Data Forum: Investigations – Data, Requirements and Best Practices

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Purpose

The purpose of this webinar is to present to Bureau of Developmental Disabilities Services (BDDDS) providers and stakeholders requirements for conducting investigations, present investigation data, and share best practices.
Why Investigations?

- BDDS serves a vulnerable population
- A situation may not always be as it appears
- In general, provider staff have not been formally trained to conduct investigations
- Many providers state they follow the DDRS Policy but components are usually missing
Today’s Topics:

I. Investigation Requirements
II. Investigation Data
III. Investigation Types
IV. Investigation Components
V. Best Practices
VI. Resources
VII. Questions/Discussion
VIII. Contact Information
I. Investigation Requirements
Investigation Requirements

Regulations, Policies, and Waiver Requirements:

- 460 IAC 6-9-4
- 460 IAC 6-9-5
- 460 IAC 6-10-7
- 460 IAC 6-25-3
- 460 IAC 6-25-10
Investigation Requirements

Regulations, Policies, and Waiver Requirements:

- DDRS Policy: Mandatory Components of an Investigation (BQIS 460 0316 043, eff. 3/16/2012)
- Community Integration & Habilitation Waiver
- Family Supports Waiver
II. Investigation Data
Complaint Investigations

Two allegation types were used for the data calculations in this webinar as they are focused specifically on a provider’s internal investigation.

Allegation Types:

• Failure to Investigate (460 IAC 6-9-4)
• Mandatory Components of an Investigation (DDRS Policy: Mandatory Components of an Investigation)
## Investigation Data

### Complaint Investigations

Date Range: 1/1/2016-12/31/2018

Community Integration and Habilitation and Family Supports Waivers

<table>
<thead>
<tr>
<th>Allegation Type</th>
<th>Found</th>
<th>Unfound</th>
<th>Grand Total</th>
<th>% Found</th>
<th>% Unfound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to Investigate</td>
<td>21</td>
<td>17</td>
<td>38</td>
<td>55%</td>
<td>45%</td>
</tr>
<tr>
<td>Mandatory Components of an Investigation</td>
<td>17</td>
<td>5</td>
<td>22</td>
<td>77%</td>
<td>23%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>38</td>
<td>22</td>
<td>60</td>
<td>63%</td>
<td>37%</td>
</tr>
</tbody>
</table>
## Investigation Data

### Complaint Investigations
**Date Range:** 1/1/2016-12/31/2018

<table>
<thead>
<tr>
<th>Outcome</th>
<th>All Allegation Types</th>
<th>Only Allegation Types: Failure to Investigate and Mandatory Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # Allegations</td>
<td>1372</td>
<td>60</td>
</tr>
<tr>
<td>Found</td>
<td>777</td>
<td>38</td>
</tr>
<tr>
<td>% Found</td>
<td>57%</td>
<td>63%</td>
</tr>
<tr>
<td>Unfound</td>
<td>595</td>
<td>22</td>
</tr>
<tr>
<td>% Unfound</td>
<td>43%</td>
<td>37%</td>
</tr>
</tbody>
</table>

4% of Total Allegations
Mortality Reviews

Follow-up Required due to Incomplete internal investigation
Mortality Reviews
Date Range: 1/1/2016-12/31/2018
Community Integration and Habilitation & Family Supports Waivers, Supported Group Living

<table>
<thead>
<tr>
<th></th>
<th>FS Mortalities</th>
<th>CIH Mortalities</th>
<th>SGL Mortalities</th>
<th>Other Mortalities</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortalities</td>
<td>133</td>
<td>474</td>
<td>216</td>
<td>487</td>
<td>823</td>
</tr>
<tr>
<td>Investigation Follow-up Required</td>
<td>1</td>
<td>200</td>
<td>91</td>
<td>73</td>
<td>292</td>
</tr>
<tr>
<td>Percent of cases with Follow-up</td>
<td>1%</td>
<td>42%</td>
<td>42%</td>
<td>15%</td>
<td>35%</td>
</tr>
</tbody>
</table>
Investigation Data

Mortality Reviews
Date Range: 1/1/2016-12/31/2018

Most common follow-up requests:
• Internal investigation not submitted.
• Assigned staff ratios.
• Signed and dated statement from all parties.
• Narrative summary of a review of relevant provider policies and procedures.
Mortality Reviews

Most common follow-up requests:

• Explanation of discrepancy of any info.
• Determination
  ❖ of any violation of rights;
  ❖ if services and/or care were not provided or were not appropriately provided;
  ❖ if agency policies and/or procedures were not followed, and/or if any federal or state regulations were not followed.
Incident Reports

11 Incident reports coded as alleged Abuse, Neglect, or Exploitation were reviewed as well as the Provider’s internal investigation.
Incident Reports

Findings associated with DDRS Policy: Mandatory Components of an Investigation
(BQIS 460 0316 043, eff. 3/16/2012)
Incident Reports

*Mandated components -- Component d)* Signed and dated statements from all involved parties, including all actual and potential witnesses to the event.

- Most reports did not contain signed and dated statements from all involved parties. Instead, the interviewees’ representations were imbedded in the investigator’s commentary.
Incident Reports

*Mandated components -- Component e)* A statement describing all records and other documents reviewed associated with the event.

- Some internal investigation reports listed or mentioned the documents reviewed, some did not.
- Some reports contained the respective incident report, some did not.
Investigation Data

Incident Reports

Mandated components -- Component f) Copies of all records and other documents reviewed that provide evidence supporting the findings of the investigation.

- Although some investigation reports included a copy of the incident report, many did not.
- The only documents typically included with the report were interview notes. None of the reports reviewed contained copies of other documents.
Incident Reports

*Mandated components -- Component g)* If there are any discrepancies between the evidence gathered, the discrepancy is [to be] resolved and/or explained.

- Some had identified discrepancies and clearly noted resolution.
- Some seem to note allegations by the Individual, denial by staff, and non-substantiation but some discrepancies were not identified and some were not resolved and/or explained.
Incident Reports

*Mandated components -- Component h) A determination if rights have been violated, if services and/or care were not provided or were not appropriately provided, if agency policies and/or procedures were not followed, and/or if any federal or state regulations were not followed.*

- Some reports directly commented on rights but others were silent.
- Some reports directly commented on provision of services and/or care but others were silent.
Incident Reports

*Mandated components -- Component h) Continued*

- Some reports commented on adherence to agency policies and/or procedures but others were silent.
- Some reports commented on adherence to federal or state regulations but others were silent.
Incident Reports

*Mandated components -- Component j) A definitive description of all corrective actions developed and implemented and/or to be implemented as a result of the investigation, including completion dates for each corrective action.*

Investigation reports reviewed complied with this component although they were not necessarily clear on a timeline for implementation of the corrective action.
Investigation Data

Incident Reports

*Mandated components -- Component k) The signature, name, and title of the person completing the investigation.*

Although all reports contained either a name or a signature most did not include both and some did not include the title of the investigator.
III. Investigation Types
Investigation Types

Definition of an Investigation

• To observe or study by close examination and systematic inquiry.

• An orderly collection of data or facts to describe an event.
Types of Investigations

Criminal Investigation

- Conducted by Officials of Public Law to determine if a crime has occurred and identify the individual(s) liable to punishment.

Protection Agency Investigation

- Conducted by an Agency such as Adult Protective Services to determine if abuse, neglect or exploitation has occurred.
Investigation Types

Types of Investigations

Complaint Investigation
  • Conducted by State oversight Agency to determine compliance with regulations.
Investigation Types

Types of Investigations

Provider’s Internal Investigation

• An investigation conducted by the agency to…
  – Collect the facts and data about an event
  – Make a determination
    • if individual rights have been violated
    • if services and care have been appropriately provided
• Determine if corrective action is necessary
• Ensure appropriate actions have been taken
• Conducted
  – According to the agency’s policies and procedures
  – By an individual designated by the provider
IV. Investigation Components
Investigation Components

Why are robust investigations necessary?

Individuals:
• are often unable to speak up for themselves;
• are often unable to realize they are victims;
• may fear reprisal from their abuser;
• may live in a setting where abuse and neglect are seen as normal daily activities;
• assume they have to deal with it on their own
Investigation Components

DDRS Policy: Mandatory Components of an Investigation

1. A clear statement indicating why the investigation is being conducted along with the nature of the allegation.
2. Victim(s)/Alleged victim’s name, funding source, medical diagnosis, intellectual level, and method of communication (e.g. verbal, gestures, technology device, etc.)
Investigation Components

DDRS Policy: Mandatory Components of an Investigation

3. Victim(s)/Alleged victim’s background information: IR number, provider at time event/alleged event occurred, Timeline of the event/alleged event, staff ratio at time of event/alleged event, and required staffing ratio at time of event/alleged event.
Investigation Components

DDRS Policy: Mandatory Components of an Investigation

4. A statement describing the event/alleged event including in a time-line format:
   a. what happened;
   b. where it happened;
   c. when it happened (including date and time);
   and
   d. who was involved.

5. Immediate safety measures put into place following the event/alleged event.
Investigation Components

DDRS Policy: Mandatory Components of an Investigation

6. Identification by name and title of all involved parties or alleged involved parties including: the deceased, all staff assigned to work with the Individual, all staff assigned to the victim(s)/alleged victim’s at the time of the incident, any alleged perpetrators, all actual or potential witnesses to the event/alleged event
Investigation Components

DDRS Policy: Mandatory Components of an Investigation

7. A statement describing all record and other document review associated with the event or alleged event.

8. Copies of all records and other documents reviewed that provide evidence supporting the findings of the investigation or review.
Investigation Components

DDRS Policy: Mandatory Components of an Investigation

9. If there are any discrepancies/conflicts between the evidence gathered, the discrepancy is resolved and/or explained.
10. A determination if rights have been violated.
11. A determination if services and/or care were not provided or were not appropriately provided.
Investigation Components

DDRS Policy: Mandatory Components of an Investigation

12. A determination if agency policies and/or procedures were not followed.
13. A determination if any federal or state regulations were not followed.
14. A clear statement of substantiation or non-substantiation of any allegation that includes a description/summary of the evidence that resulted in the finding.
15. A description of all corrective actions developed and implemented and/or to be implemented as a result of the investigation or review, including completion dates for each corrective action.

16. Signed and dated statements from all involved parties, including all actual and potential witnesses to the event or alleged event, and all staff assigned and present at the time of death.
Investigation Components

DDRS Policy: Mandatory Components of an Investigation

17. The signature and name and title of the person completing the internal review.
18. The date the internal review was completed.
Investigation Components

DDRS Policy: Mortality Review

Additional Components for Death Investigations

1. Timeframe -- the thirty (30) day period immediately before:
   a. the death of the Individual; and
   b. if applicable, the hospitalization or placement in a hospice setting or nursing facility in which the Individual’s death occurred.
Investigation Components

DDRS Policy: Mortality Review

Additional Components for Death Investigations

2. In conjunction with all providers of services to the deceased individual, review and document all the actions of all employees or agents of all providers for the thirty (30) day period immediately before:
   A. the individual's death;
   B. the hospitalization in which the individual's death occurred; or
   C. the individual's transfer to a nursing home in which death occurred within ninety (90) days of that transfer.
Investigation Components

DDRS Policy: Mortality Review

Additional Components for Death Investigations

3. In the case of an unexpected death or when otherwise requested provide a narrative review of the deceased Individual’s documents:

- staff notes;
- treatment records;
- medication administration records;
- physician orders;
- dietary guidelines;
- nutritional assessments;
- daily support records;

- Individualized support plan;
- risk plans;
- care plans;
- nursing notes;
- consultant notes;
- progress notes;
Investigation Components

DDRS Policy: Mortality Review

Additional Components for Death Investigations

In the case of an unexpected death or when otherwise requested provide a narrative review of the deceased Individual’s documents:

- training and treatment flow sheets including but not limited to:
  - bowel tracking;
  - seizure log;
  - input and output record;
  - vital sign records;
  - risk plans;
  - consumer specific training;

- assigned staff ratios;
- hospital & ER admission and discharge summaries; and
- all other documentation relevant to the services being provided to the Individual at the time of death.
Investigation Components

DDRS Policy: Mortality Review

Additional Components for Death Investigations

4. A narrative summary of a review of relevant Provider policies and procedures.
5. A narrative summary of the findings of all record and document review associated with the death.
6. A narrative summary description of the internal review and how it was executed.
7. A statement of specific findings from the internal review.
Investigation Components

DDRS Policy: Mortality Review

Additional Components for Death Investigations

8. Document conclusions and make recommendations arising from the investigation.
9. Document implementation of any recommendations made under subdivision (5).
Agenda

V. Best Practices
An effective investigation...

- Is implemented according to *established Criteria* (agency policy/procedure)
- Is *Objective* (critical component)
- Collects evidence
- Analyses all Evidence
- Reaches a Conclusion
- States a Recommendation for Corrective action
Best Practices

Does the agency have established criteria (policies and procedures) for investigations?

_Does it address???

• Prompt response?
• Objectivity?
• Protocols to be used to help in the investigation?
• Personnel/Positions allowed to conduct investigations?
Evidence?

Any relevant information collected during an investigation which assists in describing and explaining the incident or event.

Types of Evidence:
- Testimonial
- Documentary
- Physical
- Demonstrative
Testimonial

Information obtained orally or equivalent manner

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

Follow up questions such as:

- And then what happened?
- Did you tell anybody what happened?
- What went on before this?

Represents information from:

- olfactory, tactile, verbal, emotional, kinesthetic, visual, auditory senses
Best Practices

Documentary

• Method to preserve testimony
• Obtain statements (written and signed, when possible) after testimony/interview
Best Practices

Documentary

• Review relevant documents such as:
  - Letters
  - Memos
  - Policies and protocols
  - Job descriptions
  - Participant’s plans
  - Training curriculum
  - Training records
  - Schedules
  - Time cards
  - Notes
  - Video
  - Emails
  - Text messages
  - Sign in sheets
Physical Evidence

• Such as:
  ❖ Clothing
  ❖ Belt
  ❖ Gloves
  ❖ Liquid
Demonstrative Evidence

In place of physical evidence in a report...

- Pictures
- Diagrams
- Maps
- Explained

Signed and Dated by the person who obtained the evidence.
Evidence Analysis

The evidence as a whole must be examined for gaps, holes or other discrepancies and a determination made whether further investigation will be able to clarify the needed/missing information.
Evidence Analysis

• Was all relevant evidence gathered?
• Was all evidence reviewed?
• Were there any discrepancies/conflicts between the evidence gathered?
• Were the discrepancies resolved/explained?
Conflicting Evidence

- Comparison of all types of evidence
- Corroborating statements
- Conflicting reporting/information
- Timelines
Best Practices

Resolving Evidence Conflicts

- Re-interview
- Additional interviews
- Corroborate documents
- Compare timeframes
- Test Observations – was it possible to have been seen or heard?
Summarizing Evidence

• Determine if the individual’s rights were violated?
• Were Care/Services not provided or were inappropriately provided?
Best Practices

Summarizing Evidence

• Determine if abuse/neglect/mistreatment or exploitation occurred.
• Were any policies/procedures not followed?
• Were any federal or state regulations violated?
Investigation Report

• Brief Description of the Incident
• Investigative Procedures Used
• Evidence Collected
• Summary of Evidence
• Conclusion
• Corrective Action/Recommendations
Best Practices

Description of the Incident/Event

• Clear statement of why it was important to conduct an investigation

• Includes the nature of the allegation or event such as:
  • Abuse
  • Neglect
  • Mistreatment
  • Exploitation or
  • Injury of Unknown Origin
Best Practices

Description of the Investigation Procedure

• Timeline of the event
• Identification of all interviews
• Signed and dated statements from all parties
• Itemized list of evidence collected
• Where evidence is stored if not attached to the report
• Process of evidence analysis
Summary of Evidence

• **Analysis** of all the evidence collected
• Brief summary of the **pertinent facts** uncovered in the investigation.
• Leads you to a **conclusion** that determines what corrective action is needed.
Results of the Investigation

CONCLUSION

• Substantiated by the facts in evidence

Must specifically identify:

• Individual’s rights that were violated

• Care/services that were not provided or were inappropriately provided

• Policies/procedures that were not followed

• If abuse/neglect/mistreatment or exploitation occurred (must be stated)
Best Practices

Recommendations

Must include…

- Corrective Action(s) for individual, staff, and environment, as applicable
- Adaptations to practices, policies, and/or procedures
- Development of Preventive Plan(s)
VI. Resources

• DDRS Policy: Mandatory Components of an Investigation
• DDRS Policy: Mortality Review
• Incident Investigation Template
Investigation Components Checklist
coming soon!
VII. Questions/Discussion
A special thanks to Steve Corya at the Indiana Department of Health for assistance with investigation procedures for this presentation.
VIII. Contact Information
Bureau of Quality Improvement Services

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