Facility Incident Reporting System

Division of Residential Services
NYS Department of Health

Revisions to the Facility Incident Reporting System

Effective October 17, 2011, the process for facility reporting incidents to the Department of Health (DOH)will change.

Facilities will complete reports via the Health Commerce System (HCS), using an online report versus utilizing the Hotline to make a report.

Reports will be accessed by the Centralized Complaint Intake Unit (CCIU), triaged and entered into the Aspen Complaint Tracking System (ACTS)

Case Resolution Unit (CRU) staff will review the case to determine appropriate action.

Third party complaints will not be effected by this program.

What's Different

- Facilities will no longer call the Nursing Home Complaint Hotline (unless they are unable to access the web page)
- Information on incidents will be obtained by CCIU accessing the web site, and then entered into ACTS
- DOH has created a defined list of reportable incidents
- The Department has developed an on line reference manual for clarification of reportable incidents
- The manual lists "elements" or relevant components, that if present, render the incident reportable

Goals of this Program

Participants will:

- Review the basic process of investigating facility incidents
- Gain an understanding of the electronic facility incident reporting system
- Become acquainted with the process of reporting incidents via the HCS
- Gain awareness of what constitutes a reportable incident.

Department of Health Investigations

The role of the Department of Health:

- Determine REGULATORY compliance.
- Determine if abuse, mistreatment or neglect has occurred
- Determine if quality of care was achieved
- Determine that a plan to prevent repeat occurrences was developed, communicated and implemented

What is an Investigation

An investigation is the gathering of evidence and/or data related to an occurrence, or incident.

- The goal is to arrive at a logical conclusion based on the evidence
- Facility investigations must begin immediately, upon discovery of an incident

Facility Investigations

Facilities are required to investigate the following:

- Accidents
- Injury of unknown origin
- Abuse, mistreatment, neglect
- Misappropriation of property
- Complaints related to care
- Medication errors

This is not an all inclusive list.

Reportable Occurrences to the DOH by Facility

ABUSE

- Physical/sexual abuse by staff
- Physical/sexual abuse by resident
- Physical/sexual abuse by family or visitor
- Mistreatment
- Neglect
- Dignity/verbal or mental abuse

CARE PLAN VIOLATIONS

- Failure to follow care plan with injury
- Failure to follow care plan without injury

Reportable Occurrences Continued

RESIDENT PROPERTY

- Misappropriation of property

QUALITY OF CARE

- Medication error with harm / drug diversion
- Death related to suicide, restraints, equipment
- CPR issues
- Attempted suicide
- Injury of unknown origin
- Burns
- Accidents related to choking
- Accidents related to entrapment
- Resident found in non-resident area (basement, stairwell, etc)

Reportable Occurrences Continued

ELOPEMENT

- Elopement occurs when a resident leaves the building undetected or fails to return from a preauthorized leave of absence

PHYSICAL ENVIRONMENT

- Fires/smoke
- Faulty equipment
- Physical plant issues
- Power, water, electrical outages or any interruption of service

Incident Reporting Manual

- Can be accessed online on the HCS
- Contains relevant information for each reportable incident.
- Guides investigation by the facility, and lists materials that the facility should have available to surveyors.
- The manual lists “elements” or relevant components, that if present, render the incident reportable.

Manual Specifics

The manual also contains:

- A question and answer section on both general matters and on specific reporting categories (**The questions and answers provide examples and do not cover all situations)**
- The facility requirements concerning timely reporting of occurrences, including Failure to Report
- Guidelines for each reportable incident
- Documents that should be maintained with the facility investigation

Example of Elements

The presence of elements determines if the incident is reportable to DOH

FOR EXAMPLE: physical abuse

Two (2) of the following elements are needed for an incident of abuse to be reported to DOH:

- Intent OR recklessly perform an act
- Bodily injury and/or serious bodily injury
- Inappropriate physical contact
- Repeated incidents of resident to resident abuse

Manual Guides Investigation

The manual provides guidelines as to required documents to be used during and maintained after the investigation.

Example: Physical abuse

Investigation materials:

- Complete electronic incident form
- Have available
  - Witness statement(s)
  - Resident statement(s)
  - Accused statement(s)
  - Photographic evidence (if available)
  - Facility investigation
  - Care plan(s)
  - Resident cognition evaluation
  - Employee personnel and training records
  - Plan to prevent reoccurrence

Reportable Incidents

The manual addresses reportable incidents as follows:

- Topic
- Regulatory reference
- Elements
- Guidance on investigation materials to gather and have available to the surveyor
- Q &A related to NH scenarios

Time Frames for Reporting to DOH

- Reports must be made to the Department of Health **immediately** upon achieving the **REASONABLE CAUSE** threshold, revealing that misappropriation of property, abuse, mistreatment or neglect occurred
- Immediate is defined as "as soon as possible, not to exceed 24 hours"
- Reasonable cause is defined to mean that upon a review of the circumstances, there is sufficient evidence for a prudent person to believe that physical abuse, mistreatment or neglect has occurred
- Reports must be made to the DOH when the reasonable cause threshold has been achieved, revealing abuse, mistreatment or neglect
- **Facility is to notify DOH when they have reached reasonable cause, and then have 5 working days to complete the investigation.**

Concerns Identified During DOH Investigation

- Abuse has not been ruled out (especially with injuries of unknown origin)
- Facility investigation is inconclusive
- Staff statements are of poor quality…not signed or dated, no title, lack pertinent information
- Care plan was not appropriate to resident's individual needs (For example, the care plan was not changed to reflect resident's change in condition)

Concerns Identified During DOH Investigation

- Resident has a history of incidents but the care plan fails to reflect those occurrences
- Incidents are documented on a care plan without interventions or a plan to prevent recurrence
- Staff is unaware of changes to the plan of care. For example, the CNA card does not match POC
- Care plan is not aligned with resident's needs. For example, care plan lists an approach of "reminders not to stand" but resident has dementia and cannot remember
- Unrealistic goals and interventions are care planned

DOH Interviews

- Department staff has explicit authority to inspect the facility, interview patients or residents, review relevant records, observe care being provided and conduct necessary interviews. **Licensed facilities may not require the Department to make an appointment and may not delay an inspection**
- Our federal investigation activities are guided by the State Operations Manual (SOM) and related Appendices
- The SOM specifically recognizes that **the decision to permit or deny facility personnel involvement during the survey process is solely that of the surveyor**
- The SOM further notes that refusal of access can be a basis for termination from the participation in the Medicare and Medicaid programs

Concerns Regarding Failure to Report

- The investigation **leads you to decide** whether or not to report the issue to the Department through the Health Commerce System, Incident Reporting Form
- If the investigation was thorough and indicates that **abuse, neglect, mistreatment or misappropriation occurred, then it is a reportable incident**
- If the investigation was thorough and **offers no evidence of abuse, mistreatment, neglect or misappropriation, you can be justified in not reporting it to the Hotline, and cannot be cited for failure to report**
- In addition, some incidents are reportable under any circumstances, if the required elements are present

Concerns Regarding Failure to Report Continued

The facility can be cited for failure to complete a thorough investigation (F tag 225) if:

- The surveyor finds that the investigation failed to come to a reasonable conclusion
- The facility failed to investigate the incident
- The facility can be cited for failure to complete a thorough investigation (F tag 225)
- If it was determined that abuse, mistreatment or neglect, or misappropriation of property occurred and not reported to DOH, then they can be cited for failure to report
- Any crime must be reported to law enforcement under the Elder Justice Law. Section 1150B of the Social Security Act (the Act) as established by section 6103(b)(3) of the Patient Protection and Affordable Care Act (Affordable Care Act), requires specific individuals in long term care facilities to report a reasonable suspicion of crimes committed against a resident. Those reports must be submitted to one law enforcement agency of jurisdiction and the State Survey Agency (SA).

Adding Information to an Existing Case

To report additional information to an existing case:

- Contact the Centralized Complaint Intake Unit directly at 1 888-201-4563, or
- Email the intake hotline at NHIntake@health.state.ny.us

In Summary

- The DOH has developed an electronic incident reporting system, which will allow nursing homes to report their incidents through the HCS
- The new form will replace the previous telephone hotline method for reporting incidents
- Effective October 17, 2011 Facilities will be required to report incidents via the new Incident Reporting Form available on the HCS
- The Department has provided an Incident Reporting Manual to clarify the reporting requirements, and help ensure that facilities are reporting incidents required under State and Federal statutes and regulations
- The manual provides a list of reportable incidents that shall be reported via the HCS
- The Department's requirements for reporting incidents are consistent with past reporting requirements

Next Steps

This PowerPoint presentation has been prepared to assist providers to complete thorough investigation and to prepare nursing home employees about the process for investigating incidents, and what constitutes a reportable incident. This presentation is available on line for future viewing

A Question and Answer session will be scheduled with the Provider Associations.

The Incident Reporting Form, PowerPoint Presentation, and Incident Reporting Manual will be posted on the DOH website within the Dear Administrator Letter section.

How to Utilize the HCS Reporting System

- Reporting mechanism: https://commerce.health.state.ny.us
- The former Incident Reporting Line phone number, 1-888-201-4563, may be used in case of an emergency such as your Internet or computers are down
- Detailed instruction manual is available at the web site

Contact Information

- If facility staff have questions on this process, or on reportable incidents, please contact:
- The intake hotline at 1-888-201-4563, or
- Email the Intake mailbox at Nhintake@health.state.ny.us, or
- Contact Mark Brownell, Assistant Director of the Bureau of Complaints and Analysis or Joanne Breden, Supervisor, at 518-402-5447

The next several slides are intended to serve as an educational program for conducting thorough investigations.

Purpose of Facility Investigation

- To determine if abuse, mistreatment, neglect or misappropriation occurred
- To assure compliance with statutes and regulations
- To improve quality of care
- To identify flawed practices/policy
- To identify and correct vulnerabilities
- To assist with management of risk

Purpose of Facility Investigation

The investigation should assist the facility in determining if the concern was a result of:

- Individual(s) action (staff member acted on their own, outside of policy)
- Facility practice (flawed practice or policy)

Did abuse, mistreatment, neglect or misappropriation of property occur?

- The investigation should rule out or confirm abuse, mistreatment or neglect through a review of supporting evidence, including interviews and statements that offer valid information, observations and record review
- The outcome is determined by facts, based on the evidence and not an opinion which is subjective

Conducting an Investigation

Interview
Observation
Record Review

Proposed Methods

INTERVIEW: Obtaining statement from parties directly involved and others possessing knowledge of relevant information. This may include staff, residents and third party

OBSERVATION: of the surroundings or scene where the incident is alleged to have occurred. Observation of the general care and condition of the area is very important

RECORD REVIEW: review of medical records, care plan, any related documents

Investigation Overview

- Render aid to **protect** the residents, removing them from harm
- Protect the scene….preserve any physical evidence
- Collect evidence (ask who, what, when, where and how)
- Determine presence of intent by aggressor
- Determine your witnesses
- Conduct interviews
- Documentation (incident reporting form, medical records, interview statements)
- Determine if abuse, neglect or mistreatment has occurred
- Document your conclusions

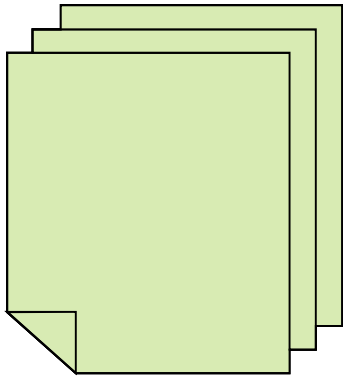
Protecting the Scene

CONSIDER THE FOLLOWING:

- With allegations of abuse mistreatment or neglect: try to leave area untouched, as much as possible
- Preserve any evidence/photographs (photos must be dated, timed and able to correctly identify the subject)
- Make note of resident condition and environmental conditions
- Staff observation
- Circumstances just prior to the event or discovery
- Evidence is: Anything that will help reconstruct the incident, identify people involved and/or identify the responsible persons

Interviews Defined

- Obtaining statement from parties directly involved and others possessing information
- A non-accusatory process in which the interviewer asks questions designed to develop factual information
- Documentation must be signed, dated and should include the individual's title



Interviews Defined

Who, what, where, when, why and how?

Maintain a list of the questions posed to the individuals being interviewed

Obtain statement from the resident(s), if they are able to provide a statement about the incident, whenever possible

Interview Tips

- Take notes during the interview
- Provide privacy, minimize distractions; listen carefully and be patient
- What does staff say
- Are you interviewing them or do they fill out a form
- What kind of questions are you asking staff
- Questions should be open ended, designed to elicit descriptions of observations, interventions, or re-enactments

Interviewing Staff

It frequently is not enough to have staff write what they know…Discussions, including the following may be more informative.

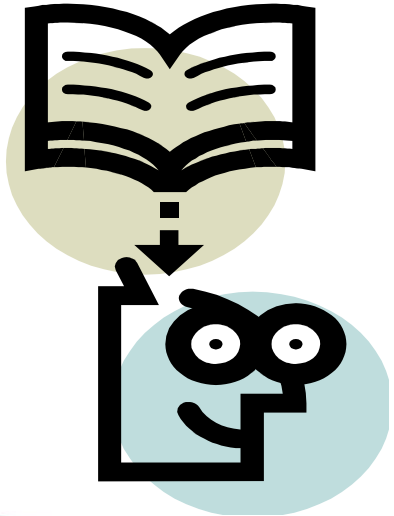
- Describe interaction with resident
- Physical demonstration of care delivered
- Did you see any one physically harm resident
- Describe force used, stance of accused and any injury
- Did you check the chair alarm
- Was it working
- Did you see “Sally” use the gait belt
- What can the resident do independently
- What did the care plan require

Written Statements

Written statements are usually needed from the accused, and from witnesses.

Additional staff statements may be necessary to determine what care was delivered. Was the care provided in accordance with the individualized plan of care.

Written statements will need to be obtained in addition to the interviews.



Written Statements Continued

Written statements should be:

- Legible
- Signed, dated, and indicate shift and job title
- The preference is to have individual write their own statement, but if they are unable, the writer should obtain signature of individual or have it witnessed

Observation

- What did you see
- What did others see
- What does the environment tell you
- Is there evidence that the care plan was followed
- What do you see when you look at or speak to other residents
- What do you hear when walking through the unit
- Do you see evidence of potential abuse or concern

Record Review

- What was required by care plan
- Was it an appropriate individualized plan of care
- What are the resident's risk factors
- Are the risk factors identified in the Plan of Care
- Was the care plan followed
- What was documented upon discovery of event
- What do nurses' reports indicate
- Were MD orders followed
- Was the CNA record completed accurately
- Were facility policies and procedures followed

Record Review- Care Plan

- Does the care plan need to be updated to prevent recurrence
- Is anything going on medically that's been missed (UTI? URI? Labs?)
- What is the resident's history
- What is the resident's behavior
- Does the care plan reflect actual care needed
- Does CNA care plan match the comprehensive care plan
- Does the CNA care plan give specific information to the staff

Record Review- Staff Records

- Is there a staff member involved
- What is the staff members performance history
- Has the staff member been counseled for care issues or failure to follow the care plan in the past
- Was care appropriately documented
- Does this indicate that the care plan was followed
- Has the staff member been educated or trained in the area being investigated, and noted in the personnel records

Gathering the Evidence

- All evidence used to determine the outcome of the investigation should be relevant to the case
- If the case is related to a medication is a hard copy of the proper Medication Administration Record in the case file
- If the case is related to a care plan violation, is the care plan in the case file
- All materials relevant to the outcome should be included in the file

Coming to a Conclusion

What is a thorough investigation

- One that comes to a reasonable conclusion as to how and/or why something occurred
- The investigation should rule out or confirm abuse, mistreatment or neglect by review of supporting evidence, including interviews and statements that offer valid information, observations and record review
- The outcome is determined by fact, based on the evidence and not on opinion

Conclusion

Upon reviewing all of the evidence, a conclusion is determined.

- Did abuse, mistreatment or neglect occur
- Is there a policy or practice issue that caused risk
- Is this an isolated incident or a systemic problem
- Does the evidence support the outcome

Final Steps

- Immediately, take corrective action including education
- Identify trends
- Implement and communicate QI interventions for long term prevention of recurrence of the matter
- Periodically review and revise interventions

Report to appropriate agency as necessary:

- If abuse, mistreatment, neglect or misappropriation, contact law enforcement
- If a professional issue, contact State Education or DOH Office of Professional Misconduct (OPMC)
- If controlled substance issue, contact the DOH Bureau of Narcotic Enforcement (BNE)