

Conducting Internal Investigations of Caregiver Misconduct



caregivers

PREVENT  PROTECT  PROMOTE
abuse/neglect *clients* *dignity*

VIDEO PARTICIPANT GUIDE

DHS/DQA/OCQ

www.dhs.wisconsin.gov/caregiver/training/trgIndex.HTM

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Learning Points

As a result of this workshop, participants will learn more about:

- Caregiver Misconduct Definitions
- Developing an Investigation Protocol
- Conducting an Internal Investigation
- Interviewing Skills
- Reporting Requirements

A Word about Prevention



Wisconsin implemented the Caregiver Law in October 1998. Since then, thousands of background checks have been conducted by health care entities statewide. Background checks are good but not enough to ensure safety. Most caregivers who mistreat clients don't have significant criminal histories. If they did, you wouldn't have hired them and misconduct would have stopped long ago.

Let's take a moment to review some thoughts on preventing caregiver misconduct:

- Focus on prevention. Detection is good, but too late.
- Training and open communication are the keys to prevention. Make sure everyone understands what "caregiver misconduct" means.
- Create an atmosphere that encourages communication between managers and staff.
- Communication starts at the top. Managers must be approachable and very visible.
- A caregiver with no support system is more likely to mistreat a resident.

- Create a facility wide team whose focus is the well-being of both residents and caregivers.
- Direct caregivers are the key to the success of your facility. Invest in them with training and support.
- Make sure caregivers understand their duty to report anything that just doesn't feel right to them. Say it over and over.

Source: Dr. Ted Bunck, Director, Central Wisconsin Center

Having said all that, caregiver misconduct is going to happen in your facility, despite your best efforts. When it does, you need to have a plan of action already in place in which everyone knows what to do.

What is Caregiver Misconduct?



Caregiver misconduct in Wisconsin includes the following:

- abuse of a resident
- neglect of a resident
- misappropriation of a resident's property

While most managers and supervisors have become quite familiar with the legal definitions of caregiver misconduct found at HFS 13.03(13), Wisconsin Administrative Code, let's take a moment to review those definitions along with some examples.

Legal Definitions

These are the legal definitions by which caregiver misconduct is measured.

- See the right hand column for examples and definitions of some phrases/words used in the definitions.
- Although you may be familiar with the definitions, it's important to keep them at hand when conducting an investigation. The elements of the definitions will help guide your investigation.
- Pay special attention to the last paragraph of the abuse and neglect definitions. Each statement defines what does NOT constitute abuse and neglect.
- Focus heavily on neglect—it's the most misunderstood.
- NOTE: The examples in the following chart are based on cases taken from DHS complaint files.

Caregiver Misconduct – Federal and State Definitions

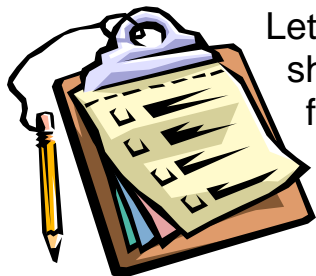
<p style="text-align: center;">Federal Language 42 C.F.R. §488.301 & WI Caregiver Law CH. HFS 13</p>	<p style="text-align: center;">Examples</p>
<p style="text-align: center;">ABUSE (Federal)</p> <p>The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.</p> <p style="text-align: center;">ABUSE (State)</p> <ol style="list-style-type: none"> 1. An act or repeated acts by a caregiver or nonclient resident, that is contrary to the entity’s policies and procedures, not a part of the client’s treatment plan and done intentionally to cause harm, which causes or could cause pain, injury or death to a client, substantially disregards clients rights or a caregivers duties. 2. An act or acts of sexual intercourse or sexual contact by a caregiver and involving a client. 3. The forcible administration of medication or the performance of psychosurgery, electroconvulsive therapy or experimental research. 4. A course of conduct or repeated acts by a caregiver which serve no legitimate purpose and which, when done with intent to harass, intimidate, humiliate, threaten or frighten a client, causes or could be reasonably expected to cause the client to be harassed, intimidated, humiliated, threatened or frightened. <p>Abuse does not include an act or acts of mere inefficiency, unsatisfactory conduct or failure in good performance as the result of inability, incapacity, inadvertency, or ordinary negligence in isolated instances, or good faith errors in judgment or discretion.</p>	<p><i>Act done to cause harm:</i></p> <ul style="list-style-type: none"> • A caregiver repeatedly hits a resident on the back with a ladle and pushes the resident causing her to fall. • A caregiver kicks a resident in the groin. <p><i>Sexual contact:</i></p> <ul style="list-style-type: none"> • A caregiver has sexual intercourse with a resident. <p><i>Course of conduct which serves no legitimate purpose:</i></p> <ul style="list-style-type: none"> • A caregiver frightens residents by holding a hammer and threatening to hit them with the hammer. • A caregiver takes a resident’s doll away from her, shakes it in front of her and throws the doll on the floor and steps on it. • A caregiver nudges, pokes at or pushes a resident and verbally taunts him. The caregiver admits to engaging in this conduct for his own enjoyment in seeing the reactions of the residents.

<p style="text-align: center;">NEGLECT (Federal)</p> <p>Failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.</p> <p style="text-align: center;">NEGLECT (State)</p> <p>An intentional omission or intentional course of conduct by a caregiver that is contrary to the entity’s policies and procedures, is not part of the client’s treatment plan and, through substantial carelessness or negligence, does any of the following:</p> <ol style="list-style-type: none"> a. Causes or could reasonably be expected to cause pain or injury to a client or the death of a client. b. Substantially disregards a client’s rights under either ch. 50 or 51, Stats., or a caregiver’s duties and obligations to a client. <p>Neglect is the intentional carelessness, negligence, or disregard of policy, or care plan, which causes, or could be reasonably expected to cause pain, injury, or death.</p> <p>Neglect does not include an act or acts of mere inefficiency, unsatisfactory conduct or failure in good performance as the result of inability, incapacity, inadvertency or ordinary negligence in isolated instances, or good faith errors in judgment or discretion.</p>	<p><i>Intentional omission:</i></p> <ul style="list-style-type: none"> • A caregiver transfers a resident without using a gait belt or the Marissa lift. During the transfer, the client starts to slip and the caregiver lowers the resident to the floor. The caregiver then retrieves a gait belt and again transfers the resident without using the Marissa lift, first back to her bed, and then to her chair. • A caregiver fails to secure the resident’s wheelchair in the van. The wheelchair rolls forward causing the resident to hit her head on the dashboard. • A caregiver fails to perform cares for an incontinent client and allows the client to lie incontinent for more than 1 1/2 hours until the next shift arrives and changes her, even though the client had asked the caregiver twice to care for her. <p><i>Intentional course of conduct:</i></p> <ul style="list-style-type: none"> • A caregiver leaves a client unsupervised and alone in an assisted living facility for approximately 50 minutes. • A caregiver leaves 4 clients with mental retardation alone in a van for approx an hour while in the grocery store. The caregiver left the keys in the ignition and the heater running. • A caregiver ties a resident to a chair in the dining room to prevent the resident from getting up out of the chair. • A caregiver pushes a resident onto the toilet to change the resident’s pants and sits on the resident when she tries to stand up. • A caregiver leaves a resident outside for approx 2 hours without sun protection. The resident suffers first and second degree burns.
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<p style="text-align: center;">MISAPPROPRIATION OF PROPERTY (Federal)</p> <p>The deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident’s belongings or money without the resident’s consent.</p> <p style="text-align: center;">MISAPPROPRIATION OF PROPERTY (State)</p> <ol style="list-style-type: none"> 1. The intentional taking, carrying away, using, transferring, concealing or retaining possession of a client’s movable property without the client’s consent and with the intent to deprive the client of possession of the property. 2. Obtaining property of a client by intentionally deceiving the client with a false representation which is known to be false, made with the intent to defraud, and which does defraud the person to whom it is made. 3. By virtue of his or her office, business or employment, or as trustee or bailee, having possession or custody of money or of a negotiable security, instrument, paper or other negotiable writing of a client, intentionally using, transferring, concealing, or retaining possession of money, security, instrument, paper or writing without the client’s consent 4. Intentionally using or attempting to use personal identifying information to obtain credit, money, goods, services or anything else of value without the authorization or consent of the client 5. Violating s. 943.38, Stats., involving the property of a client, or s. 943.41, Stats., involving fraudulent use of a client’s financial transaction card. 	<p><i>Movable Property:</i></p> <ul style="list-style-type: none"> • A caregiver takes a comforter from one client and personal effects and clothing from another. • A caregiver takes prescription pain medication belonging to client. <p><i>False representation:</i></p> <ul style="list-style-type: none"> • A caregiver borrows \$5,000.00 from client but fails to repay the money or make any arrangements to do so. <p><i>Virtue of office:</i></p> <ul style="list-style-type: none"> • A caregiver in charge of client accounts cashes checks from the accounts of the clients and does not use the proceeds of the checks for the clients’ benefit. • A caregiver cashes 2 checks on behalf of a client but keeps the cash. The caregiver alters the client’s financial account records at the facility concerning the transaction. <p><i>Personal ID:</i></p> <ul style="list-style-type: none"> • A caregiver uses a client’s identification to establish phone service and makes \$800 of long-distance calls that are charged to the client. <p><i>Transaction card:</i></p> <ul style="list-style-type: none"> • A caregiver uses a client’s credit card to pay for her personal car insurance bill. The caregiver also used the client’s financial transaction card for her own use.
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<p>INJURY OF UNKNOWN SOURCE (Federal)</p> <p>An injury should be classified as an “injury of unknown source” when both of the following conditions are met:</p> <ul style="list-style-type: none"> • the source of the injury was not observed by any person or • the source of the injury could not be explained by the resident; <p style="text-align: center;">AND</p> <ul style="list-style-type: none"> • the injury is suspicious because of the extent of the injury or • the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or • the number of injuries observed at one particular point in time or • the incidence of injuries over time. <p>INJURY OF UNKNOWN SOURCE (State)</p> <p>Refer to Federal definition.</p>	<p><i>Injury of Unknown Source:</i></p> <ul style="list-style-type: none"> • A CBRF resident appears at breakfast with a bruise on his shin. No notes appear in the resident’s log regarding any incident, and no staff recall observing anything that could have led to the bruise. When asked, the client doesn’t remember how he got the bruise. <p style="text-align: center;">AND</p> <ul style="list-style-type: none"> • A physical assessment conducted by the RN discovers other fresh bruises to the resident’s abdomen and upper back. • The nurse checks the resident’s records and finds a note about an unexplained bruise to the resident’s abdomen 4 weeks earlier.
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Developing an Investigation Protocol



Let's move on to developing a protocol. Your protocol should be written down and shared with everyone in the facility. It's critical that every staff person knows your protocol and their role when caregiver misconduct is suspected.

Misconduct Investigation Protocol

1. Develop a written protocol in advance of any allegation of caregiver misconduct. (See the table below for a sample protocol.)
2. Identify a lead investigator and other supervisory/professional staff who will comprise the investigation team. Document a reporting hierarchy and timeline for team notification.
3. Share the protocol with all staff and ensure that caregivers, residents and family members know to whom they should report a concern.
4. Create an atmosphere that welcomes reporting of concerns.
5. Implement the protocol immediately when any of the following occurs:
 - Receiving a verbal or written statement of a resident, caregiver or anyone with knowledge of an incident
 - Discovery of an incident after it occurs
 - Hearing about an incident from others
 - Observing injuries (physical, emotional or mental) to a resident
 - Observing theft of a resident's property
 - Otherwise becoming aware of an incident
6. Treat all allegations as potential misconduct. Make no decisions until the investigation is complete.

Sample Protocol

STEPS	PROCEDURES
Step One: Protect the Resident	<ul style="list-style-type: none"> • Supervisor immediately assesses resident’s personal safety and potential of harm to other residents • If a caregiver is named, supervisor immediately removes the accused caregiver from the patient care area • Notify designated managers of the allegation
Step Two: Assess the Effect on the Resident	<ul style="list-style-type: none"> • Nursing supervisor immediately completes a body assessment and documents findings • Lead investigator/nursing supervisor must assess for psychosocial changes and document findings • Provide appropriate medical/psychosocial treatment and support to resident • Contact family members if resident wishes and is able to make his/her own decisions
Step Three: Investigate the Allegation	<ul style="list-style-type: none"> • Contact law enforcement if appropriate • Determine whether accused caregiver may continue working • Collect and protect evidence • Photograph injuries or other pertinent items • Obtain written, signed statements from all witnesses or persons with information • When possible, obtain a detailed account of the incident from the resident, including feelings, pain or discomfort • Obtain a written, signed statement from the accused caregiver • Determine if the resident or legal representative want to involve law enforcement • Document, document, document!

<p>Step Four: Conclude the Investigation</p>	<ul style="list-style-type: none"> • Review all components of the investigation • Determine whether the incident must be reported further • Submit required reports to other agencies, e.g. Division of Quality Assurance, DHS; Adult Protective Services, etc. • Inform accused caregiver that a report to another agency has been submitted
<p>Step Five: Follow-Up</p>	<ul style="list-style-type: none"> • Contact the person who reported the incident. (Give no details of the investigation, only that administration is aware of the concern and is investigating) • Reassure the resident and family that the facility has zero tolerance for retaliation • Inform the resident and family if the caregiver will continue to be employed and make sure the resident is comfortable with the caregiver. If not, consider a re-assignment. • Stress to staff, residents, and family members your facility’s commitment to a safe environment for all residents • Examine facility policies and procedures to determine how to prevent caregiver misconduct, improve reporting, support residents, etc. Plan educational workshops, in-services.

Investigating the Allegation



Let's focus in on Step # 3 in the Protocol, Investigating the Allegation. It's vital to treat the investigation as a fact-finding mission. Remaining neutral and fair are top priorities. Make no conclusions until you have all the facts.

1. Focus on the specific incident: Who, What, Where, When, Why and How?

- What exactly is the allegation? Write it down. This is the basis of your investigation. Refer to it often. Compare the allegation to the definitions of caregiver misconduct. Ask yourself if the information you are gathering is related to the incident and addresses the elements of the offense.
- Who was present at the time of the incident? (Victim, perpetrator, witness?)
- Who else might have information about the incident? (Other caregivers on duty, supervisors, visitors, maintenance or kitchen staff, social workers?)
- Where did it happen? (Specifically where.)
- When (date and time) did it happen?
- How did it happen? (Recreate the alleged incident. Could it have happened the way the reporter stated?)
- Why did it happen? What was happening immediately prior to the incident? What happened immediately afterward?

2. Contact law enforcement if appropriate. Facilities are strongly encouraged to contact local law enforcement in the event of a serious crime, e.g. physical or sexual abuse or assault, negligence that leads to injury, significant loss of property or a pattern of lost property, etc. A

2002 report from the GAO (General Accountability Office—Congress’s “watchdog” agency) states that local law enforcement officials are seldom summoned to nursing homes to immediately investigate allegations of physical or sexual abuse. Some of these officials indicated that when they were called, evidence had been compromised.

Trained law enforcement officials have vast experience in conducting criminal investigations and have the added advantage of being a neutral third-party to the events. Law enforcement officers may ask you to suspend your own investigation if they are investigating. In that event, you must still report to the state agency within timelines for your facility type. Inform the agency that law enforcement is involved and attach any available reports.

- 3. Preserve evidence.** Take photos of injuries, broken or overturned furniture, and other physical evidence that is relevant to the incident and may change over time. Label your photos or other evidence with date, time, location and signature. Keep them in a safe and secure place. Why a secure place? You want to be able to truthfully state at a hearing or in circuit court that your evidence could not have been tampered with. In the event of a sexual assault, it is best to immediately contact law enforcement so that evidence can be collected properly and a chain of evidence maintained.
- 4. Document the effect on the victim.** Findings of caregiver misconduct and criminal prosecutions often take into account the effect on the victim. While it’s important to photograph physical injuries, it’s also important to document psychosocial effects such as fear, withdrawal, depression, etc. Document the victim’s diagnosis and any physical limitations (dementia, physical or cognitive disabilities, etc.)
- 5. Document the caregiver’s duty to provide care to the client.** In other words, document whether or not the caregiver knew or should have known that her actions could result in harm to the client.

You may assume that a reasonable caregiver knows or should know that physical or sexual abuse or theft of a client's property will result in harm. However, think about how you would document that:

- Do your facility orientation materials or work rules state the definitions of caregiver misconduct?
- Do you have a written policy that prohibits caregiver misconduct?
- Can you demonstrate that the caregiver is aware of those definitions and rules?

What if neglect is the issue? How can you determine whether the caregiver's act was negligent? If the issue is an improper transfer, for example:

- What type of transfer is ordered for the resident?
- If a two-person transfer is ordered, where is that documented?
- Can you demonstrate that the caregiver knew or should have known the transfer method?
- Why did the caregiver choose the improper transfer?

6. Diagram the scene. Diagram or photograph the scene of the incident (e.g. the resident's room) and the location's relationship to the rest of the facility. Include dimensions of the area and/or distances to other locations.

This will help you determine whether witnesses could actually see the incident from their vantage point. It will also help you visualize a witness's version of the incident.

7. Review facility/other records

- Check patient records, nurse's notes or other written records at your facility that document resident care around the time of the incident.
- Check time cards or schedules. Was the accused caregiver or witness actually at work on the day and time?

- Check personnel records of the alleged perpetrator and witnesses. Are there any positive or negative actions contained in the file? Any information about ability to get along with co-workers? A history of filing untrue allegations against others?
- Check the Wisconsin Circuit Court Automation Programs (CCAP) at <http://wcca.wicourts.gov/index.xsl> or request an updated Caregiver Background Check. Recent court actions may provide information on an accused caregiver's state of mind.

8. Develop a list of persons to interview.

- Interview the reporter
- Who else do you wish to interview? Who might have information about the allegation?
- Interview the victim when possible. The interviewer should be someone who has the ability to communicate well with the victim.
- Obtain written or recorded statements from witnesses.
- Interview the accused caregiver last when possible. Information from other resources and witnesses may give you a sense of whether or not the accused was actually involved. (For example, "Mary, four other employees told me they saw you coming out of the resident's room that night and that you seemed upset.") We'll discuss interviewing tips a bit later.

9. Write your report.

- Review the facts that you have gathered.
- Have you explored all the available resources?
- Do your actions include steps 1 through 8?
- Does your report include facts and give you sufficient information about reporting further or allowing the accused caregiver to resume contact with residents?

Incident-Specific Requirements

Additional elements must be included in your investigation based on the type of caregiver misconduct. Let's talk a bit about those additional elements.

Physical Abuse

1. Written statements by witnesses which include a description of the amount of physical force used. This may include, but isn't limited to, the acceleration of force, the range of motion of the perpetrator, open hand or closed fist.
2. A description of the victim's reaction to the physical force. For example, the victim fell backwards, victim vocalizations, or indications of pain.

Verbal Abuse/Psychological Abuse

1. A statement of the exact words used to the best of the witnesses' or victim's recollection
2. The volume and tone of voice of the caregiver, e.g. loud or soft
3. A description of the caregiver's body language or any accompanying gestures
4. The effect of the words on the victim, e.g. fear, crying, angry, etc.

Sexual Abuse

1. The results of any physical assessment conducted by a medical professional including doctors, Sexual Assault Nurse Examiners (SANE nurses)
2. The results of any psychological assessment conducted by a mental health professional or social worker
3. A copy of the police report
4. All medical information related to the incident

Neglect

1. Documentation of the treatment, service, care, goods or supervision required but not provided
2. Documentation verifying the caregiver's duty to provide care to the individual
3. Verification that the caregiver's act or failure to act resulted in or could reasonably have resulted in harm

Misappropriation

1. A description of any stolen items
2. Copies of all financial records related to the incident including cancelled checks or credit card statements
3. A copy of the police report
4. Verification that the stolen items belonged to the victim
5. Verification that the victim did not/could not give consent to the caregiver

The Art of Interviewing



Interviewing witnesses, accused caregivers and victims is critical to the success of your investigation. Let's review some tips for successful interviews:

Tips for Successful Interviews

1. **Ensure privacy without interruptions.** You may bring a witness, but only one.
2. **Prepare.** Make notes in advance of the essential things you need to learn.
3. **Adopt a relaxed and open demeanor.** Put the person at ease—you're likely to get more information that way.

4. **Arrange the seating in an informal way.** Don't sit behind a desk directly facing the witness. It creates an unspoken barrier between you and the witness.

5. **Begin by explaining clearly and concisely the reason for the interview.** You're on a fact finding mission, not looking to place blame.

6. **Clarify dates, times, witnesses.**

7. **Ask open questions.** Avoid leading the witness. For example, "You don't get along with Mary, do you?" Rather, "What is your relationship with Mary like?" Ask open questions that encourage the flow of information. Open questions usually begin with who, what, where, etc. Closed questions can usually be answered with a "yes" or "no."

8. **Stay on the subject.** If the person strays from the topic, gently steer them back.

9. **Show empathy.** Support the interviewee by acknowledging their feelings. If they are struggling with giving you information, encourage his/her decision to do the right thing.

10. **Listen well!** Make sure the interviewee does most of the talking. Use silence to your advantage. Don't interrupt.

Signs of Deception



Is the person lying? Odds are, you'll never know. Although people have been communicating with one another for tens of thousands of years, more than 3 decades of psychological research have found that most people make poor lie detectors. In a worldwide study, scientists asked more than 2,000 people from nearly 60 countries, "How can you tell when people are lying?" The number-one answer was the same: Liars avert their gaze.

But averting one's gaze or looking away, like other commonly held stereotypes about liars, isn't linked automatically with lying, studies have shown. Liars don't shift around or touch their noses or clear their throats any more than truth tellers do.

One thing, however, is certain: There is no single telltale sign for a lie.

Clues to Behavior

By studying large groups of participants, researchers have identified certain general behaviors that liars are more likely to exhibit than are people telling the truth.

Fibbers may:

- move their arms, hands, and fingers less and blink less than people telling the truth. The extra effort needed to remember what they've already said and to keep their stories consistent may cause liars to restrain their movements.
- speak in a tense or high-pitched voice and pause more often.
- make fewer speech errors than truth tellers do, and they rarely backtrack to fill in forgotten or incorrect details.
- tell stories that are too good to be true or don't make sense.
- adopt a closed posture (arms crossed, body turned away).

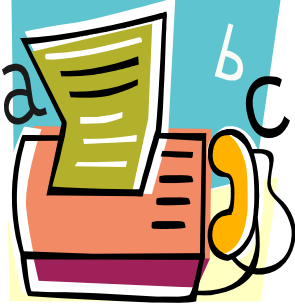
- place an object between himself/herself and the interviewer (creating a “barrier” of sorts).
- repeat questions instead of answering (stalling for time to make up an answer).
- speak in incomplete sentences, hesitating.
- make jokes or use sarcasm.
- change the subject.

But not all liars display these signals, and one can't conclude people are lying because they don't move their arms or pause while telling their stories. These could be natural behaviors for them, not signs of lying.

People don't seem to be very good at spotting deception signals. On average, over hundreds of laboratory studies, participants distinguish correctly between truths and lies only about 55 percent of the time. This success rate holds for groups as diverse as students and police officers.

The best way to tell whether someone is lying is by comparing their expressions, body language and speech patterns during an interview to more normal circumstances. It's important to keep in mind that statistics tell us that we aren't very good at picking out liars—another good reason to base your investigation on facts!

Reporting Requirement Resources



There are a variety of requirements and timelines in Wisconsin for reporting caregiver misconduct, depending on facility type. Because the Caregiver Law has been in effect since 1998, and nursing home reporting began in 1993, most of you are very familiar with how and to whom you must report.

Listed below are some online resources that you may find helpful when reporting and investigating caregiver misconduct. Begin by accessing:

www.dhs.wisconsin.gov/caregiver

Listed on this website are links to the most current version of information pertaining to reporting requirements.

- **The Wisconsin Caregiver Program Manual.** Chapters 6 and 7 cover misconduct reporting and investigations.
- **Caregiver Misconduct Complaints.** Includes report forms (DDE 2447 and DDE 2617) as well as reporting requirements and DQA memos concerning the caregiver law. Also includes the caregiver reporting worksheet and flow chart for help in determining whether an incident must be reported.
- **Elder Abuse Resource Information.** Contains links to state and national organizations concerned with the prevention of elder abuse.
- **Caregiver Misconduct Registry.** A link to a list of non-credentialed caregivers with findings of caregiver misconduct.

Additional Resources

Wisconsin Caregiver Program Manual

<http://dhs.wisconsin.gov/caregiver/publications/CgvrProgMan.htm>

DQA Regulated Entity Background Check Process

<http://dhs.wisconsin.gov/caregiver/CBCprocess.htm>

Caregiver Misconduct Complaints

<http://dhs.wisconsin.gov/caregiver/contacts/Complaints.htm>

Wisconsin Caregiver Misconduct Registry

<http://dhs.wisconsin.gov/caregiver/misconduct.HTM>

Suggested Sexual Assault Response Protocol

http://dhs.wisconsin.gov/dsl_info/InfoMemos/DDES/CY_2004/InfoMemo2004-03.htm

Caregiver Investigation Protocol, unpublished, DHS, 2005

NOTE: This material was developed by the Wisconsin Department of Health Services-Division of Quality Assurance and the University of Wisconsin-Oshkosh Center for Career Development and Employability Training (CCDET) as part of the federal Caregiver Abuse and Neglect Prevention Project. The project was funded through the federal Centers for Medicare and Medicaid Services and ended on September 30, 2007. For further information, contact: Caregiver_Intake@dhs.wisconsin.gov

All project materials may be downloaded and re-printed from the internet at www.dhs.wisconsin.gov/caregiver/training/trgIndex.HTM. Any changes made to the material should be noted by the editor and not attributed to the Department or the University of Wisconsin-Oshkosh.

Activity #1: Simplified Definitions

You may find this one-page handout useful in educating your caregivers about the definitions. The most commonly misunderstood definition is neglect. While both abuse and neglect include an intentional act or failure to act, only abuse includes the ***intent to harm*** a person. It's interesting to note that a caregiver may be charged with neglect even if there was no harm done, particularly if the negligent act had significant potential to do harm.

Because direct caregivers are your eyes and ears in detecting misconduct, it may be helpful to offer a plain-English or simplified version of those definitions. When we have provided this handout to caregivers in other trainings, they were surprised by some of the examples given—they were unaware that some of the actions could be caregiver misconduct.

Above all, caregivers must be encouraged to report anything that just doesn't feel right to them.

Caregiver Misconduct – Simplified Definitions

MISCONDUCT	SIMPLE DEFINITION*	POSSIBLE EXAMPLES
ABUSE	<p><i>An intentional act that:</i></p> <p>Contradicts a health care facility’s policy/procedures AND Is not part of the care plan AND Is meant to cause harm.</p>	<ul style="list-style-type: none"> • Physical abuse – hitting, slapping, pinching, kicking, etc. • Sexual abuse – harassment, inappropriate touching, assault • Verbal abuse – threats of harm, saying things to intentionally frighten a client • Emotional abuse – humiliation, harassment, intimidation with threats of punishment or depriving care or possessions
NEGLECT	<p><i>A careless or negligent act that:</i></p> <p>Fails to follow facility procedure or care plan AND Causes or could cause pain, injury or death BUT Is not intended to cause harm.</p>	<ul style="list-style-type: none"> • Not using a gait belt when required or transferring a client alone • Failure to perform ROM exercises • Turning off a call light • Leaving a client wet or soiled • Skipping work in a client’s home without notifying your employer • Disregarding hydration orders • Failure to deliver or administer medication
MISAPPROPRIATION	<p><i>An intentional act that:</i></p> <p>Is meant to permanently deprive a client of property OR Misuses a client’s personal property AND Is done without the client’s consent.</p>	<ul style="list-style-type: none"> • Theft of cash, checks, credit cards, jewelry, etc. • Misuse of property, e.g. using phone to make toll calls • Identity theft

These definitions apply to caregivers in health care facilities regulated by the Department of Health and Family Services.

A caregiver with a substantiated finding of abuse, neglect or misappropriation is listed on Wisconsin’s Caregiver Misconduct Registry. Caregivers with findings may not work in certain facilities unless approved through the Rehabilitation Review process.

Activity #2: Checking Your Protocol

Think about your own protocol. Using the chart below, check the box if your facility already has a step in place. If not, note how you might implement the step.

Develop a written protocol in advance of any allegation of caregiver misconduct. When everyone knows the steps to take, you can focus entirely on the alleged incident. In other words, be prepared!

Identify a lead investigator and other supervisory/professional staff who will comprise the investigation team. Document a reporting hierarchy and timeline for team notification—most administrators want to be notified immediately (at home, in the middle of the night) when an allegation of caregiver misconduct is received.

Share the protocol with all staff and ensure that caregivers, residents and family members know to whom they should report a concern.

Create an atmosphere that welcomes reporting of concerns.

Know when to implement the protocol (immediately when any of the following occurs):

- Receiving a verbal or written statement of a resident, caregiver or anyone with knowledge of an incident
 - Discovery of an incident after it occurs
 - Hearing about an incident from others
 - Observing injuries (physical, emotional or mental) to a resident
 - Observing theft of a resident's property
 - Otherwise becoming aware of an incident
 - Treat all allegations as potential misconduct. Make no decisions until the investigation is complete.
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Activity #3: Case Studies of Caregiver Misconduct

This activity gives you the opportunity to practice how you would investigate an allegation of caregiver misconduct. All these examples are taken from actual allegations of caregiver misconduct, reported to DQA.

You may use the training materials that we've reviewed so far in planning your investigation. You will notice that we did not include an example of investigating sexual abuse. In all suspected cases of sexual abuse or assault, we highly recommend contacting law enforcement immediately.

Please discuss what steps you need to take to ensure a thorough investigation. You may use the "Investigating the Allegation" and "Incident Specific Requirements" steps to help out. **Jot down some elements of the investigation that you see as particularly important in the example.**

You can assume that you have already taken steps to protect and/or treat the resident. You have also determined how to deal with the accused caregiver, and notified all appropriate managers of the alleged incident.

NOTE: The Answer Key at the end of this section lists possible observation and strategies.

Example #1: Allegation of Physical Abuse

Resident Jerome tells you that he just saw Don, the cook at your CBRF, hurt another resident, Maria. Upon further questioning, Jerome tells you that he was walking by the kitchen and noticed that Maria was there talking to Don. Don seemed upset about something and was yelling at Maria. Jerome says he saw Don turn to Maria with a soup ladle in his hand and strike Maria on the wrist. Don then pushed Maria, who fell to the floor.

Example #2: Allegation of Verbal/Emotional Abuse

On April 5th, CNA Molly comes to your office, visibly upset. She tells you that she has just come from Resident Perry's room. Molly says that Perry was lying in his bed crying when she entered the room. When Molly asked Perry what was wrong, Perry didn't respond. Molly asked Perry if he would like to go for a walk since it's such a beautiful day. Molly knows how much Perry enjoys being outside. Perry became very upset, insisting that he couldn't get out of bed.

Finally, Perry said that LPN Max told him that if he got out of bed again, his bed pad monitor was set to electrocute him.

Example #3: Allegation of Neglect

On November 27th, John Brown, the grandson of Resident Faye, reports the following to you: Earlier that day, John saw one of the CNAs (he thinks her name is Brenda) take his grandmother to the bathroom and leave her unattended. John believes that his grandmother became dizzy while she was on the toilet, fell and hit her head on a metal wastebasket, causing a large laceration to her forehead. You know that Faye was taken to the hospital, and required several stitches to her forehead.

Example #4: Allegation of Misappropriation

On July 13th two clients, Juan and Tasha, report to you that Caregiver Alicia has stolen their money. You know that both Juan and Tasha have cognitive disabilities, but manage their own money with assistance. Juan and Tasha relate the following events to you: On July 9th, Alicia took both Juan and Tasha to the bank and a local discount store. At the bank, Juan says he withdrew \$50 from his savings account and Tasha cashed a check for \$100. Juan and Tasha gave the cash to Alicia for safekeeping.

At the discount store, Juan stated that he purchased a DVD priced at \$19.99, and Tasha says she bought a pink scarf for \$7.99. When they returned home, Juan and Tasha asked Alicia for their change. Alicia told them that they had spent all their money and had no change.

Example #5: Injury of Unknown Source

On March 19th, Activity Director Carol is helping several residents who regularly come to the activity center to weave and do needlework. Carol notices that one of her regulars, Maybelle, has a large bruise on her arm. Carol thinks the bruise is shaped something like a handprint. Carol asks Maybelle how she got the bruise. Maybelle looks at the bruise curiously, and says she doesn't remember. Maybelle has struggled recently with memory issues, and Carol fears that Maybelle has been abused but can't remember the incident. Carol worries about the bruise, thinks about it over the weekend, and reports it to you on March 22nd.

Answer Key

Example #1: Allegation of Physical Abuse

- Assess Jerome's statement; check his care plan and medical history.
- Interview Jerome in more detail if possible, e.g. his location when he witnessed the incident; on what part of Maria's body did Don strike her, Don and Maria's locations in the room, what specifically Don was "yelling."
- Interview Maria.
- Where is the ladle?
- Document Maria's injuries.
- Interview Don. Check personnel records for Don; any history of similar incidents?
- Interview any other persons who may have seen/heard the incident.
- Ascertain what was happening immediately before and after the incident.

Example #2: Allegation of Verbal/Emotional Abuse

- Is there a monitor on Perry's bed (or any other device that Perry might think is a monitor)?
- Interview Perry.
- Interview other staff who work with Perry. Have they noticed a change in his demeanor or a refusal to get out of bed? Have they overheard any staff making threats to Perry?
- Review Max's personnel file and any complaint files you may have. Any history/other complaints against Max?
- Interview Max.

Example #3: Allegation of Neglect

- Identify the CNA. Ask John for a description. Was Brenda working at the time of the allegation?
- Ask John about his location at the time of the incident. Why does he think Faye fell and hit her head on a garbage can?
- Check Faye's care plan. Is she supposed to receive assistance with toileting? (This is a key element—did the caregiver know or should she have known that Faye needed assistance or to be constantly attended?)
- Check the garbage can? Is it tipped over? What material is it made of? Is there blood on the garbage can? Take a photo of the garbage can. Diagram the area.
- Photograph Faye's injury and collect any medical reports.
- Interview Brenda. Check any personnel records or incident files.]

Example #4: Allegation of Misappropriation

- Does Tasha have a pink scarf in her possession; does Juan have a new DVD?
- Are there any receipts for the purchases?
- Interview Alicia. (She may have a reasonable explanation.)
- Check bank statements for Juan and Tasha. Were withdrawals made in the amounts stated on the date reported?
- Accompany Juan and Tasha to check their rooms, drawers, wallets, etc. for the cash/change.
- Check your facility policies to ensure that resident funds are well-monitored and safe.

Example #5: Injury of Unknown Source

- Remind Carol to report immediately when something doesn't feel right.

- Check Maybelle's care plan; health history, medications. For example, is Maybelle taking any medication that might contribute to excessive bruising? Are there any notations on her chart that might explain the bruise, e.g. Maybelle bumped into a doorway?
- Photograph Maybelle's injury, including her face as an identifier.
- Interview Maybelle re: the injury. Carol says she didn't remember how she got the bruise, but ask again.
- Check the definition of an injury of unknown source. It has specific requirements for an incident to qualify.