Virginia Department of Behavioral Health & Developmental Services

# FACILITY LOOK-BEHIND STUDY

## The Office of Human Rights

# Facility Look-Behind Study

## First Year Results (CY 2017)

This is the first annual report for the Facility Look-Behind (FLB) study conducted by the Office of Human Rights (OHR) in collaboration with the Office of Data Quality & Visualization (DQV). These first year results refer to retrospective reviews of closed human rights abuse investigations that occurred in calendar year 2017. Most state facilities are included in the sample (see definitions section for excluded facilities).

## Background

OHR previously implemented a review for community abuse investigations and has now expanded their study to assess investigations in state facilities. Although not directly related to the Settlement Agreement, it is considered a best practice as DBHDS works to build its quality management system.

Regulations outline the Department's responsibility for assuring the protection of the rights of individuals in facilities and programs operated, funded, and licensed by DBHDS (see definitions section for definitions of abuse).

## Reviews

There were 1,121 cases of abuse/neglect distributed for review; however, 8 reviews were not completed, reducing the total number of reviews to 1,113. Feedback on these 8 incomplete reviews indicated an unspecified duplication issue in the CHRIS reporting system, wherein some of these cases were duplicates of others already assigned for review. Furthermore, a distribution error resulted in CCCA receiving quarter 2 cases again in quarter 3. Therefore, 30 cases were removed from analysis, reducing the total number of reviews from 1,113 down to 1,083.

**Table 1. Abuse Allegation Types and Substantiated Cases**

| Abuse Type | Count | Substantiated |
|---|---|---|
| Neglect (Peer-to-peer) | 736 | 2 |
| Physical Abuse | 121 | 19 |
| Neglect | 111 | 36 |
| Verbal Abuse | 85 | 12 |
| Other Abuse/Neglect | 23 | 3 |
| Sexual Abuse | 22 | 0 |
| Restraint | 12 | 2 |
| Exploitation | 3 | 1 |

Of the 1,083 case reviews completed, 69 were substantiated for abuse (6%). The counts of substantiated cases differ in Table 1 because cases may have more than one abuse type. Three cases were substantiated under the category of 'Other.' OHR is developing plans to assess the 'Other' abuse type category in a separate study.

## CHRIS Data

Of these 1,083 cases, the initial allegations were reported in CHRIS within 24 hours of discovery in 659 cases (61%). Calculations were made between the date the facility director was notified and the date the advocate was notified. Advocates were instructed that if it was neither the same or next day, it was not reported within 24 hours. The CHRIS entry was closed by OHR within 60 days in 704 cases (65%). Although there may often be valid reasons why a case is not closed within 60 days, OHR has already begun work to address this administrative issue by including the closure requirement in each advocate's employee work profile (EWP).

An injury was noted to have occurred to the individual in 235 of the cases reviewed (22%). An open text narrative may also have been submitted during reviews regarding whether this injury received medical care. This narrative information will be assessed by OHR.

## Neglect Peer-to-Peer Reviews

During the first quarter of reviews, facility advocates provided feedback about cases of alleged neglect peer-to-peer (see definitions section) that typically do not undergo a full 201 facility investigation and therefore, most questions on the review form would not be applicable. Beginning with quarter 2 reviews, a new section of the review form entitled "Neglect peer-to-peer checklist" was developed to assess whether these particular cases underwent a full investigation.

Of the 1,083 cases reviewed, 736 were among cases where the only allegation was neglect peer-to-peer. Other cases may have neglect peer-to-peer included along with other abuse types.

For these 736 neglect peer-to-peer cases, the new section to identify full investigations among neglect peer-to-peer cases was available in 537 cases (quarters 2, 3, and 4). The section to identify full investigations was not available in quarter 1 reviews; therefore, these cases must be eliminated, as there is no way to determine which cases received an investigation.

Of the 537 cases of neglect peer-to-peer, the advocate identified a full investigation did not occur in most of these cases (459, 85%). Different facility actions were often performed in place of a full investigation, such as a special review by the facility Director or filing of an incident

report (51% and 52%, respectively). 'Other' unspecified actions were also noted to have occurred in 40% of these cases. This narrative information will be assessed by OHR.

In the 537 neglect peer-to-peer cases, advocates indicated that a full investigation did occur in 78 cases. Therefore, these cases were included in the full investigations section of this report. These 78 cases, in addition to the 345 cases reviewed that featured an abuse type that was not purely neglect peer-to-peer, comprise the final set of 423 cases that were included in the full investigations analysis.

## Full Investigations Analysis

Investigations were completed within the allotted timeframe in 328 out of the 423 cases (78%). Of the 95 investigations that were not completed within timeframe, Table 2 shows CHRIS data regarding whether an extension was granted appears to be divided among Yes (granted), No (requested but not granted), and N/A (never requested).

**Table 2. Investigation Completed within Timeframe and CHRIS extension granted?**

| | **Investigation completed within timeframe?** | | |
|---|---|---|---|
| **CHRIS Extension Granted?** | FALSE | TRUE | Grand Total |
| *(left blank)* | *23* | *73* | 96 |
| N/A | 28 | 217 | 245 |
| No | 25 | 28 | 53 |
| Yes | 19 | 10 | 29 |
| Grand Total | 95 | 328 | 423 |

Table 3 shows a higher proportion were N/A (never requested) as evidenced in the Investigative file. This may be an area for education regarding when to submit a request for an extension during investigations that exceed the allotted timeframe for completion.

**Table 3. Investigation Completed within Timeframe and Investigation file extension granted?**

| | **Investigation completed within timeframe?** | | |
|---|---|---|---|
| **Investigation File Extension Granted?** | FALSE | TRUE | Grand Total |
| *(left blank)* | 24 | 122 | 146 |
| N/A | 36 | 195 | 231 |
| No | 18 | 6 | 24 |
| Yes | 17 | 5 | 22 |
| Grand Total | 95 | 328 | 423 |

Several facilities did not respond to either question regarding the extension (indicated as "*left blank"*), despite having an N/A response option, and most non-responses were attributed to one

facility. Determining why advocates failed to respond to questions regarding investigation extensions may be an opportunity for improvement in future data collection or form re-design.

## Advocate Actions

Of the 423 full investigation cases reviewed, facility advocates indicated that 1,420 actions were taken (Table 4). The actions "Okay to Close" accounted for over half of all actions taken (807, 57%). "Reviewed Investigation Report" was the second most popular choice (396, 28%). OHR considers these actions to be 'passive' as they are generally applicable to all cases.

**Table 4. DBHDS Advocate Actions Taken for the 423 Full Investigation Cases**

| Advocate Actions | TRUE |
|---|---|
| OK to Close Case | 807 |
| Reviewed Investigation Report | 396 |
| Monitored Investigation | 94 |
| Other | 69 |
| Agreed with Provider's Corrective Action | 23 |
| Participated in Investigation | 10 |
| Recommendations for Corrective Action | 7 |
| Notified Client of Investigation Findings | 7 |
| Referral to Office of Licensing | 4 |
| Other notification | 3 |
| CSB/Licensed program notified | 0 |
| Conducted Independent Investigation | 0 |
| Citation of Violation sent to Office of Licensing | 0 |
| **TOTAL** | **1,420** |

Other actions are considered 'active,' meaning they go above general requirements and are indicative of the advocate actively participating in an investigation. 'Active' actions include "Participated in Investigation" (10, 1%) and "Recommendations for Corrective Action" (7, 1%).

Some actions may not be applicable in all cases, such as those involving Licensing or citations. The CCCA was the only state facility that held a license up until November 28, 2017, at which point they surrendered it to the Office of Licensing. Although these options will continue to be available in CHRIS as they pertain to community investigations, OHR may consider removing these actions from future FLB reviews.

## Corrective Actions

Of the 423 full investigation cases reviewed, advocates indicated that 481 corrective actions were taken by the facility in regards to the case, despite whether it was substantiated or not

(Table 5). "Appropriate Staff Action Taken" was the most popular choice (348, 72%), with "Reinforce Policy and Procedure" as the second most popular choice (35, 8%).

**Table 5. Corrective Action Taken by Facility for the 423 Full Investigation Cases**

| Corrective Action | TRUE |
|---|---|
| Corrective Action: Appropriate Staff Action Taken | 348 |
| Corrective Action: Reinforce Policy and Procedure | 35 |
| Corrective Action: Train Individual Staff | 27 |
| Corrective Action: Train All Staff | 18 |
| Corrective Action: Supervisory/Administrative Staff Change/Action | 13 |
| Corrective Action: Increase Staffing | 9 |
| Corrective Action: Improve QA | 8 |
| Corrective Action: Appropriate Notification to Office of Licensing Made | 8 |
| Corrective Action: Increase Supervision (Change Patterns of Supervision) | 6 |
| Corrective Action: Individual(s) were Moved | 4 |
| Corrective Action: Environmental Modification | 3 |
| Corrective Action: Support Plan Modification | 2 |
| **TOTAL** | **481** |

## Corrective Action Plans

Of the 25 cases involving a full investigation in the CCCA facility, there were 6 cases substantiated for abuse. Documentation of a Corrective Action Plan issued by the Office of Licensing was found in the investigative file for one of these cases.

## Quality Checks

One aspect of the FLB is a quality check on the information entered into the CHRIS system as compared with the information found on-site in the investigative file. Several of these quality checks consider whether specific notifications were made regarding the investigation. For notifications to an Authorized Representative/Guardian and the Police, most were 'not applicable' according to advocates (Table 6). A response was considered 'not applicable' if they responded as such in either CHRIS, or in the investigative file, or both.

**Table 6. Notifications Made: A Comparison of CHRIS Data with Investigation File Documentation**

| Response Options | Authorized Rep./Guardian | Dept. of Social Services | Police | DBHDS Office of Licensing |
|---|---|---|---|---|
| No | 16 | 14 | 29 | 0 |
| Yes | 80 | 186 | 12 | 3 |
| Not Applicable | 202 | 47 | 237 | 0 |
| Not Matching CHRIS | 4 | 17 | 0 | 0 |

| | | | | |
|---|---|---|---|---|
| Not Matching File | 0 | 15 | 0 | 0 |
| *No response* | 121 | 144 | 145 | 420 |
| **Grand Total** | **423** | **423** | **423** | **423** |

'No' and 'Yes' indicates the advocate responded the same way to both CHRIS and investigative file notification questions. 'Not matching CHRIS' indicates a No response in CHRIS but evidence for the notification was found in the investigative file, while 'Not matching File' indicates the opposite. *No response* indicates a non-response to either the CHRIS questions, or the Investigative file questions, or both.

## Interviews

Advocates indicated there was evidence in the investigative file that involved staff and individual(s) were interviewed or submitted written statements in most full investigation cases (360 of 423, 85%), as well as most of the full investigation cases that were also substantiated (61 of 68, 90%).

## Administrative Issues and Director's Conclusions

After a thorough retrospective review, advocates determined that the facts of these 423 full investigation cases supported the facility Investigator's conclusions in 393 cases (93%). One facility accounted for most of the 30 'False' responses, and which also accounted for over a third of their own full investigation cases. This is most likely attributed to data entry error.

Similarly, advocates determined that the Director's finding matched the investigators' conclusion in 393 of these 423 cases (93%). Again, one facility accounted for the majority of the 30 'False' responses, which again accounted for almost a third of their own full investigation cases.

Administrative issues were identified in 61 of these 423 full investigation cases (14%). One facility identified administrative issues in the majority of their full investigations (67%), while all others identified it in their full investigation cases less than half the time (between 3% - 44%).

OHR will examine the three open text narratives which may have been submitted by advocates to describe important details for these issues and discrepancies.

## Written Notice of Investigation Findings

Advocates indicated that none of the cases showed any supporting evidence in the investigative file that written notice of investigation findings were provided to the affected individual or AR/Guardian; however, the CHRIS system shows facilities affirmed such written documentation was sent in 398 cases of the 423 full investigations (94%).

### Investigator Training

Advocates indicated the person conducting the investigation had been trained to conduct such investigations in 317 of the 423 full investigations (75%). Most indicated training conducted by Central Office/Denise Dunn (303 cases, 96%). There were 14 cases that indicated 'other' training for investigators.

## Interrater Reliability

Due to travel issues, the Central Office Advocate Review did not receive a full sample for the first quarter of 2017. For the rest of 2017 reviews, the full sample was used. With respect to these budget and travel considerations, interrater reviews were stratified by facility location across the state according to geographic areas:

- Northwest
- Southeast, and
- Southwest

A single reviewer served as a second rater on all of the selected cases. Of the 117 cases initially designated for interrater analysis, 87 ultimately met the criteria for inclusion in the analysis. This is due to the removal of CCCA duplicates, the exclusion of neglect peer-to-peer cases in quarter 1 (investigations could not be identified), as well as the exclusion of neglect peer-to-peer cases in quarters 2, 3, and 4 where a full investigation did not occur.

The majority of the items required advocates to either check a box or leave it blank, meaning that the only two possible outcomes were "TRUE" or "FALSE." When two raters score multiple cases on a binary outcome, 50% agreement is expected due to chance alone. Therefore, in addition to calculating percent agreement, Maxwell's Random Error Coefficient (RE) for binary data was also computed. Maxwell's RE rates agreement on a scale from 0 (agreement due to chance alone) to 1 (perfect agreement). A more commonly used statistic, Cohen's kappa, was also considered but found to be less appropriate for the data because the kappa coefficient is reduced when one of the outcomes is highly prevalent.

High agreement was found for the DBHDS advocate action checklist. The advocate and second reviewer agreed an average of 92% on these items (mean RE = 0.84). Agreement was also high for the corrective action checklist, with an average agreement of 97% (mean RE = 0.94).

Interrater agreement was weaker on the items that asked reviewers to assess the timeliness of the report and the investigation. Reviewers agreed only 69% of the time when indicating whether incidents were reported within 24 hours and whether they were closed within 60 days (RE = 0.38 for both items). Asked whether the investigation was "completed within timeframes",

the raters agreed 79% of the time (RE = 0.59). These items were not intended to be subjective since all dates and times appear in CHRIS; however the results suggest that reviewers used different interpretations. One possible source of disagreement is the issue of whether "completed within timeframes" should include any extensions that were granted. Future versions of the Look-Behind review form will clarify that within timeframes means "10 business days, not including weekends or holidays, not including extensions."

The Investigation Review Checklist included subjective questions, so at least some disagreement should be expected. Agreement was relatively strong, however, on the question of whether the facts supported the investigators' conclusions (85%; RE = 0.70) and whether the Director's finding matched the Investigator's conclusions (91%; RE = 0.82). Agreement was lower on the question of whether "involved staff and individuals" were interviewed or submitted statements (61%; RE = 0.22), possibly because reviewers had different thoughts on who should have been considered "involved" for the purpose of the investigation.

The lowest agreement was observed on the question of whether the "Person conducting investigation has been trained to conduct investigations" with only 55% agreement, little more than what would be expected due to chance alone (RE = 0.10). In the text responses, one of the reviewers frequently cited a lack of proof as the reason for marking FALSE; this reviewer's higher standard of proof appears to explain the discrepancy.

Overall, the interrater analysis indicates high reliability for the majority of the items on the worksheet. However, reliability was lower than expected on questions of timeliness, whether involved persons were interviewed, and investigator training. Additional instructions and norming may be needed on future Look-Behind studies, in addition to wording changes on the review form itself.

**Table 7. Interrater Reliability Results**

| Worksheet Item | Percent Agreement | Maxwell's RE |
|---|---:|---:|
| DBHDS advocate action checklist (average) | 92% | 0.84 |
| Corrective actions checklist (average) | 97% | 0.94 |
| Incident reported in CHRIS within 24 hours | 69% | 0.38 |
| Investigation closed by OHR within 60 days | 69% | 0.38 |
| Investigation completed within timeframes | 79% | 0.59 |
| Facts support Investigators' conclusion | 85% | 0.70 |
| Director's finding matches conclusion | 91% | 0.82 |
| Administrative issues identified | 77% | 0.54 |
| Involved staff and individuals interviewed | 61% | 0.22 |
| Investigator trained to conduct investigations | 55% | 0.10 |

# Definitions

**Non-participating facilities** include NVTC and SSVTC as these locations are closed, and SWVTC due to its imminent closure in June 2017. CVTC was excluded due to a small and shrinking population and also has a closure date set for 2020. Furthermore, this facility recently received a 1-on-1 training with the Office of Human Rights. All other state facilities are included in the sample.

**Abuse** means any act or failure to act by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, and that caused or might have caused physical or psychological harm, injury, or death to a person receiving care or treatment for mental illness, mental retardation, or substance abuse.
1. Rape, sexual assault, or other criminal sexual behavior;
2. Assault or battery;
3. Use of language that demeans, threatens, intimidates or humiliates the person;
4. Misuse or misappropriation of the person's assets, goods or property;
5. Use of excessive force when placing a person in physical or mechanical restraint;
6. Use of physical or mechanical restraints on a person that is not in compliance with federal and state laws, regulations, and policies, professionally accepted standards of practice, or the person's individualized services plan; and
7. Use of more restrictive or intensive services or denial of services to punish the person or that is not consistent with his individualized services plan. See §37.2-100 of the Code of Virginia.

**Exploitation** means the misuse or misappropriation of the individual's assets, goods, or property. Exploitation is a type of abuse. (See §37.2-100 of the Code of Virginia.) Exploitation also includes the use of a position of authority to extract personal gain from an individual. Exploitation includes violations of 12VAC35-115-120 (Work) and 12VAC35-115-130 (Research). Exploitation does not include the billing of an individual's third party payer for services. Exploitation also does not include instances of use or appropriation of an individual's assets, goods or property when permission is given by the individual or his authorized representative:
1. With full knowledge of the consequences;
2. With no inducements; and
3. Without force, misrepresentation, fraud, deceit, duress of any form, constraint, or coercion.

**Neglect** means failure by a person, program, or facility operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary

to the health, safety, or welfare of a person receiving care or treatment for mental illness, mental retardation, or substance abuse. See §37.2-100 of the Code of Virginia.

**Peer-on-peer aggression** means a physical act, verbal threat or demeaning expression by an individual against or to another individual that causes physical or emotional harm to that individual. Examples include hitting, kicking, scratching, and other threatening behavior. Such instances may constitute potential neglect.