Department of Health and Social Services

DHSS Policy Memorandum 46 November 2013
Subject: Injury to Clients

I. PURPOSE

a. To protect the right of residents/clients of Delaware Health and Social Services (DHSS) facilities to be free from abuse, neglect, mistreatment, financial exploitation or significant injury.
b. To require that each Division that has, or contracts for the operation of, residential facilities establish standardized written procedures for the reporting, investigation and follow up of all incidents involving suspected resident/client abuse, neglect, mistreatment, financial exploitation, significant injury, or unanticipated death.
c. To require that all DHSS residential facilities comply with The Patient Abuse Law (Title 16, Chapter 11, section 1131, et seq.) and Title 29, Chapter 79, sections 7970 and 7971 (Attachments I and II); and that all Medicaid and/or Medicare certified long term care facilities and Intermediate Care Facilities for Mental Retardation (ICF/MR) comply with the federal regulations (42 CFR) and State Operations Manual for such facilities. In addition, all residential facilities and Medicaid and/or Medicare certified long term care facilities and Intermediate Care Facilities for Mental Retardation (ICF/MR) comply with Title 11, Chapter 94, Victims Bill of Rights, Subchapter I and Subchapter II. Compliance with Title 11, Chapter 5, Subchapter V Offenses Relating to Children and Incompetants, Subpart A Child Welfare; Sexual Offenses is required by all facilities that provide residential and/or inpatient services to children.
d. To require that all DHSS residential facilities comply with all applicable state and federal statutes, rules and regulations pertaining to suspected abuse, neglect, mistreatment, financial exploitation, significant injury or or unanticipated death . Applicable statutes include Title 11, Chapter 5, Subchapter II Offenses Against the Person, Subpart A Assaults and Related Offenses.

II. SCOPE

a. This policy applies to anyone receiving services in any residential facility operated by or for any DHSS Division, excluding any facilities/programs in which the only DHSS contract is with the DHSS Division of Social Services Medicaid Program.
b. This policy is not intended to replace additional obligations under federal and/or state laws, rules and regulations.

III. DEFINITIONS

a. Abuse shall mean:
   1. Physical abuse the unnecessary infliction of pain or injury to a resident or client. This includes, but is not limited to, hitting, kicking, pinching, slapping, pulling hair or any sexual molestation. When any act constituting physical abuse has been proven, the infliction of pain shall be assumed.
   2. Emotional abuse - This includes, but is not limited to, ridiculing or demeaning a resident or client, cursing or making derogatory remarks towards a resident or client, or threatening to inflict physical or emotional harm to a resident or client.

b. Neglect shall mean:
   1. Lack of attention to the physical needs of the resident or client including, but not limited to, toileting, bathing, meals, and safety.
   2. Failure to report client or resident health problems or changes in health problems or changes in health condition to an immediate supervisor or nurse.
   3. Failure to carry out a prescribed treatment plan for a resident or client.
   4. A knowing failure to provide adequate staffing (where required) which results in a medical emergency to any patient or resident where there has been documented history of at least 2 prior cited instances of such inadequate staffing within the past 2 years in violation of minimum maintenance of staffing levels as required by statute or regulations promulgated by the department, all so as to evidence a willful pattern of such neglect. (Reference 16 DE Code, §1161-1169)

c. Mistreatment shall mean the inappropriate use of medications, isolation, or physical or chemical restraints on or of a resident or client.

d. Financial exploitation shall mean the illegal or improper use or abuse of a client's or resident's resources or financial rights by another person, whether for profit or other advantage.

e. Significant Injury is one which is life threatening or causes severe disfigurement or significant impairment of bodily organ(s) or functions which cannot be justified on the basis of medical diagnosis or through internal investigation.

f. Unanticipated death is a death that occurs suddenly when the deceased was in apparent health, or when the deceased was unattended by a physician, or in any suspicious or unusual manner. Upon review of the death by the Office of the Medical Examiner, that office shall determine whether they have jurisdiction of the case. Should OME assume jurisdiction of the case, the death will be considered as unanticipated.

g. Assault (including sexual assault) as defined in Del.Code Title 11 § 611, § 612 and § 613.

h. Attempted Suicide shall mean an intentional attempt at the taking of one's own life.

i. SANE – Sexual Assault Nurse Examiner.

j. Residential Facility shall include any facility operated by or for DHSS which provides supervised residential services, including Long Term Care licensed facilities, group homes, foster homes, and community living arrangements.

k. Long Term Care Facility is any facility operated by or for DHSS which provides long term care residential services and the Delaware Psychiatric Center.

l. High managerial agent is an officer of a facility or any other agent in a position of comparable authority with respect to the formulation of the policy of the facility or the supervision in a managerial capacity of subordinate employees.

IV. RESPONSIBILITIES

a. The Director, or his/her designee of each Division within the scope of this policy, is hereby designated as an official DHSS designee under the State Mandatory Patient Abuse Reporting Law.

b. Each Division will develop written procedures consistent with the standards contained in this policy and which will be activated immediately upon discovery of any suspected abuse, neglect, mistreatment, financial exploitation, significant injury or unanticipated death of or to a client of a residential or long- term care facility. These procedures must clearly outline the reporting chain from the witness to the Division Director, and other appropriate parties, to require the expedient relay of information within the required time frames.

c. These standardized procedures shall also apply when the preliminary inquiry suggests that the assault, significant injury, suspected abuse, neglect, unanticipated death, suicide attempt, mistreatment or financial exploitation may have been caused by a staff member of the residential facility, whether on or off the grounds of the residential facility. Suspicion of facility/program negligence (including inadequate supervision resulting in client-client altercations) and incidents involving abuse by persons who are not staff members of the residential facility shall also be reported.

d. The standardized procedures shall be approved by the appropriate Division Director prior to implementation. The Division Director or designee shall forward a copy of the approved procedures to the Chief Policy Advisor, Office of the Secretary, and other appropriate agencies.

e. Each Division will require that the standards established in this policy are incorporated in all residential operational procedures and all residential contracts. Each Division shall require that all residents and providers of these programs be informed of their specific rights and responsibilities as defined in the Division's written procedures.

f. Each Division shall require that all levels of management understand their responsibilities and obligations for taking and documenting appropriate corrective action.

g. Each Division shall require appropriate training of all staff and contract providers in the PM 46 policy and procedures. Such training shall also

include the laws prohibiting intimidation of witnesses and victims (11 Del. C., sections 3532 through 3534) and tampering with a witness or physical evidence (11 Del. C., sections 1261 through 1263 and section 1269).

h. Each Division shall develop quality assurance/improvement mechanisms to monitor and oversee the implementation of the PM 46 policy and procedures.

i. Each Division must ensure that all employees of, or contractors for, residential facilities shall fully cooperate with PM 46 investigations.

V. STANDARDS/PROCEDURES

Standard and consistent implementation of this Department policy is required. Each Division's written procedures shall include the following:

a. Employee(s) of the residential facility, or anyone who provides services to residents/clients of the facility, who have reasonable cause to believe that a resident/client has been assaulted, abused, mistreated, neglected, subjected to financial exploitation, or has received a significant injury, attempted suicide or whose death is unanticipated shall:

   1. Take actions to assure that the residents/client(s) will receive all necessary medical attention immediately, including calling '911' for transportation to the hospital, especially in the cases of assault, sexual assault, and serious physical injury. In the cases of sexual assault, a SANE examination should be completed at the hospital.
   2. Take action to report all crimes to the police through the '911' call system. All victims of crimes must be offered the ability to access victim advocate services, either through the police agency or other agencies. Victim advocates can be contacted by calling 1-800-VICTIM1 (1-800-842-8461). The Delaware Helpline can provide advocate information and Contactlifeline can provide confidential accompaniment to the hospital in cases of sexual assault.
   3. Take actions to protect the residents/client(s) from further harm.
   4. Report immediately to the Division of Long Term Care Residents Protection (if the incident occurred in a long term care facility or if the client was a resident of a long term care facility); and to the Department of Services for Children, Youth and Their Families/Division of Family Services (if the client is a minor, as required under 16 Del. C., section 903). It is essential that the reporting person ensure that the report be made to the appropriate division designee immediately.
   5. Report immediately to the facility/program director and the Division's designated recipient(s) of PM 46 reports.
   6. Follow up the verbal report with a written initial incident report to the persons/ agencies named in (a) 3 and (a) 4 (above) within 48 hours.

b. In addition to the above named persons, any other person may make a report to a staff person of the facility or to the Division director or his/her designee. Such a report shall trigger activities under V(a), items 1 through

c. Each written initial report of assault, suspected abuse, neglect, mistreatment, financial exploitation, attempted suicide, significant injury, or unanticipated death (completed by the reporting employee) must include:
   1. The name and gender of the resident or client.
   2. The age of the resident or client, if known.
   3. Name and address of the reporter and where the reporter can be contacted.
   4. Any information relative to the nature and extent of the assault, abuse, neglect, mistreatment, financial exploitation, attempted suicide, significant injury or unanticipated death.
   5. The circumstances under which the reporter became aware of the assault, abuse, neglect, mistreatment, financial exploitation, attempted suicide, significant injury or unanticipated death.
   6. The action taken, if any, to treat or otherwise assist the resident or client.
   7. Any other information that the reporter believes to be relevant in establishing the cause of such assault, abuse, neglect, mistreatment, financial exploitation, attempted suicide, significant injury or unanticipated death.
   8. A statement relative to the reporter's opinion of the perceived cause of the assault, abuse, neglect, mistreatment, financial exploitation, attempted suicide, significant injury or unanticipated death (whether a staff member or facility program negligence).

d. The Division's designated recipient of PM 46 reports shall report all allegations of assault, abuse, neglect, mistreatment, financial exploitation, attempted suicide, significant injury, or unanticipated death to the Office of the Secretary; the Office of the Attorney General/Medicaid Fraud Control Unit (for Medicaid and/or Medicare certified long term care facilities); the appropriate state licensing agency for the program, if applicable; and the Division Director or designee, within 24 hours of receiving notification of such. In instances where a suspected crime has been committed, the police must be notified immediately and they will take the lead in the investigation of the suspected crime.

e. In instances where there is immediate danger to the health or safety of a resident/client from abuse, mistreatment or neglect; any sexual assault or alleged sexual assault; any physical abuse that leads to injury; any allegations of verbal abuse; any allegations of vandalism; any allegations of financial exploitation; any suicide; any assault or alleged assault, any suspected criminal action; or if a resident/client has died because of suspected assault, abuse, mistreatment, neglect, suicide, or significant injury, the Division Director or his/her designee shall immediately notify the appropriate police agency. The Division of Long Term Care Residents Protection, and the Office of the Secretary, shall be notified if the police were contacted. Further, the Division Director or his/her designee shall notify the Office of the Attorney General/Medicaid Fraud Control Unit, the Office of the Secretary, the Chief Medical Examiner, if a

resident/client has died because of suspected assault, abuse, mistreatment, neglect, suicide, significant injury, if the death is unanticipated or has happened as a result of any cause identified by 29 Del. C., section 4706 and Title 11, Chapters 5 and 94. In accordance with Title 16 § 5162, the Division Director or his/her designee shall notify the Community Legal Aid Society, Inc within seventy-two hours of the date of any patient or resident death.

f. The Division Director or his/her designee shall review the initial incident report and initiate an investigation into the allegations contained in the report. The investigation, with a written report, shall be made within 24 hours, if the Division has reasonable cause to believe that the resident's/client's health or safety is in immediate danger from further assault, abuse, neglect, attempts of suicide, or mistreatment. Otherwise, the investigation and written Investigative Report, up to and including the Division Director's or designee's signed review of the report, shall be made to the Division of Long Term Care Residents Protection (DLTCRP) within 10 days. This timeframe may be extended by DLTCRP if extenuating facts warrant a longer time to complete the investigation. If the facility is a Medicaid-Medicare certified long-term care facility, or an ICF/MR facility, the report of suspected assault, abuse, neglect, mistreatment, financial exploitation, attempted suicide, significant injury or unanticipated death shall be sent to the appropriate authorities, as required in the respective regulations under 42 CFR, within 5 working days of the incident.

g. The investigative process shall be confidential and not subject to disclosure both pursuant to 24 Del. C., section 1768 and because it is privileged under the governmental privilege for investigative files. Each Investigative Report shall be labeled as confidential and privileged, pursuant to 24 Del. C., section 1768. Each investigation shall include the following:
    1. A visit to the facility or other site of incident.
    2. A private interview with the resident or client allegedly abused, neglected, mistreated, whose finances were exploited or whose injury was significant.
    3. Interviews with witnesses and other appropriate individuals.
    4. A determination of the nature, extent and cause of injuries, or in the case of exploited finances, the nature and value of the property.
    5. The identity of the person or persons responsible.
    6. All other pertinent facts.
    7. An evaluation of the potential risk of any physical or emotional injury to any other resident or client of that facility, if appropriate.

h. A written report (Investigative Report) containing the information identified in V (g) shall be completed within the time frames identified in V (f) and shall include a summary of the facts resulting from the investigation. (Attachment 3)

i. The Investigative Report shall be sent to the facility director and to the Division Director or designee. The Facility Director and the Division Director or designee shall review the report. If the incident is serious, the

Division Director must review the incident with the Department Secretary prior to the completion of the report. The Facility Director and the Division Director or designee shall indicate in writing their concurrence or non concurrence with the report. If the facts show that there is a reasonable cause to believe that a resident/client has died as a result of the abuse, neglect, mistreatment, significant injury, or the death is unanticipated, the Division Director or designee shall immediately report the matter to the Office of the Attorney General/Medicaid Fraud Control Unit, the Division of Long Term Care Residents Protection, and the Office of the Secretary.

j. All Investigative Reports shall be forwarded by the reporting division, forthwith, to the Division of Long Term Care Residents Protection. The Division of Long Term Care Residents Protection shall complete the investigation by making a determination of findings and documenting their conclusions.

k. If a determination is made at the Division level (upon consultation with the Division of Management Services, Human Resources office) that discipline is appropriate, the Investigative Report shall be forwarded to the Human Resources office. Human Resources shall determine the appropriate level of discipline, forward their recommendations to the Office of the Secretary and to the originating division for implementation, and proceed as appropriate.

l. The Office of the Secretary shall be informed by the Division of Long Term Care Residents Protection, in writing, of the results of the investigation, including the findings and recommendations, within 5 days following the completion of the investigation.

m. The Division Director or designee shall notify the appropriate licensing or registration board, if the incident involved a licensed or registered professional, and the appropriate state or federal agency, including the appropriate state licensing agency of the program, if applicable, upon a finding of: 1) assault, abuse, mistreatment, neglect, financial exploitation, attempted suicide, significant injury or unanticipated death; 2) failure to report such instances by a licensed or registered professional; or 3) failure by a member of a board of directors or high managerial agent to promptly take corrective action.

n. The Division Director or designee shall notify the employee, resident/client, the guardian of the resident/client, if applicable, and the incident reporter of the results of the facility-based case resolution, unless otherwise prohibited by law. They shall also advise the parties of the fact that there is a further level of review that will occur through the Division of Long Term Care Residents Protection and/or the Office of the Attorney General/Medicaid Fraud Control Unit.

o. The Division of Long Term Care Residents Protection shall, at the conclusion of their review of the case, notify the DHSS employee (or the agency director for contract providers), the resident/client, or the guardian of the resident/client, if applicable, and the originating Division Director or designee, of the substantiated or unsubstantiated status of the case,

unless otherwise prohibited by law. The Division of Long Term Care Residents Protection shall also notify the Office of the Attorney General/Medicaid Fraud Control Unit of all substantiated cases.

VI. IMPLEMENTATION

a. This policy shall be effective immediately (upon the completion of mandatory departmental training).
b. In carrying out this policy, all parties must protect the confidentiality of records and persons involved in the case, and may not disclose any Investigative Report except in accordance with this policy.

VII. EXHIBITS

a. Attachment 1 - Delaware Code, Title 16, Chapter 11, Sections 1131-1140.
b. Attachment 2 - Delaware Code, Title 29, Chapter 79, Sections 7970-7971.
c. Attachment 3 - Investigative Report form
d. Attachment 4 – Delaware Code, Title 11, Chapters 5 and 94.

Rita M. Landgraf 11/27/13

Rita M. Landgraf
Cabinet Secretary

Date