ID/DD Nurses & The Justice Center for the Protection of People with Special Needs 2017

NYS ID/DD NURSES ASSOCIATION, INC.
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Why are folks in this industry?...

Helping others achieve their dreams

Todays Goals

- Empower with useable and easy to implement tactics
- Discussion…want to hear from you

The concepts we discuss today may help not just with the JC but civil liability, licensing and some have applicability in any location a medical professional practices.

Nothing herein is intended to conflict with or supersede applicable laws, regulations and policies (they control)

No legal advice; general considerations

- Justice Center and OPWDD are not the enemies…they are trying to protect vulnerable persons
- Shortcuts, laziness, poor systems; these are the enemies we must and <u>can</u> deal with
- Focus on what you can do…and do it as part of your daily routine.

Protect Quality

- Not trying to get you out of accountability.
- Never stop trying to make things better for those we serve.
- Limit negative impacts for less culpable situations and help you function in your job
- Protecting you should in effect protect those you serve

All Medical Professionals have to account no matter where they practice

- Criminal (i.e. false records)
- A.P.S. /C.P.S.
- Education Law, etc.
- Lawsuits
- Hospital/Institutional QA departments

JC adds a layer to ID/DD RNs

- New punishment; categories 1, 2 & 3 and the “list” (? Of impacts) and
- New/different standard of care

What specifically changed with JC June 2013 ?

- Investigations now criminal proceeding (in addition to QA)– Can it be both?
- Perpetrator centric; Is the teachable moment gone?
- Definitions are different, i.e. Neglect
- Categories 1-4 for substantiations a/k/a convictions
- "List"- more than exclusion list
  - A state held list that shows any finding of abuse or neglect against a disabled/vulnerable individual
  - Permanent – only "sealed" after 5 years
  - At a seminar in April 2016 the JC stated that category 3's are not reviewable by outsiders and only kept to look for trends…hopefully stays that way
- Statutory appeal rights added
- Reduced confidentiality in substantiated cases also CAP audits are subject to freedom of information requests
- Jurisdictional confusion between OPWDD and JC.

JC interactions

- Something you might run into while doing something enjoyable…seems to have three possibilities:
  - May not ever experience it
  - Might run into it and fix it quick (goes away)
  - Or it might be a larger/longer impact

The “key” is prevention

JC developments and trends

- As of 2017 lawyers can be at interview
- Overlapping jurisdiction issues coming to surface
- Automobile infractions; cat 2 [do all infractions seriously endanger the health, safety or welfare of service recipients ?]
- RNs:
  - Pressure wounds
  - Failure to check previous records
  - Policies not followed
  - Medication ordering (2017-22)
  - Delays in “medical care” (2016-162)
  - “hospital coverage” (policy ,2016-29)

Correct a misperception

- Defensive practice, self advocacy; taking steps to protect yourself and your agency should if done correctly lead to better care for individuals…

- Some mistakenly believe that such steps indicate self preservation over care of those served: not true if done correctly. Should not be a zero sum game.

How to protect yourself

Three general areas to consider

1. **Before Investigations/Incidents (prevention)**
   - Help establish RN responsibilities in policies and plans
   - Work in a system of best practices; systemic consistency/defensive practice/charting tips and make it part of your daily routine
   - Talk with QA (train them)
2. **Investigation Stage**
3. **Appeals**

Start with:

Self advocacy and protecting yourself is a primary goal; this not contrary to providing quality service to individuals

"Neglect"
everything relates to the definition

- Action/inaction/lack of attention.
- Breach of custodian's duty. [what is RN's duty? Two elements; responsibility and/or medical standard of care?]
- Results in or "likely" to result in [NOT "potentially"]
- Physical injury [significant worsening or diminution of physical condition SSL 488(6)] or serious or protracted impairment (of physical, mental, emotional) [does slight intermittent pain meet this definition of injury?]

Each element must be met by "preponderance of evidence"

You and the Investigator need to understand intricacies of the definition and use this language. The words were chosen by legislature to limit minor incidents. Quality versus protecting form bad acts

1. Before Investigations/Incidents

a. Be Involved in establishing RN responsibilities

- Agency policies – simplify & clarify where your responsibility ends
- Know what you are accountable for
- Beware of responses to regulators like CAP or POCA, that increases your responsibility
- Beware of agency decisions, like admission of high medical needs, that may increase your responsibility; such items should be reviewed by nursing

Where do RN responsibilities arise?

- Policies, i.e. Nursing Oversight Policy
- Administrative memos, i.e. OPWDD ADM # 2003-01 (duties of RN with direct care staff)
- Regulations
- Statutes, i.e. Practice of Nursing, NY Education Law § 6902
- 45/60 day letters or POCA- OPWDD
- Corrective Action Plan and audit - JC
- Which can you impact?

Policy considerations

- Are RNs involved in policy making?
- Carefully delineate RN responsibilities (meet regulations); you are responsible for anything in policies that exceeds regulations. "If you write it, you own it"; public policy issues
- You cannot create holes in care or avoid obligations otherwise established. Thus you <u>cannot</u> simply go through policies and remove RN related responsibilities.
- Any changes to RN responsibilities need to be done carefully and consistently with governing rules.
- Generally, if no license needed try to delegate to appropriate staff; increase agency efficiency and focus RNs on important medical issues.

Policy wording

- For policies that may be referred to during an event consider a checklist format
- Use caution restating first aid requirements if not necessary; do not create medical treatise (do not want inconsistencies with training)
- Consider including RN discretion where appropriate
- Best practice versus mandatory reg/policy requirement? “RN shall do X, additionally RN may in RN’s discretion do Y as well, however Y is not mandatory”
- Include a training component in policy implementation, proof of training and who is responsible to get to training.

Policy wording con't

- Be careful in word choice of policies i.e.:

"the agency shall deliver the best, highest quality care known to mankind, meet every medical need of those served and make everything perfect" or

"the RN is responsible for everything medical, make all assessments and make sure every medical issue is resolved everyday "

Why is this a concern?

Well intentioned language can, if drafted poorly, become enforceable: by regulators and in court; it becomes the standard you are measured by.

Chose wording carefully like: "the agency endeavors to provide …"

- Disclaimer language?

Policy wording example to clarify role of RN

- Currently reads:
  - "The RN completing the initial medication practicum or recertification will ensures that the DSP has demonstrated the knowledge required for this policy."
- Can the following be added ?:
  - "DSP staff are responsible to schedule all required practicums or re-certifications and maintain required certifications. "

b. Best Practices

- Create and operate in a system; provide for automatic diary /checking, limit the number of documents written, cut and paste, do not rely on "remembering", use calendars and checklists. Seek help to correct bad systems.
- Every phone call, review or consult is potential liability for you; treat them accordingly;
- ON CALL RN must emphasize record
- Records are your best defense; write them to defend you
- Write for third parties to read: "Billboard Test".
  - Surveyors, investigators, judge, jury, family, fellow staff, etc.
- Write not just what you did but why – basis of your decision. Self-explanatory
- Explain variations in protocols or plans of care
- Record should be understandable and stand on its own

c. Charting Tips

- Concise, bullet points, not long winded; justify action
- No speculation: cite facts or reported facts. i.e. "found on floor" vs. "fell" – DC staff is generally bad with this concept
- Careful with conclusions and charting blame unless very relevant
- Note time and whom you spoke with
- Use quotes or say " X reported"
- Do not attack staff/others – leave personal observations out: i.e. "not happy with manager" v. "notified manager on Tuesday no action taken"
- Changes can be made to records if done properly. Follow protocols: i.e. note date of change and sign
- Never try to edit record to cover up – ILLEGAL
- Never add under anyone else's name (don't sign in under different name) – ILLEGAL

1. Before Investigations/Incidents cont’d

d. Practice Traps

- Ask all relevant questions, “staff didn’t tell me that” – if you don’t ask, ignorance may not help. “staff stated no other symptoms”
- “Individual refusals” – document refusal and multiple, good faith efforts to get them to comply…i.e. PRESSURE WOUNDS and DIABETES
  - Individuals have no right to make bad decisions
  - Use outside help i.e. MDs and family
  - Pursue to discharge if refusals threatens well-being.
- Do not let things sit unresolved! (i.e. MD Orders & prescriptions)
- Beware of MD “suggestions”, “recommendations” ; clarify
- ER Discharges
  - Does not mean individual is okay
  - Beware of multipage general information with directions buried within
  - Follow-ups (system)

Practice Traps Continued 2 of 2

- Caution in relying on someone else to follow-up, have a way to confirm it was done

  Medical Issues: Delegation must not be outside of the scope/ability of the staff and you may be ultimately responsible.
- Issues you can't fix; do not let sit.
  - Seek outside medical or kick upstairs.
  - Document your efforts.
- "Observation" – gets odd treatment in OPWDD world; explain in record why done (why not send to ER), what staff is monitoring "go to ER if appears in pain" and condition of individual; "not exhibiting pain"
- Know individual's background before giving advice (i.e. with falls beware of osteoporosis, if not sure assume it)
- Think advocacy; what needs to be in record to protect me?

- General areas of concern for RNs:
  - Missing follow-up (i.e. MD orders, testing, prescriptions)
    - Create systems to help prevent this oversight, i.e. software and involve other staff
  - Delays in seeking treatment (i.e. observation, wound care)
    - “When in doubt send out” (? Of public policy to save medical visits/cost)
    - When “observing” mark records carefully why being done. Is this a “medical treatment”?
    - Use outside resources; you are not on an island.
  - Beware of missing things in record especially transfers/new/vacations…need system

e. Review RN Incidents and interact with QA

- Make sure QA understands the concepts of:

  1. "professional medical discretion", not all medical decisions work out perfectly and
  2. The true definition of Neglect;

- RN Departments or nurse organizations should do "root cause" analysis of incidents against RN's.
  - Look for trends
  - Work together, distribute best practices
  - Limiting claims protects quality
  - Consider systemic issues, look past individual omission

You can win with best practices

2. Investigation Stage

You get the call from the investigator; now what?

remember:

You have rights…sort of

&

As a medical professional you are in a unique position

It is generally believed you have the following "legal" rights when dealing with the JC: *

* Robert Hussar, Partner, Barclay Damon , power point presentation "The Broad Reach of the Justice Center: How to Protect Yourself and Your Agency", June 9, 2016 Buffalo, New York

- To remain silent (you do not have to agree to be interviewed).;
- To ask if you are a target (subject) of the investigation;
- To ask if the investigation is criminal in nature OR has the potential to become criminal in nature;
- To request immunity from prosecution if you agree to be interviewed;
- To pick a location to meet. You can refuse to meet investigators either at work or at another private or public location (park, coffee shop, etc.);
- Not to be a witness in any trial (unless you are subpoenaed).
- **As of 2017 the JC says you can have an attorney present during questioning.**

NOTE: "legal" rights do not equate to employer policies and expectations; you may face employment penalties if you refuse to participate. Difference between legal rights and employer obligations.

“rights” continued

- You may not be informed about these legal rights.
- You may get pressured to participate and or intimidated during questioning; if that happens contact HR immediately and consider stopping the interview.
- “Obstruction” does not apply to the exercise of your legal rights
- Not participating does not mean the JC cannot take action against you anyway

You do not have the right and you should never:

- Lie, create fake information or alter documents, talk to others in an attempt to intimidate them or work together to create a consistent perspective or otherwise obstruct the investigation in any way. Cover-up can be worse than initial allegation; follow your agency incident policy.

2. Investigation Stage

tips when part of investigation (witness or target) 1 of 4

- Be truthful, understand why being interviewed and take it seriously
- Help investigator frame and understand issues within medical context
- As a medical expert use definition language: "There was no likelihood of injury", " there was no significant worsening or diminution of or serious or protracted impairment"
- Delineate your limited role/interactions "duty": 1. you may not be responsible (even in medical cases) - not "treating" professional 2. you may have fulfilled all medical standards of care.
- "Professional Judgement" & "Medical Standards of Care"; may impact "custodian's duty"
  - i.e. "Reasonable medical practice is to observe the same when there is little pain…" and/or "there was no injury or likelihood of injury arising from that.."
  - basing decisions/assessments regarding individual's health on current practice protocols like "Triage Logic"

Investigation Phase Cont'd

- As medical professional you are, in some cases, in a unique position to defend your actions; "medical expert". "In my professional medical opinion …" (use caution giving medical opinion regarding third party actions since you may not have all the relevant facts)
- Get your side of the story out. They may not ask relevant questions, show them why you took a certain tack. Don't assume they know your position and don't accept facts you don't know.
- Occasionally facts get misrepresented use caution in responding to things that don't sound right.
- Ask to see and review documents that may be relevant. If investigator doesn't have documents – you may not be able to answer; "can't say for sure".
- Don't feel pressure to fill gaps in conversation. Silence is an interview ploy.
- Avoid negative comments about others, focus on you.
- Use neglect definition terms: "that is not my duty", "that was not likely to cause an injury", "there was no significant worsening or diminution of physical condition"…

Investigation Phase Cont'd

- Be careful of questions that seek a conclusion (about you or others), i.e. if "A &B happened does that = neglect"? "I don't know, need more facts i.e. was there an "injury"?"
- Careful of admitting wrongdoing inadvertently – "I could have done it better". That is an admission. i.e. question "Is there anything you could have done differently"? Answer "Not with the facts I had at the time". There is a fine line between showing an interest to do better and an admission of guilt. "I always want to do a better job" is ok.
- Remember to keep everything strictly confidential, however there is virtually no confidentiality to what you say in substantiated cases; thus family and targeted staff may read your testimony.
- Do not let investigators end inquiry with simplistic QA standards (i.e. policy not followed) get them to consider medical discretion and each element of the actual definition.

Investigation Phase Cont'd

- Don't be afraid to ask questions understand what the issue is.
- Don't be led into answer, "Isn't it true Johnny had a seizure because he did not get his medication? Answer "I do not know they are related"
- Use caution adopting their language: "so you dragged him…" "No I moved him gently along the floor to allow access…"
- Don't be forced to give definite answer if you are not certain
- Do not let the result (i.e. a negative medical outcome) drive the conclusion; get them to understand what you did with what you knew, to look at things from your perspective. Not retroactively. "At the time I was presented with the following facts…my action was based on those, I am not a fortune teller". Thus you may have met your "duty"
- Affirmatively advocate your position. Be proactive but don't add things that are not relevant to the issue.
- Medical issue may not necessarily be an RN error, know what you are responsible for and clarify your role.
- Role of lawyer/ right to silence

Investigation Phase Cont'd

Interview example; How it should go

Question; "Isn't it correct that you directed staff to put the individual to bed and it turned out the following day he had a fracture and he suffered all night?"

Potential answers:

a. "yes" (this frequently the end of the inquiry and basis of finding)

versus

b. "Can I please see the notes from the call?...You can see here that the individual was not exhibiting any outward signs of injury (swelling, motion, bruising) and little or no pain, from a medical standpoint it was appropriate to give Tylenol put to bed with specific directions to monitor including what to look for including pain or discomfort. If the individual was truly exhibiting pain or discomfort then the staff should have called back or gone to ER. The fact that the next day staff noticed continued pain and called me back where I directed a doctor visit is consistent with appropriate medical care. The care provided did not result in additional injury and the pain was only intermittent and minor. No negative medical outcome arose from the care provided. There was no "injury" as defined …"

-if the individual was in pain then the DSPs may have committed neglect but not the RN (sometimes in these cases pain seems to be assumed)

-observation is medical care and did the RN breach a duty?

3. Appeals

Appeal Process; "requesting amendment" SSL 494

- Never had before – chance to challenge both substantiations and assigned category.
- 2 step process; letter review then a hearing. Strict time frame; miss by a day and you are done
- Appeal letter should be comprehensive (facts to each element of definition) and reserve the right to amend based upon review of the file.
- Immediately upon receiving the LOD, ask for a copy of investigation and everything in investigator's file. (SSL 496(2)(a). Also demand any IRC minutes. If they don't give you the whole file note as objection in writing and at the hearing.

3. Appeals cont'd

Appeal Process Administrative review letter

- Point out errors in assumptions and facts. Attack errors and attack omissions (what is not in report can be important)
- Fill out record: i.e. facts or provide medical standards or policies. Don't assume the JC knows or understands.
- Confirm individual is covered by JC: "A "facility or provider agency" is, generally, a facility or program that is operated, licensed or certified by OPWDD", more and more programs are uncertified
- Look at each element of the definition and using those terms show how all or any or not met by a preponderance of evidence
- You can ask your employer for records; sent to the JC and you request from JC. Never take records directly
- Stress professional judgement/discretion and standards of care and your role: "met my custodial duty"
- Consider a lawyer
- Few decisions are changed at this stage, do not get disheartened
- If agency investigator and IRC did not substantiate make sure that is known by hearing officer and tell them who sits on the committee, i.e. MD or RNs, may not control but should help (2016-164)
- Go to hearing; as RN you are in unique position

Medical Expert

- You are more than just another staff person, you are a medical professional and possibly an expert witness.
- This is relevant in certain cases depending on the exact issue, i.e. defining “custodian duty”, “likelihood of injury” or “injury” itself.
- Explain why observation was appropriate, that a delay may not have actually caused any injury
- Qualify yourself:
    - I have the following education…
    - I have the following training…
    - I have given presentations as follows…
    - I am a member of the following professional groups…
    - I hold the following license/certifications…
    - I have the following experience…
    - I am an expert in the care of ID/DD individuals
- Why it matters…question of proof

Analysis of Guilt; plan of defense

- First, question and verify facts are accurate (never assume). Make them prove their facts in hearing then show if not accurate. This may involve adding some addition items not necessarily contradicting their version. "Did it happen as alleged ?"
- Second, each element must be met by "preponderance of evidence"

For Neglect

- Action/inaction/lack of attention.
- Breach of custodian's duty. [was it your responsibility? "not my job", or did you perform medical standard of care? "did everything I could"]
- Results in or "likely" to result in [NOT "potentially"]
- Physical injury or serious or protracted impairment (physical, mental, emotional) [was this met? "significant worsening or diminution of physical condition" SSL 488(6)]

Force focus on definition terms, not on: "it could have been done better", "that outcome was not idea", "there was a delay", "you did not follow protocol exactly"…these maybe relevant for QA, but not alone controlling for neglect conviction. It is not as simple as showing a violation of policy; need to show how that violation meets the definition.

Hearing

- The JC tries to limit appeals by a number of tactics;
  - Strict timeframes: if not start review timely…done
  - Not providing the investigation and all other material in the file on a timely basis as required under SSL 496(2)(a). They make you demand it, so demand it, all of it immediately.
  - Formality: they will require your participation in pre-trial meeting and disclosure of witnesses (witness list: "the following ……….and all individuals interviewed in the investigation, any witnesses needed to contradict those witnesses or any other witnesses of the JC and I reserve the right to call others that may be material based on facts as presented")
  - Delays: they drag the process out for months, some folks lose interest
  - Intimidation: JC will be represented by an attorney who knows the procedure and lexicon. Do not let them push you around.
  - Remember you are the expert simply get your points out.
- The JC also may change its theory of liability to work around proof you submit; they should be limited to the theory outlined in the investigation.
- The burden of proof is on the JC to prove each fact at the hearing. SSL 494(1)a; careful stipulating to facts or admission of documents

DO NOT BE INTIMIDATED

Future RN care considerations

- Consider new technologies;
  - New drug therapies i.e. Injectables
  - Telehealth; different types of setups and regulatory issues
  - Properly integrated software (use caution)

- Shift to managed care;
  - Opportunity
  - What does this mean for ID/DD RNs?
  - Public Policy cost saving v JC issues
  - Understand shifting responsibilities
  - Partnerships with medical providers

QUESTIONS & DISCUSSION

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