Investigating and Reporting Allegations of Misconduct in DQA-regulated entities

caregivers

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

PARTICIPANT GUIDE

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Learning Points

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

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

A Word about Prevention

Allegations of misconduct can occur by any person, not just caregivers. However, because many allegations do involve caregivers, it's important to talk about preventing caregiver misconduct. 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 do not have significant criminal histories. If they did, you would not have hired them, and misconduct would have stopped long ago.

Let's take a moment to review some key thoughts on preventing caregiver misconduct. These strategies may also serve as preventative measures with non-caregivers.

- Focus on prevention. Detection is good, but too late.
- Training and open communication are the keys to prevention. Make sure everyone understands what "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 client.
- Create a team whose focus is the well-being of both clients and caregivers.

- Direct caregivers are the key to the success of your entity. 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

Take a moment to write down how you might specifically adapt some of these keys to prevention or list any other strategies to prevention that you currently use in your own care setting.

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Having said all that, misconduct can happen in your care setting, despite your best efforts. If it does, you need a plan of action in place so that everyone knows their role.

Guidance Reminder Regarding Handheld Devices and the Potential Misuse of Such Devices

Per DQA Memo 16-04, it is recommended that entities adopt a written policy that defines the accepted appropriate use and the unaccepted inappropriate use of personal handheld devices in that entity's healthcare setting. This policy may be included as part of the entity's human resource policy and procedure manual and may incorporate the following:

- Personal devices are never to be used to record images of residents/patients/or clients. If such images are needed for purposes of care or training, they should be obtained by authorized persons only and use only the equipment specified in the policy.
- Indicate that any authorized photographs or images are the sole property of the entity and that the distribution of these photographs or other images to any person outside the entity's setting without written authorization for a permissible use is prohibited.
- Define the areas of the entity and the circumstances in which personal cell phone and other wireless handheld devices may be used, i.e. on breaks or lunch in the break room or outside, etc. Specify the consequences for failure to abide by the entity's policy.
- Inform residents/patients/clients (or designated responsible agent) and family/visitors about privacy considerations and the use of personal cameras, cell phones and wireless handheld devices.
- Ensure that all staff, contract/pool agency staff, students and volunteers are aware of and trained on the entity's written policy on the use of personal cell phone and other wireless handheld devices.

Social Media Awareness Materials for Caregivers

In recent years, an increasing number of cases related to the misuse of handheld devices to share information and personal photos or videos of clients have been reported to DQA. The Office of Caregiver Quality (OCQ) has substantiated numerous instances of caregiver misconduct related to these reports.

Examples of potential caregiver misconduct or violation of client rights via handheld devices include:

- Posting a photo or video to Facebook that includes personal and identifying characteristics of a client.
- Sending or posting a photo on Snapchat or Instagram that includes any parts of a client's body.
- Having an image or video of a client on your Snapchat storage or on your camera storage without the client's written consent or knowledge.
- Taking a video or photo on your phone of another employee mistreating or degrading a client and not reporting it to your direct supervisor.

In an effort to improve awareness regarding client rights and caregiver misconduct in Wisconsin nursing homes, DQA has implemented an awareness campaign through the use of brochures, posters, and videos.

The resources, including the videos that were developed as part of this project, can also be accessed by going to: https://www.dhs.wisconsin.gov/caregiver/social-media.htm. Please share these resources with your team.

Developing an Investigation Process

Please refer to your handout, Misconduct Investigation Process.

Your investigation process should be written down and shared with everyone in the entity. It's critical that all staff understand the process as well as their responsibilities when misconduct is suspected.

Activity: Checking Your Process and Protocol

Using the chart below, check the box if your entity already has that process in place. If not, note how you might implement the process or think about referring the issue to someone in your entity.

☐ **Develop a written protocol in advance of any allegation of misconduct.** Ensure that all staff understands what constitutes "misconduct." Define the reporting timelines and the mechanisms required for reporting.

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

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☐ **Share the protocol** with all staff and ensure that employees, clients and family members know to whom they should report a concern.

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☐ **Create an atmosphere** that welcomes reporting of concerns.

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

- Receiving a verbal or written statement of a client, caregiver or anyone with knowledge of an incident
- Discovery of an incident
- Hearing about an incident from others
- Observing injuries (physical, emotional or mental) to a client
- Observing theft of a client's property
- Otherwise becoming aware of an incident

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☐ **Treat all allegations as potential misconduct.** Make no decisions until the investigation is complete.

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Wrap-Up

- Developing an Investigation Process
- Protocol Steps
- Reminder on Checking Your Process/Protocol Upon Return to Work

Understanding the Definitions of Misconduct/Mistreatment for All DQA-Regulated Entities

Let's review the DQA handout, "Misconduct Definitions" (P000976-11/2017).

This publication contains the definitions for both federal and state-regulated entities. In general, that refers to nursing homes (federal) and state-regulated (all other entities). You will notice that there are many similarities, but there is one very big difference:

Because the federal definitions do not specify that the incident must involve a caregiver, federally regulated entities (nursing homes) are required to report allegations of mistreatment by anyone to DQA immediately, including client-to-client altercations.

We will discuss more about incident reporting later in the training. Let's learn more about the definitions themselves.

Federal Misconduct Definitions

Federal definitions define misconduct committed by any person in these categories:

- Abuse
- Neglect
- Exploitation
- Misappropriation of Client Property
- Injuries of Unknown Source

Note that the federal definition (in the left-hand column) of abuse indicates that the act must be "willful" and that it needs to have resulted in physical or psychosocial harm to the client or would be expected to have caused harm to a "reasonable person" if the client cannot provide a response.

"Willful" means that the individual intended the action itself that he/she knew or should have known could cause physical harm, pain, or mental anguish. Even though a client may have a cognitive impairment, he/she could still commit a willful act.

However, there are instances when a client's willful intent cannot be determined. In those cases, a client-to-client altercation should be reviewed under F689/F700.

Participating Medicare and Medicaid care service programs must first review the federal definitions; if an incident potentially meets the federal definition, it is not necessary to review the Caregiver Misconduct definitions found in Wisconsin Administrative Code, DHS 13.05, and in the right-hand column of the form.

Caregiver Misconduct Definitions

In Wisconsin, Caregiver Misconduct includes:

- Abuse
- Neglect
- Misappropriation
- Injuries of Unknown Source

DHS 13 also specifically defines abuse, neglect, and misappropriation. Use the federal definition of injuries of unknown source in the left-hand column. These definitions are guidelines for non-nursing home entities to determine whether or not an incident meets one of the definitions and whether the incident must be reported to the DHS Division of Quality Assurance (DQA). Let's take a moment to review those definitions individually.

Simplified Definitions of Misconduct

Let's review the handouts: Federal Misconduct – Simplified Definitions and Caregiver Misconduct – Simplified Definitions. Select the handout that fits your entity type.

The definitions are similar to each other but differ from the perspective of "who" is allegedly committing the act. Let's review the handout, Federal Misconduct – Simplified Definitions. The biggest difference between the versions is the alleged perpetrator of the misconduct or mistreatment. Under the federal definition, misconduct or mistreatment of a client ***by any person*** must be reported.

In the handout, Caregiver Misconduct – Simplified Definitions, the focus is on misconduct **by caregivers**.

As we discussed before, 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 important to note that an incident may meet the definition even if there was no harm done, particularly if the negligent act had significant potential to do harm.

Above all, individuals must be encouraged to report anything to a supervisor or manager that just doesn't feel right to them.

Allegations of mistreatment, abuse or neglect of a client, misappropriation of a client's property and client injuries of an unknown source are all considered "incidents" that require reporting to DQA.

Wrap-Up

- Learning Point: Definitions of Misconduct (both versions)

Investigating the Allegation

Let's focus on Step # 3 in the Protocol – Investigating the Allegation.

It is 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.

The entity must investigate any allegation or incident reported to them. A timely and thorough entity investigative report is critical to the potential substantiation of a finding of misconduct.

An internal investigative report provides:

- A record of the entity investigator's activities and findings so that nothing is left to memory
- A permanent official record of the entity investigator's actions, observations, and discoveries
- A basic reference of the case
- Information on what has been done concerning the case
- A basis for deciding further action
- A method to communicate the findings of the case
- Information that can be evaluated and analyzed to detect and identify patterns of conduct

Entity reports should be written whenever an incident of misconduct or an injury of unknown source is reported to an entity and each time a contact has been made as part of the internal investigation.

Any employment action taken against a caregiver while a complaint is pending is an internal entity decision. An entity is not required to suspend or terminate a caregiver against whom an allegation has been made and reported. During this period, options available to the employer include, but are not limited to:

- Increased supervision
- Alternative work assignment
- Employment sanctions

Until a final decision is made, it is up to the employer to choose appropriate interim options.

Elements of an Investigation

There are many avenues to explore when conducting an investigation. The following important elements of an investigation serve as guidelines. Be sure to consider the appropriate elements each time you conduct an investigation.

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 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?)
- Include all individuals who are connected in any way with the incident under investigation. Identify each person separately in such a manner that he/she cannot be confused with any other individual, including full name, nicknames, demographic and contact information.
- Interview other staff who you believe might know or have information about the behaviors of the clients or the staff person in question.
- 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?

Contact Law Enforcement

The Elder Justice Act is designed to provide federal resources to prevent, detect, treat, understand, intervene in and, where appropriate, prosecute elder abuse, neglect, and exploitation. The Elder Justice Act is a comprehensive elder abuse prevention law, which was enacted as part of the Patient Protection and Affordable Care Act on March 23, 2010. The Elder Justice Act imposes additional mandatory individual reporting requirements; broadens the scope of who is required to report; and requires affirmative obligations on entities to provide annual training to covered individuals, to post a conspicuous notice, as well as develop internal policies.

The Elder Justice Act requires assisted living facilities to report to both their licensing agency as well as to one or more local law enforcement agencies if there is any "reasonable suspicion" of crimes against a client or person receiving care at the types of facilities listed above. "Reasonable suspicion" is not defined within the act. According to the statutes of the act, "crime" is defined by the laws of the applicable city, county, state, township or village where the long-term care entity is located which would include the definitions outlined in this guide which includes physical or sexual abuse or assault, negligence that leads to injury, significant loss of property or a pattern of lost property, etc.

There are two reporting timeframes depending on whether the client suffers serious bodily injury. Serious bodily injury is defined as an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ or mental faculty; or requiring medical intervention such as surgery, hospitalization or physical rehabilitation. If the client suffers serious bodily injury, it must be reported within two hours of the event. If there is no serious bodily injury, then a report must be filed within 24 hours of the event.

In addition to the Elder Justice Act, there are other federal requirements for long-term care entities, including nursing homes and others, to report reasonable suspicion of a crime in a long-term care entity to both the state agency and law enforcement.

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 DQA within timelines for your entity type. Inform the agency that law enforcement is involved and attach any available reports.

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.

If you are using the camera feature on a cell phone (especially a personal phone), either print them for safe storage or save them to a flash drive that can be secured confidentially.

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.).

In the event of neglect without injuries, document details that demonstrate the potential for harm. For example:

A caregiver props open and deactivates an alarmed door in order to go out to her car and get back into the building quickly. A client with a history of absconding slips away unnoticed through the open door and walks to a local convenience store four blocks away. The client is recovered quickly and returned to her home unharmed.

While the client was recovered quickly and suffered no injuries, the potential for harm was great.

Documenting the effect on the victim also extends to misappropriation. For example:

A client's wallet disappears from his room. The client states that there was $20 in the wallet.

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 their actions could result in harm to the client.

You might assume that a reasonable caregiver knows or should know that abuse, neglect, misappropriation of property, or exploitation can result in harm. However, think about how you would document that:

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

In a case of neglect, 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 client?
- 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?

Diagram the Scene

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

This will help 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.

Review Entity/Other Records

- Check client records, nurse's notes or other written records that document client care around the time of the incident.
- Check timecards or schedules. Was the accused or witness 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?
- 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 the accused's state of mind or motivation.

Develop a List of Individuals 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 last when possible. Information from other resources and witnesses may give you a sense of whether the accused was actually involved. (For example, "Mary, four other employees told me they saw you coming out of the client's room that night and that you seemed upset.") We'll discuss interviewing tips a bit later.

Write Your Report

- Review the facts that you have gathered.
- Have you explored all the available resources?
- Do you include appropriate elements outlined above?
- Does your report include facts and give you sufficient information about reporting further or allowing the accused to resume contact with clients?

These steps should be taken as part of the entity's initial attempt to determine what, if anything, happened and to determine the complete, factual circumstances surrounding the alleged incident.

The entity must document the results of their internal investigation using the Misconduct Incident Report form, [DQA form F-62447 (11/2017)]. We will discuss other reporting requirements for reporting to DQA later in the training.

Incident-Specific Requirements

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

Physical Abuse

- 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.
- 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

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

Sexual Abuse

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

Neglect

- Documentation of the treatment, service, care, goods or supervision required but not provided (check the Care Plan)
- Documentation verifying the caregiver's duty to provide care to the individual
- Verification that the act or failure to act resulted in or could reasonably have resulted in harm

Exploitation (NHs)

- Copies of any financial records related to the incident, e.g. checks, credit card statements, titles to property, records of assets, etc.
- Statements from victims and witnesses of verbal threats or other coercion for the alleged perpetrator's personal gain.

Misappropriation

- A description of any stolen items
- Copies of all financial records related to the incident including cancelled checks or credit card statements
- A copy of the police report
- Verification that the stolen items belonged to the victim
- Verification that the victim did not/could not give consent to the individual

Client-to-Client Altercations (NHs)

- Do the circumstances meet one of the definitions?
- Documentation of each client's cognitive abilities, diagnosis, etc.
- Analysis of the altercation to determine if the client(s) had willful intent (e.g., through immediate interviews of clients and eyewitnesses, observations, etc.).
- Consideration of the client's ability to form intent or to act knowingly
- Determination of a client's ability to understand the possible outcome of his/her actions. Does the client understand that if he/she hits, bites, pushes, etc. another person, that person could possibly be hurt? Does the client remember the occurrence and know that his/her actions could have harmed another?

Activity: Case Studies of Misconduct

Now that we've explored the protocol and investigation steps, let's use some real-life examples to determine how you would investigate an allegation of misconduct. All examples are taken from allegations of 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, contact law enforcement immediately.

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

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

In each example, you may assume that you (or your group) represent the person responsible for investigating the alleged incident and that only the information in each example was reported to you.

Example #1: Allegation of Physical Abuse

CNA Jerome reports to you that he just observed Client Maria's husband slap Maria and then leave the building. When Jerome asked Maria if she was ok, she denied that her husband had hit her. Maria told Jerome he should not make up lies about her husband.

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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 Client 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 monitor was set to electrocute him.

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Example #3: Allegation of Neglect

On November 27th, John Brown, the grandson of Client 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 on her forehead. You know that Faye was taken to the hospital and required several stitches to her forehead.

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Example #4: Allegation of Misappropriation

On July 13th, Client Harry reports to you that Caregiver Alicia has used his credit card improperly. Harry states that about a month ago, he told Alicia that he wanted a new clock radio for his room. Alicia offered to purchase one for him over the weekend but said she didn't have enough money to pay for it. Harry gave Alicia his credit card. That next Monday, Alicia brought Harry the new radio, the receipt and his credit card. Yesterday, Harry received his credit card statement which shows charges at a gas station, hair salon and women's clothing store, totaling $350. Harry says he did not charge those items, and he believes the charges were made the same weekend that Alicia had his credit card.

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Example #5: Injury of Unknown Source

On March 19th, Activity Director Carol is helping several clients 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.

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Wrap-Up

- Learning Point #3: Conducting an Internal Investigation
- Investigation Steps
- Incident Specific Requirements

Top 10 Interviewing Tips

Some insist that interviewing is more art than science. Interviewing witnesses, accused caregivers and victims is critical to the success of your investigation.

Let's review those tips.

1. **Ensure privacy without interruptions.** You may bring a witness, but only one. Interview only one person at a time.

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 their 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.

Activity: Interviewing Skills Video

Next we have a video that demonstrates some of the interviewing tips that we just discussed. While you're watching the video, think about specific examples that you see. I'll give you a few minutes after the video to jot down your thoughts.

This interview occurs at Havenhill on Thursday, March 23rd. Juan, the Administrator, is preparing to interview Amy, a CNA at Havenhill. Juan has discovered that Amy may have witnessed an incident between another CNA named Suzy and a client named Emma. Let's watch as Juan prepares for the interview.

Activity: Video Discussion

Let's take a moment to compare the Interviewing Tips with the conversation in the video. How did Juan use the tips effectively in his interview?

Use the chart below to list some examples from the video in the right column.

Tips for Successful Interviews

Interviewing Tip	Video Example:
Ensure privacy	
Be prepared	
Relaxed Demeanor	
Seating	
Explain the reason for the interview	
Clarify dates, times, witnesses	
Ask open questions	
Stay on the subject	
Show empathy	
Listen well	

Wrap-Up

- Learning Point #4: Interviewing Skills
- Interviewing Tips

Reporting Allegations of Misconduct

Reporting requirements and procedures are not all the same for entities regulated by DQA. Reporting requirements for nursing homes are different from those for all other non-nursing home DQA-regulated entities.

Let's review the requirements based on the handout for your provider type:

Reporting Allegations of Misconduct/Mistreatment in Nursing Homes

-or-

Reporting Allegations of Misconduct in DQA-Regulated Facilities (Except Nursing Homes)

When in Doubt, Report it Out!

If an entity is unsure about whether an incident should be reported, it's best to opt for reporting to DQA. The Office of Caregiver Quality (OCQ) in DQA maintains records of all reported incidents. Incident reports concerning caregivers are filed by the caregiver's name—not entity.

OCQ screens each report it receives to determine investigative merit. When a pattern exists of similar (but perhaps minor) complaints against a caregiver, the report may be screened in for further investigation.

Because entities may be unaware of past reports submitted by previous employers, reporting is always the best choice.

If an entity is unsure about submitting a report that does not involve a caregiver, it is still best to submit the report.

Reports Involving Credentialed Staff

In the past, entities were required to submit the report either to DQA or to the Department of Safety and Professional Services (DSPS). This process has been streamlined to eliminate reporting to two different agencies. All caregiver misconduct reports are submitted to DQA, who will forward reports involving credentialed staff (physicians, RNs, LPNs, social workers, etc.) to DSPS for review.

Reporting on Behalf of Adults-at-Risk

State statutes go beyond the Caregiver Law requirement to report misconduct by caregivers in entities regulated by DQA. The law also requires that **any** employee of **any** entity report allegations of abuse, neglect or exploitation made by an adult-at-risk (vulnerable adult age18 and over including those over age 60) who is seen in the course of the person's professional duties under certain conditions.

Condition	Action Required
Adult-at-risk has requested that the employee make a report	Any entity employee is required to report
Reasonable cause to believe an adult-at-risk is at imminent risk of serious bodily harm, death, sexual assault, significant property loss and is unable to make an informed judgment about whether to report	Report if there is serious concern about future risk; not applicable to situations that only involve past incidents
Other adults-at-risk are in danger of serious bodily harm, death, sexual assault, significant property loss	Report past incidents only if the possibility of mistreatment still exists for other adults at-risk

Example:

Client Ann tells Caregiver Richard that her daughter, who just left the entity, slapped Ann in the face while visiting. Ann says that her daughter was angry because she wouldn't write her a check. She wants Richard to "do something" so that her daughter can't hurt her again.

Although this incident does not meet the definition of "caregiver misconduct" found in DHS 13, the caregiver is still required under the adult-at-risk provisions, to report the incident. If the incident occurred in a nursing home or federally regulated entity, reporting to DQA is also required.

The adult-at-risk law closely mirrors reporting requirements for federally regulated nursing homes.

For more information, read the following:
Adult-at-Risk, including Elder Adult-at-Risk, Reporting Requirements for Entities Regulated by the Office of Quality Assurance

https://www.dhs.wisconsin.gov/publications/p01214.pdf

Wisconsin Caregiver Misconduct Registry

The Wisconsin Caregiver Misconduct Registry is a record of the names of nurse aides and other non-credentialed caregivers with a substantiated finding of caregiver misconduct.

Entities should review the Registry monthly for the names of caregivers most recently added due to a substantiated finding of misconduct. Employees who did not have a finding when hired may receive one while employed but fail to report the finding to the employing entity. Accordingly, the only way to know about new findings is to check the updated Misconduct Registry each month.

These monthly additions of caregivers with a finding of misconduct on the Wisconsin Caregiver Misconduct Registry are posted by the 15th of the month and may be viewed on the Internet at:

http://www.dhs.wisconsin.gov/caregiver/misconduct.HTM

Federal regulations require that nurse aides with a finding of caregiver misconduct be permanently barred from working in any capacity in federally regulated nursing homes or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

The Caregiver Misconduct Registry identifies each caregiver by name, date of birth and type of caregiver.

More detailed information is available at Wisconsin's Internet-based Nurse Aide Registry at: http://www.dhs.wisconsin.gov/caregiver/NATD/NrsAidTrgPrgInf.HTM

Scroll down to "Nurse Aide Registry Services" then click on "Search Nurse Aide Registry."

For a nurse aide (NA): Information will be provided regarding the aide's employment eligibility and whether a finding of misconduct has been placed under the aide's name.

For any other non-credentialed caregiver (CGE): The name of any other person defined as a "caregiver" under Wisconsin law who has a substantiated finding will also be placed on the Registry. No person listed on the Registry may be employed as a caregiver in any entity regulated by the Wisconsin DHS unless approved through the Rehabilitation Review process.

Review Learning Points

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

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

Resources

All Entity Types:

Wisconsin Caregiver Program Manual
https://www.dhs.wisconsin.gov/publications/p0/p00038.pdf

Guidance Reminder Regarding Handheld Devices and the Potential Misuse of Such Devices
https://www.dhs.wisconsin.gov/dqa/memos/16-004.pdf

Nursing Homes:

Nursing Home Reporting Requirements for Alleged Incidents of Abuse, Neglect, Exploitation and Misappropriation P-00981 (11/2017)
https://www.dhs.wisconsin.gov/publications/p00981.pdf

Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility (LTC): Section 1150B of the Social Security Act
https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/SCLetter11_30.pdf

All Entities Except Nursing Homes:

Wisconsin Caregiver Program Manual
https://www.dhs.wisconsin.gov/publications/p0/p00038.pdf

Reporting Requirements for All Entities Regulated by the Division of Quality Assurance (Except Nursing Homes) P-00907
https://www.dhs.wisconsin.gov/publications/p00907.pdf