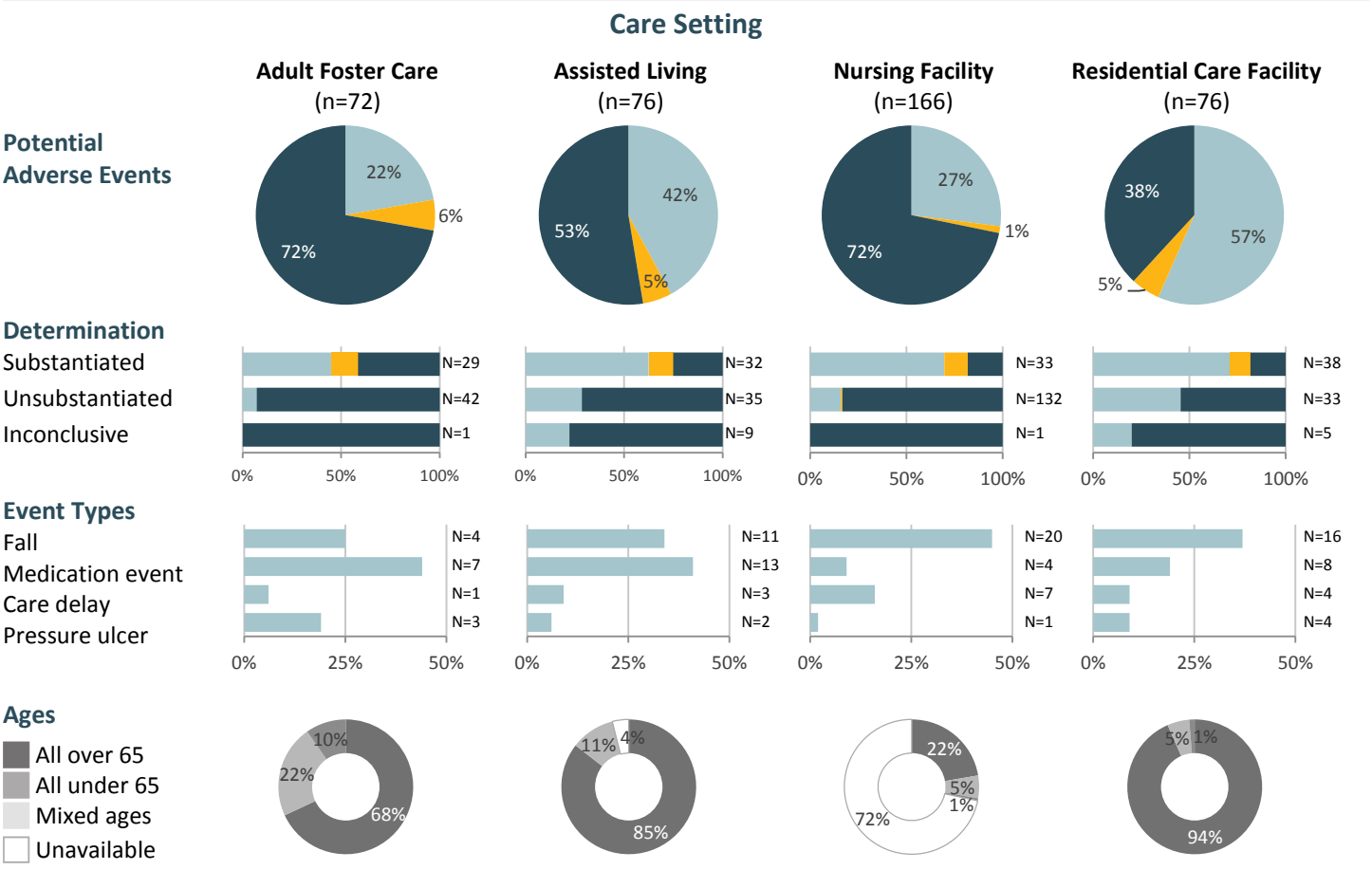
Not an adverse event: The *Adverse Event Algorithm* determined that 17 investigations were not adverse events. All but one of these events was substantiated wrong-doing. In 10 of the 17 cases, the documentation indicated the individual had adequate training and could have made a better choice. In 7 of the 17 cases, the documentation indicated the action and consequences were as intended, suggesting that the act was likely malicious.

Excluded from the algorithm: Not all events were eligible for the *Adverse Event Algorithm*. Of the events that were excluded from the algorithm, reasons for exclusion included no evidence to support the allegation (61%), involved the patient's/resident's underlying medical condition (8%), and potentially criminal acts (8%).

Abuse Allegation Investigation Case Review, by Care Setting (2011, n=390)

The case review sample included abuse allegation investigations from four different long-term care settings: nursing homes, assisted living facilities, residential care facilities, and adult foster homes. The number of investigations reviewed for each care setting was based on proportions of abuse allegation investigations from each care setting provided in the *Adult Protective Services (APS) Community and Facility Annual Report, 2010.*

Potential adverse event	an event that was determined to meet the criteria of an adverse event
Not an adverse event	an event that was determined not to meet the criteria of an adverse event
Excluded from the algorithm	an event where there was no evidence of an event, was related to the patient's/resident's underlying medical condition, was related to hygiene or the patient's/resident's personal choices, potentially criminal acts, and resident-to-resident violence



Appendix III

Comparison of State Definitions of Elder Abuse

Comparison of what is defined in statute as part of or independent of *abuse* in each of the 50 states, plus DC. There are 52 total entries (OR has two statutes concerning the elderly), although three are blank as those states (IN, SD, VA) do not define abuse in statute.

Key

- ✓ Independent definition
- ○ Part of the definition of Abuse, but also defined independently
- ● Part of the definition of Abuse
- ⁂ Overarching definition that includes Abuse
- ● Part of some other definition

State	Mal- or Mistreatment	Physical Harm	Sexual Harm	Neglect	Self-Neglect	Deprivation	Abandonment	Mental or Emotional Harm	Intimidation	Verbal	Exploitation	Financial Exploitation	Deception	Unreasonable Confinement	Punishment	Restraint (Phys. or Chem.)	Isolation	Involuntary Seclusion	Abduction	Threat of Harm	Risk of Harm
AL		○	✓	✓	●	●		○	□	□	✓	✓		●	●	●	●	□		□	□
AK		●	●	✓	✓		✓	●			✓		□		□	□			□	□	□
AZ		●	●	✓						□	✓			●	□	□				□	□
AR	⁂	●	●	✓				●	●	□	✓			●	●	□				●	□
CA		○	●	○		●	○	○				○	□			●	○		○		●
CO	⁂	●	●	●	✓			●		□	✓			●		●					●
CT		●		✓	●	●	✓	●			✓										
DE	✓	●		✓			●	●			✓					●	●			●	
DC		●	●	✓	✓	●		●		□	✓			●						●	
FL		●	✓	✓				○	✓		✓		✓							●	●
GA		●		✓		●		●		□				●						●	
HI		○	○	○	○		●	○				○									
ID		●		✓	●			●			✓										
IL		●	●	✓	✓			●				●								●	
IN										□				□							
IA		○	●		●	●				□	●			●	●						●
KA		●	●	✓		●		●			✓	○			●	●	●			●	●
KY		●	●	✓	●			●	●	□	✓		✓	●	●						
LA		●	○	✓	✓		○	●		□	○			●		●	○				
ME		●	○	✓		●		●	●	□	✓			●	●					●	
MD		●		✓	✓						✓										
MA		●			●			●				○									
MI	●	●	●	✓	●			●			✓	□								●	
MN	⁂	●	●	✓		●		●		●	●	✓		●							
MS		●	●	✓	●	●		●			✓			●							
MO		●	●	✓				●				●									●
MT		○	✓	✓		●		○			✓										
NE		○	○	✓	●						✓			○	○						
NV		●		✓	●	●		●			✓					●	✓				
NH		○	●	✓	✓	●		●		●	✓			●							●

State	Mal- or Mistreatment	Physical Harm	Sexual Harm	Neglect	Self-Neglect	Deprivation	Abandonment	Mental or Emotional Harm	Intimidation	Verbal	Exploitation	Financial Exploitation	Deception	Unreasonable Confinement	Punishment	Restraint (Phys. or Chem.)	Isolation	Involuntary Seclusion	Abduction	Threat of Harm	Risk of Harm
NJ		●		✓	●	●		●			✓			●							
NM		●	●	✓	✓	●		●			✓										
NY		✓	✓	✓	✓	●	●				✓	✓				●	●			●	
NC		●		✓	●	●		●			✓			●							
ND		○	○	✓				○			●	○		●							
OH		○		✓	●			●	●		✓			●	●						
OK		●	○	✓	✓	●		●		✓	✓	✓		●							●
OR1		●	○	○			●		✓	○		●				●		●			
OR2		●	●			●		●		●		●			●			●			
PA		○	○	✓	●	●	✓	●	○		✓			●	●					●	●
RI		●	●	✓	✓	●	●	●	●		✓						●			●	
SC		○	●	✓	●			○			✓			●	●	●					●
SD																					
TN		●	✓	●		●		●			✓										
TX		●	●	✓				●	●		✓			●	●						
UT		○	●	✓	✓	●	✓	○	✓	●	✓					○	○			●	●
VT		●	○	✓				●			✓			●		●					●
VA																					
WA		●	●	✓	✓		✓	●	●	●	●	✓		●	●	●					
WV		●		✓								●		●						●	
WI		○	○	✓	✓			○		●		✓		○		○		●			●
WY		○	○	✓	✓	●	✓	●	○		○			●	●						

Appendix IV

Sample Abuse Definition Algorithm

Note: This is a sample algorithm to inform the Resident Safety Review Council's recommendation to develop an abuse definition algorithm and is not intended to be, in itself, the recommended algorithm.