97-19 Nurse Aide Misconduct Investigations, Department of Health and Family Services

Summary

Nursing homes, home health services, and other providers of health care services frequently employ staff to perform routine patient care such as monitoring patients' conditions, assisting with personal care and activities such as eating, and carrying out nurses' and physicians' orders. Generally referred to as nurse aides, these staff typically are paid less than $10.00 per hour; many work part-time and non-standard schedules.

Nurse aides have close contact with dependent or vulnerable patients, which frequently occurs when no one else is present, providing opportunities to abuse, neglect, or steal from patients. To protect vulnerable patients, both the federal and state governments have instituted a system of training and certification requirements for nurse aides and a system of investigating complaints of misconduct by nurse aides.

To implement these federally required safeguards, the Department of Health and Family Services created the Nurse Aide Training and Registry Unit. This unit establishes the training requirements for nurse aides, certifies training programs, and maintains a registry of individuals who have successfully completed the requirements for certification. This unit also investigates complaints of abuse, neglect, or theft by nurse aides that occur while the nurse aide is employed in a nursing home, hospital, home health agency, hospice, or facility for the developmentally disabled. If an investigation determines that the nurse aide engaged in "willful and wanton" misconduct, and if the decision is not successfully appealed, this finding is permanently recorded on the registry. All nursing homes and some facilities for the developmentally disabled receiving Medicare or Medical Assistance payments are prohibited by federal regulation from hiring any nurse aide designated on their state's registry as having engaged in misconduct.

Currently, more than 106,300 nurse aides are listed on the registry in Wisconsin, approximately 23,800 of whom are employed by nursing homes. Only a small minority are found to have engaged in misconduct: during its five years of operation, the nurse aide unit has determined in 439 cases that aides engaged in conduct serious enough to merit a notation on the registry.

In late 1996, concerns were raised that complaints of nurse aide misconduct were not being resolved promptly and that a backlog of unresolved complaints was accumulating. In March 1997, a series of newspaper articles drew attention to the concerns of family members and others regarding delayed investigations of nurse aide misconduct. In addition, the limitations of the Department's authority to take action on complaints of misconduct by nurse aides employed by health care providers other than nursing homes, hospitals, home health agencies, hospices, and facilities for the developmentally disabled raised concern that current laws were not protecting all vulnerable patients.

As a result, the Joint Legislative Audit Committee directed a review of the Department's efforts regarding nurse aide misconduct, and a broader evaluation of the Department's efforts to ensure quality nursing home care, which will be addressed in a subsequent report. In addition, the Legislature included provisions in the 1997-99 biennial budget that significantly expand the Department's responsibilities related to misconduct by health care employes within the next few years. The Department responded to the concerns by assigning temporary staff to reduce the backlog of unresolved complaints and by conducting an internal management audit. This internal management audit was completed in April 1997 and identified several potential program improvements, some of which have been implemented.

In fiscal year (FY) 1996-97, the unit's expenditures were approximately $784,800, of which $522,700 was federal funds and $239,300 was state funds. The remaining expenditures were funded by program fees. The Department estimates that 75 percent of the unit's expenditures were related to responding to complaints of nurse aide misconduct; the remainder supported the nurse aide training, certification, and registration functions. In December 1996, the program

operated with 10.9 full-time equivalent positions, 6 of whom were investigators. Additional staff, known as surveyors, conduct separate investigations of the facilities in which the misconduct is alleged to have occurred, as well as intake for the majority of complaints in the Department's regional offices.

Most reports of nurse aide misconduct received by the Department are made by nursing home administrators, who are required by federal regulations to report possible misconduct to the Department within five working days of becoming aware of the alleged incident. Typically, the nursing home administrator will initiate, if not complete, an internal investigation before contacting the Department. Nursing home administrators who do not report suspected misconduct could be subject to professional discipline, and their nursing homes could be subject to regulatory action.

The Department's resolution of a complaint of nurse aide misconduct involves three separate components. First, the Department must determine whether the complaint merits further investigation. Although 5,947 complaints have been reported since 1992, only 2,128 were accepted for investigation. Examples of complaints that do not merit investigation are those that fall outside the Department's jurisdiction, such as when the accused individual was not employed as a nurse aide, or those that describe conduct that could not be considered misconduct even if true. Decisions to pursue investigation are generally made in five to seven days.

Second, the Department must determine whether the nurse aide's employer took appropriate and timely steps in response to the reported misconduct, and whether conditions exist within the facility that might allow similar misconduct to recur. This investigation is conducted by surveyors in the regional office, sometimes in conjunction with other work performed within the facility, but it is usually completed within 60 days.

While these first two steps are generally performed in a timely manner, the third component of the Department's response to complaints of misconduct—the determination regarding the nurse aide's alleged misconduct—has been characterized by significant delay and a large backlog of complaints awaiting resolution since the inception of the program. These investigations are performed, except in rare cases, by staff in the central office in Madison.

Federal policies governing the program require states to "assure the timely review and swift investigation of allegations." Wisconsin Administrative Code is more specific: it directs the Department to complete investigations within 60 days after the complaint is made. However, the Department appears to have anticipated and tolerated lengthy processing time for misconduct investigations. For example, written procedures for these investigations instruct staff to inform facility administrators "not to expect results of (the) investigation quickly." Of the 1,918 cases resolved from the beginning of the program in 1992 until September 1997, only 80, or 4.2 percent, were completed within 60 days. The average time to disposition has been 345 days.

This delay raises serious concerns about the level of protection provided to those who receive care from nurse aides. Although accused nurse aides are often dismissed from employment by the facility in which the conduct is alleged to have occurred, they are free to seek similar employment with another facility until the Department reaches its determination. In our review, we found cases in which delay reduced the ability of the Department to conduct a useful investigation: by the time the investigations were initiated, the nurse aide had been found to have engaged in misconduct in another case, the nurse aide or witnesses could not be located, or the alleged victim had died. Finally, prompt resolution of the misconduct complaints is necessary for other reasons, including fairness for the accused nurse aides, and to promote efficient operation of facilities employing nurse aides, which in many cases have difficulty hiring sufficient qualified staff and in some cases may retain the accused nurse aide on paid suspension until the case is resolved.

We examined 70 seriously delayed cases in detail to determine the points at which delay was occurring. Among these cases, the fact-finding portion of the investigation was not a source of significant delay. Once the case was assigned to an investigator, work was completed within an average of 47.6 days, or only two days more than prescribed in program procedures.

Instead, delay has occurred mainly at two other points. First, in the 70 significantly delayed cases reviewed, assignment to investigators occurred from approximately 8 months to more than 36 months after complaints had been received by the Department. Program staff described a practice of expediting assignment of cases involving more serious allegations, but only 13 of 70 long-delayed cases involved allegations that could be characterized as minor, such as

verbal abuse or thefts of small value.

The delay in assigning cases to investigators was the result of a backlog that developed soon after the Department began to handle misconduct complaints. The Department points out that staff were not hired as investigators until nine months after the first complaints were received and the number of pending cases had grown to 234. Later, from January 1993 through July 1995, more than half of the investigative staff consisted of limited-term employes who could work no more than six months, although managers report that six to eight months of experience are needed before an investigator can handle a full caseload. Beginning in August 1995, the Department assigned additional permanent employes as investigators. However, other factors, such as low morale, inadequate written guidance for staff, and assignment of the investigative staff to other projects, reduced productivity. By the end of December 1996, the number of pending cases had grown to 477.

In early 1997, the Department took steps to reduce the backlog by assigning additional staff, both permanent and temporary, to investigate complaints. By focusing on less serious allegations of misconduct, the unit was able to reduce the backlog of cases by more than one-half, to 210 by August. The entire backlog is expected to be eliminated by March 1998. The Department has also recently adopted productivity standards for the investigative unit, but the program's experience indicates that these standards may be too low to encourage adequate productivity; we have recommended that the Department re-examine and revise these standards.

The second significant delay occurred after the investigators submitted their work to an internal review process. Internal review took an average of 75 days among all completed cases and more than 10 days—that portion of the 60-day processing period available for internal review—in 88.0 percent of the cases. Program managers attribute lengthy internal review to the quality of the investigators' work, which is frequently not accepted as complete until the investigators have gathered additional information and corrected such information as the job titles and spelling of witnesses' names. Lack of effective guidance and supervision provided to investigators contributed to these problems.

In addition, the quality of the investigators' work may have been impaired by inadequate training and unclear assignment of authority to direct and review their work. The Department has taken steps to improve training and has reclassified the lead investigator position to be an investigator supervisor, although that position is not currently filled. However, the Department will need to ensure that these improvements lead to the elimination of the delay in internal review. We have recommended that the written procedures to be adopted contain timeliness objectives for internal review as well as other steps, and that the entire process require no more than 60 days.

Other aspects of program management have also contributed to delay or reduced program managers' ability to identify and address these problems. The Department has moved to address a lack of adequate management information by providing program staff with software and training to create a case-tracking system until a larger but outdated information system for regulatory functions is replaced. In addition, we have recommended some procedural efficiencies, such as asking accused nurse aides if they will consent to having misconduct noted on the nurse aide registry before an extensive investigation is initiated, and increasing the misconduct investigators' access to case-related information gathered by the regional office at the time they begin their investigations.

If the Department implements recommendations of its internal management audit that will help to reduce the time needed to reach resolution, as well as the recommendations of this evaluation, we believe it is reasonable to expect that misconduct complaints could be resolved within an average of 60 days of the date received. Although a limited number may require some additional time, a resolution process that generally takes longer than 60 days is neither acceptable, because of the potential consequences for the individuals under the nurse aides' care, nor consistent with federal policies that require timely review and swift investigation. Furthermore, recently adopted state legislation will increase the Department's responsibilities for responding to complaints of misconduct by health care and supportive care workers, and possibly necessitate a more thorough redesign of the program.

Under provisions of 1997 Wisconsin Act 27, the Department will be responsible for investigating suspected misconduct by all individuals employed by or under contract with providers who have contact with patients, not just nurse aides, beginning in October 1998. The legislation also requires many additional facilities, organizations, or services to report allegations of misconduct beginning in October 1998, including community-based residential facilities, home health

agencies, hospices, hospitals, and treatment facilities for the alcohol dependent. Now, only nursing homes receiving federal reimbursement are required to report suspected misconduct.

Finally, the legislation also introduces expanded requirements for criminal background checks of all types of employes in a wide variety of health care and supported-living settings, beginning in October 1999. Act 27 authorized 13.65 new positions to carry out these responsibilities. However, the precise number of staff needed will not be evident until the program is underway.

As the Department designs new programs to incorporate expanded responsibilities for misconduct investigations, it will need to take steps to ensure that problems similar to those that created and maintained a backlog of nurse-aide complaints are avoided in the new program. These include:

- ensuring that the new complaint-resolution procedures provide for appropriate coordination with the Department's current responsibilities, so that existing information and resources are used efficiently;

- establishing specific time guidelines for each step of the new procedures, and providing program managers with the capability to monitor the investigations' timeliness;

- providing program staff, upon initiation of the new program, with adequate written guidelines for the complaint-resolution procedures; and

- ensuring that authorized positions are filled upon initiation of the new responsibilities, and that staff productivity is monitored to determine the number of staff needed to handle the volume of complaints received.

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