

Aging and Long-Term Support Administration

APS Fatalities & Near Fatalities – The Washington Quality Assurance Approach

Presentation to the National Adult Protective Services Association

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APS Fatalities & Near Fatalities – The Washington Quality Assurance Approach

This presentation will cover:

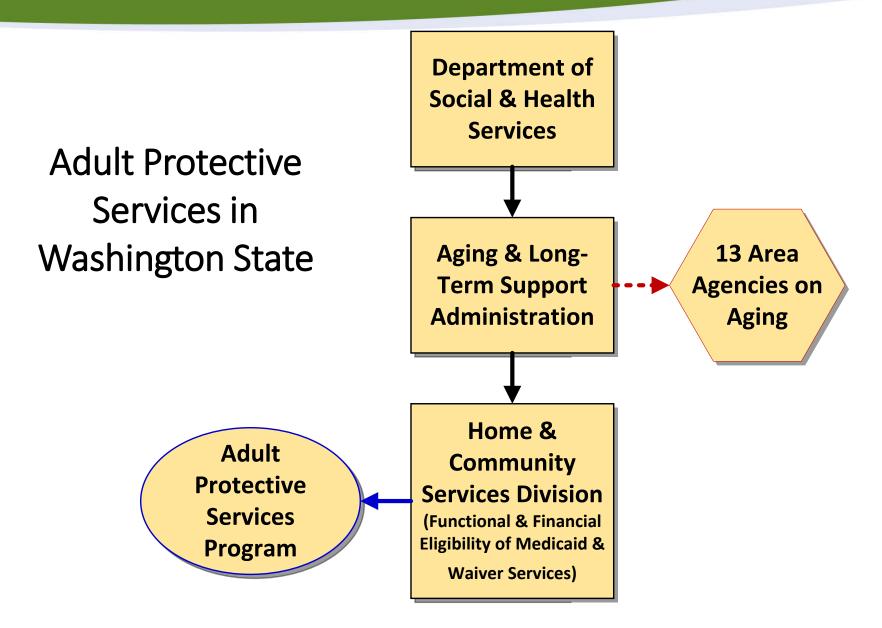
- The evolution of Adult Protective Services
- The current Fatality Review process
- The Near Fatality Review process
- The future of the Fatality and Near Fatality Review processes

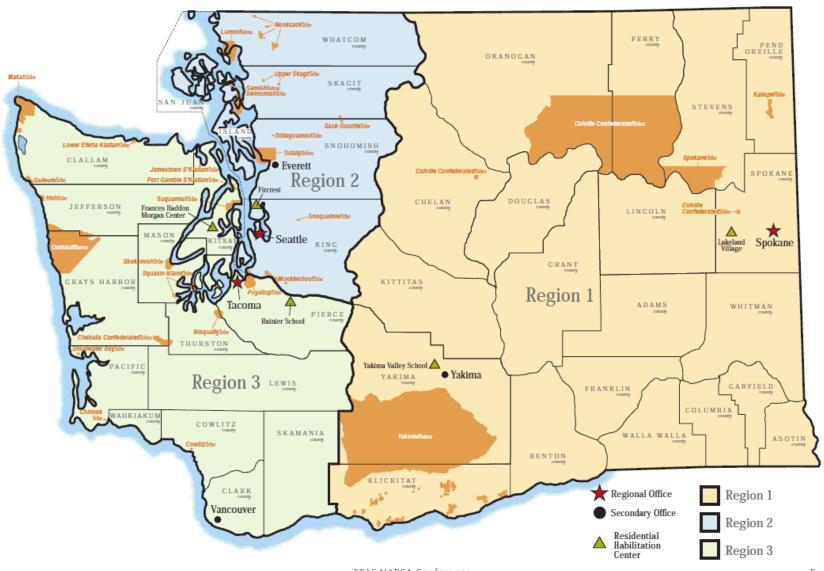


Evolution of Adult Protective Services in Washington State

Abuse of Vulnerable Adults Act 1984







Evolution of Adult Protective Services in Washington State

238.5 case carrying FTE and 95.9 non case carrying FTE

Case Carrying

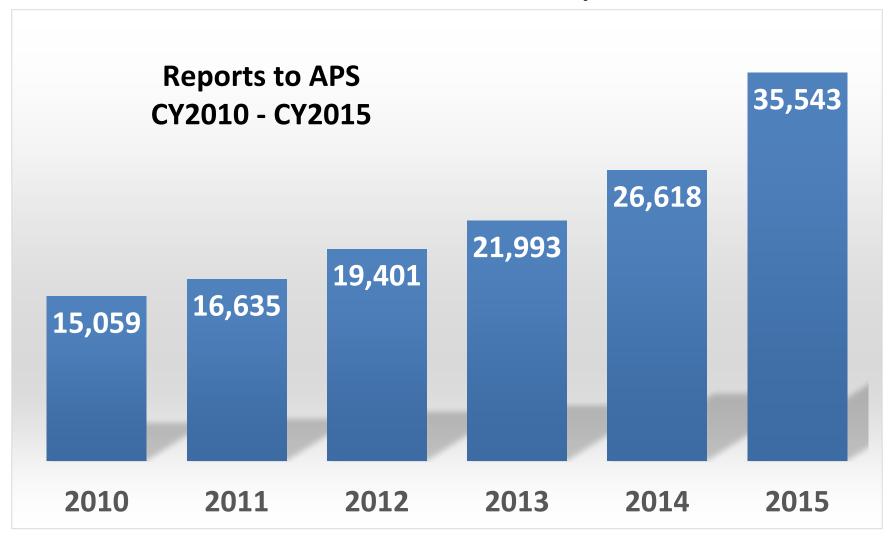
Investigators

Non-Case Carrying

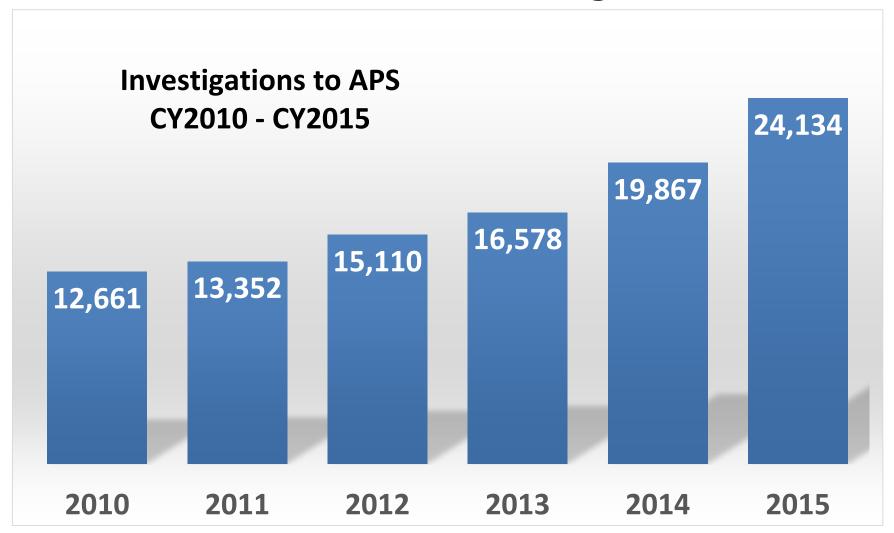
- Intake Workers
- Supervisors
- Field Program Managers
- Legal Benefits Advisors (Attorneys)
- HQ Program Managers

Budget
Approximately
\$27 Million

136% Growth in Reports



91% Growth in Investigations



Fatality Reviews



Fatality Reviews

Revised Code of Washington 74.34.300

- Conduct vulnerable adult (VA) fatality reviews
- Reason to believe the death may be related to abuse, abandonment, financial exploitation, or neglect of the vulnerable adult or may be related to the vulnerable adult's selfneglect

Amended Statute

 Within the job duties of one APS Program Manager at Headquarters

Fatality Reviews

Policy Mandate

- Receiving Home and Community Based Services in his or her own home or licensed or certified settings within 60 days preceding his or her death, or
- Living in his or her own home or licensed or certified settings and was the subject of an APS report within 12 months preceding his or her death

Fatality Review Notices

- Field notification
- Systems crosswalk
- Critical Incident Reports

Metric: Fatality Reviews



Fatality Review Findings

2011 - 2015

- Enhance training
- Recommend RCW/WAC changes
- Recommend policy and procedural amendments
- Increase community collaboration and coordination

2015 Statewide APS Quality Assurance Team

- February, two APS Quality Assurance Program Managers hired
- Creation of a new APS Quality Assurance Tool
- January 2016 APS Quality Assurance Team started reviewing cases statewide
- Efficient method of looking at the process and educating staff

Fatality Reviews as a Component of the APS Quality Assurance Process

- Focus of the department to enhance and improve our fatality review program
- September 2015, awarded grant from the Administration for Community Living (ACL)
- November 2015, first dedicated APS Fatality Review Program Manager hired

Research, Research, and More Research

- Other states processes
- Multiple meetings, calls, emails, and observations to start new approach to fatality reviews
- Development of new policy
- Development of definition of a "Near Fatality"
- Development of new After Event Review Quality Assurance Tool

Statute amended RCW 74.34.300

- Changed language from <u>may</u> to <u>shall</u>, and
- Added the requirement for the department to conduct fatality reviews in licensed and certified settings



A Near Fatality is when a physician has informed the department that the vulnerable adult is/was in serious or critical condition and their condition is suspected to be related to abuse and/or neglect.

Near Fatality Factors

- ✓ Abandonment
- √ Abuse
- **✓** Elopement
- ✓ Exploitation
- ✓ Neglect or Self-Neglect
- ✓ Negligent treatment or maltreatment
- ✓ Suicide

- ✓ Endangerment with a controlled substance
- ✓ Medical equipment or the application and monitoring of medical equipment
- ✓ Restraint or seclusion

ACL - Washington Enhanced Adult Protective Services Grant Outcomes

- Improve and expand APS reporting application to be consistent with NAMRS data collection
- Improve policy and procedures for APS clients at risk of fatality or near fatality based upon findings
- Establish and convene an After Event Review Team
- Gain knowledge regarding trends in practice that impact fatality or near fatality events for vulnerable adults served through APS
- Improve skills and capabilities of 300+ APS staff through training
- Development of an After Event Review Quality Assurance system that will track incidents

DSHS Mission:

To Transform Lives

ALTSA Mission:

To transform lives by promoting choice, independence and safety through innovative services.



Questions



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