PROTECTING PEOPLE FROM HARM: EVALUATING THE QUALITY OF CRITICAL INCIDENT INVESTIGATIONS

ODP Certified Investigator Peer Review (CIPR) Manual

PA Department of Human Services, Office of Developmental Programs through contract with Temple University Harrisburg

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Overview

The Office of Developmental Programs (ODP) supports Pennsylvanians with intellectual and developmental disabilities to achieve greater independence, choice, and opportunity in their lives. People with disabilities want to be fully in control over everything about their lives; to have choice and control over things they do, to be healthy and safe, to fully participate in the life of the community, to have friends and family, to work, and to enjoy all the freedoms of citizenship.

It is the expectation and responsibility that individuals supported through the ODP system deserve not only quality services and programs but are afforded the same protections as individuals outside of the service system, to be protected from harm, particularly from incidents involving abuse, neglect, exploitation, and rights violations. To accomplish this principle, the Incident Management Bulletin outlines key roles and responsibilities service providers must have in place to ensure that when an incident occurs, or is suspected or alleged to have occurred, the response to the incident protects and promotes the health, safety, and rights of the individual and is to more effectively manage incidents involving harm, or the potential for harm, for individuals receiving services.

This commitment comes from ODP's mission and is supported through the federal Medicaid Waiver and State Medicaid ICF/ID funds the Commonwealth State of Pennsylvania receives through the Centers for Medicare and Medicaid Services (CMS). With this funding, ODP is responsible for assuring to CMS that the basic health, safety, and welfare of individuals receiving services and supports through the ODP service delivery system occurs.

The incident, risk, and quality management processes are some of the ways ODP works to provide assurances to CMS that Pennsylvania is striving to protect the health, safety, and welfare of Medicaid recipients. One aspect of how these assurances are satisfied is through the requirements outlined in the **Incident Management (IM) Bulletin 00-21-02**, issued by ODP. The IM Bulletin requires the identification, reporting, and management of certain types of incidents involving harm, or the potential for harm, to people receiving services.

One aspect of incident management is the requirement that **Department Certified Investigators** (CIs) conduct critical incident investigations for the categories of abuse, neglect, and other significant events identified in the IM Bulletin. The information collected and preserved through the investigative process helps improve decisions and future actions affecting the basic health, safety, welfare, and quality of life of people receiving services and supports by organizations and the ODP service delivery system. It is also used to assure accuracy of the classification of incidents involving harm, or the potential for harm to people receiving services. Thus, the investigation process is an integral component of ODP's risk and incident management functions and is a key element of quality management activities.

Another quality management activity associated with the investigation process is through a peer review process called the Certified Investigator Peer Review Process (CIPR). As in academia and scientific communities, the ODP CIPR is used by organizations to complete a thorough review of submitted investigations and organization practices related to the investigations. Studies have shown that having someone who completes the same activities as the person being reviewed and providing feedback on their work can be helpful to all participants. This process provides space for an exchange of information to take place in the form of feedback for both the reviewer and reviewee. The reviewee is given an opportunity to receive feedback from the reviewer that may allow them to learn about practices being followed by fellow peers to enhance their quality of work. In a like manner, the reviewer is able to analyze their peer's work for practices that may benefit them when completing a similar task. During the CIPR, the reviewer is expected to take an interest in learning what the CI did during the investigation process and why. The "why" factor allows the reviewer to understand the pros and cons of the specific techniques that were used by the CI. Feedback that is provided as a result of the CIPR can help the CI's organization and provide best practices to other organizations through information sharing.

The CIPR is a systematic review of a sample of the investigations that were completed by an organization during a specified time frame. During this review, a committee uses CIPR forms to evaluate the quality of the investigation and the Administrative Review that was completed by the organization. By applying the standards identified through conducting CIPRs, valuable information is provided regarding the quality of investigations completed by CIs. This in turn supports the quality management and continuous quality improvement framework outlined in the IM Bulletin.

As stated in Incident Management Bulletin 00-21-02:

> "All organizations are responsible for the quality of the work performed in direct (or via contract, agreement, etc.) relation to incident investigations. In order to facilitate consistent quality measures related to investigations conducted by a CI, ODP has created the CIPR process.
>
> The CIPR process helps mitigate risks by monitoring the quality of investigations and monitoring of incident data and trend analysis. If a CI does not conduct investigations following the minimum standards on which the CI is trained, the organization's ability to mitigate and manage risk may be compromised, resulting in individual harm. In the context of continuous quality improvement, the CIPR process is the core for assessing the quality of the investigation process and incident management practices within an entity or system.
>
> The CIPR process assists with:
> - Evaluating and improving the quality of investigations, and
> - Providing performance feedback directly to the CI
>
> All entities that complete investigations are required to conduct the CIPR process as outlined in the ODP CIPR manual."

In 2004, ODP issued the Certified Investigations Bulletin 00-04-11, which outlines eligibility, initial training, and recertification requirements to become a CI. This Bulletin also includes the requirement that a CI wishing to be recertified at the end of the three-year certification cycle must:

- Complete three certified investigations during a three-year certification period
- Successfully complete the Recertification process.

If a CI wishes to continue to conduct investigations and has done fewer than three investigations during the certification period, the CI must actively participate in Certified Investigator Peer Reviews (CIPRs) by serving as a member of a Peer Review committee or Risk Management committee. Participation is defined as using the evaluation tools included in this manual to review at least three investigations and discussing the results with the committee.

By applying the standards identified through conducting CIPRs, valuable information is provided regarding the quality of critical incident investigations. This in turn supports the quality management and continuous quality improvement framework outlined in Incident Management Bulletin 00-21-02.

For additional guidance on ODP's incident management policies and procedures, refer to your organization's incident management team or contact your region's (ODP) Risk Manager or Incident Manager.

ODP Department Certified Investigator Peer Review Manual

This manual and related evaluation tools reflect the most current standard for ***"Evaluating the Quality of Incident Investigations".***
This manual includes the following content that is to be used in assessing the quality of investigations:

1. Standards identifying the requirements of a quality investigation,
2. Tools used to measure the quality of investigations, and
3. Instructions and guidelines regarding the process used when conducting CIPRs.

In accordance with the ODP Bulletin on Incident Management, #00-21-02, issued by the Pennsylvania Department of Human Services and Office Developmental Programs (ODP), this manual was developed to provide continuing guidance to entities performing Certified Investigator Peer Reviews (CIPRs).

As this manual guides you through each item of the CIPR, you will notice the following icon:

This web icon indicates a reference to a web page where additional information related to the CIPR process can be found.

Part I: CIPR Purpose and Standards

The process of measuring the quality of investigations applies to critical incidents that require an investigation, as outlined in the ODP IM Bulletin (e.g., allegations of abuse, neglect, exploitation, death, serious injury, etc.). The primary CIPR tool is intended to provide information about the quality of investigations through an assessment of the following core areas:

1. Identification and collection of evidence
2. Completion of required documentation
3. Decisions made by the Administrative Review committee

In its most fundamental use, the CIPR process assesses the quality of investigations from a peer or supervisory perspective and thus provides performance feedback directly to the CI. In the larger context of continuous quality improvement, the CIPR process becomes core in assessing the quality of the investigation process and incident management practices within an organization or system.

For CIs, the CIPR process guides them in improving the quality of investigations they conduct. For administrators and managers responsible for assuring incidents and investigations are managed properly in organizations, the CIPR process is used to obtain objective information about the overall quality of the investigation process in their organization. For oversight entities, the CIPR process provides the ability to objectively assess the overall quality of investigations conducted by a service provider or within their own organization. It can also be used to assess the quality of investigations throughout the system as a whole, i.e., throughout a specific region, or across the entire ODP service delivery system.

Part II: Guidelines for Conducting CIPRs

General Guidelines

The following are general guidelines that should be followed to conduct proper CIPRs:

1. The person conducting the review should have experience and/or training in conducting investigations or managing the investigation process.
2. Throughout the evaluation process, the reviewer must think of the evidence and information being reviewed as if they were the investigator, i.e., "if I was assigned this investigation, what relevant evidence should be identified and collected for the investigation?"
3. The **entire** Provider Investigation File should be reviewed prior to completing this evaluation, including **all relevant physical, testimonial, and documentary evidence** that was identified and/or collected for the investigation.
4. The most current available CIPR tools must be used to complete this process.
5. Documentation of all conducted CIPRs must be kept by the entity completing the process.

All current documentation that can be used for the purpose of the CIPR can be accessed at www.myODP.org.

Professionals > Certified Investigator Program > CI Help & Resources > **All Documents**

Structuring the CIPR Process

Given the scope and complexity of organizations, several alternatives exist as to how the CIPR process should be structured, including who should participate. For the CIPR evaluation requirements, the State Operated Intermediate Care Facility for Individuals with Intellectual Disabilities ("State Centers") and entities providing Support Coordination Services (SCOs) are considered service providers.

Service Providers and Administrative Entities (AEs):

a. Service Providers and Administrative Entities can structure the process through an existing Safety or Incident Management/Risk Management committee or by establishing a new CIPR committee.
b. Committees should include a minimum of two (2) members. When possible, membership should be rotated. This allows for the continuing education of staff through the "hands-on" review process. Organizations that lack sufficient staff to have at least two (2) members involved with the CIPR committee should organize membership based on the resources available and consult with the ODP

vendor for the Certified Investigator Program for additional technical assistance, if necessary.

c. Although not required for participation in the CIPR evaluation process, it is suggested that members of a CIPR committee complete either the ***Certified Investigator's*** or the ***Peer Review*** course offered by ODP.
d. At minimum, members of a CIPR committee should be familiar with the guidelines presented in this manual, as well as the Certified Investigator's Manual and Administrative Review Process Manual.
e. The CIPR process can be approached by using a true peer-review model consisting of only CIs in an organization that are reviewing each other's investigations.
f. If the CIPR process includes external stakeholders (e.g., service provider organizations, consumers, or other groups within the ODP service delivery system), members should be asked to sign a confidentiality agreement with the understanding that the information contained in the investigative files is to be used only for the CIPR process.

Frequency of CIPRS

Service Providers:

a. Service Providers must conduct CIPRs at least quarterly for investigations completed by the service provider or on behalf of the provider via a contract or agreement with another organization.
b. An organization may decide to conduct CIPRs more frequently than the minimum standard. This is an agency policy decision that should be based on the scope and complexity of the organization's incident and risk management program.

Administrative Entities:

a. AEs must conduct the CIPR process at least semi-annually for investigations completed at the AE or on behalf of the AE via a contract or agreement with an outside organization.
b. An AE may decide to conduct CIPRs more frequently than the minimum standard. This is an agency policy decision that should be based on the scope and complexity of the organization's incident and risk management program.
c. AEs should consider completing the CIPR process for service provider investigations as resources allow. These reviews would be on an ad hoc basis as the AE is not required to complete this activity on any scheduled frequency. ODP strongly encourages using the CIPR process as part of a formal Corrective Action Plan (CAP) or for other quality improvement efforts directed towards service providers.

Additional guidance for AEs conducting the CIPR process can be found within Incident Management Bulletin 00-21-02, which can be accessed at www.myODP.com.

Professionals > Certified Investigator Program > CI Help & Resources > All Documents > Bulletins

How to Prepare for and Conduct the CIPR Meeting

Regardless of whether it is a Service Provider or AE, committee participants can conduct CIPRs in several different ways. Consistent CIPR standards can be established by selecting one of the following procedures:

1. Divide the selected cases between committee members, **or** 2. Have each member of the committee review every case selected. This can be helpful in establishing inter-rater reliability with new committees, or when adding new members to a committee. If using this method, committee members should review the cases independently. After completing this task, committee members should meet to discuss their individual reviews and resolve any differences with individual feedback.

The following guidelines are suggested for conducting CIPR committee meetings:

a. The committee meeting should consist of a discussion of the CIPR findings for each case sampled. If there is discrepancy or disagreement among members on any item, consensus should be reached.
b. Committee members should not evaluate their own cases.
c. To expedite the meeting process, committee members should review/evaluate assigned cases prior to the CIPR meeting.
d. Documentation of the CIPR process must be kept and results must be shared with appropriate parties to facilitate improvement strategies.

Selecting Investigations for the CIPR

The number of investigations subject to a CIPR is flexible based on the needs of the organization. The number of investigations selected for CIPR should be proportionate to the number of investigations completed annually and the number of CIs within an organization. The number of investigations selected for CIPR must be no less than ten percent (10%) of the investigations conducted during the review period.

Organizations should consider these factors when selecting investigations for review:

1. Select at least one (1) investigation that was conducted by each CI during the review period. This provides an opportunity for each CI to receive constructive, objective feedback on the quality of the investigation process and content of the Provider Investigation File. This also provides feedback supporting the CI's focus on his/her own skill/knowledge areas that may need improvement.
2. Include investigations that were problematic, challenging, or complicated to allow the CI(s) and the organization the opportunity to learn from those experiences.
3. Review investigations with a variety of final determinations, including inconclusive, to examine what factors contributed to the Administrative Review committee's determination.
4. Select investigations from various categories of incidents.
5. If there were no investigations conducted during the current review period, then select cases from previous time periods that were not previously reviewed.

Use of the Evaluation Findings

Findings from the CIPR evaluation can be used in several different ways:

1. As a learning resource for CIs to assist with improving the quality of the investigations they complete. A copy of the CIPR evaluation can be provided to the CI at the completion of the review process.
2. As a supervisory tool to review and discuss cases during supervision.
3. As an organizational quality monitoring of investigations and how risk mitigation is being done to prevent future incidents.
4. As a data source after annual CIPR evaluation results are compiled. Aggregate data can be used to identify systemic opportunities within an organization to help improve quality initiatives (i.e. resource allocation, training, development of policies and procedures). Organizations can develop internal processes for sharing and acting on CIPR findings.

Oversight of the Investigation Process

The oversight of the incident investigation process for service providers will be the responsibility of the AE. Reasons for an AE to complete the CIPR process includes, but is not limited to:

- Routine technical assistance and quality improvement activities related to the implementation of the incident management process.

- Targeted technical assistance activities related to complex incidents.
- As part of a Corrective Action Plan (CAP) issued by the AE to the service provider.

In addition, ODP will utilize the vendor of the Certified Investigator Training Program to provide external oversight using the CIPR process for investigations conducted by the Service Provider and AE. When requested, Service Providers and AE's must provide investigation files in a timely manner to ODP and ODP's vendor.

Part III: Provider Investigation File

To complete the CIPR, the reviewer participating in the peer review process must review the entire Provider Investigation File (including all collected evidence) in conjunction with the EIM (Enterprise Incident Management) Incident Report. The EIM Incident Report includes both the Provider Certified Investigator Report (completed by the CI) and Provider Administrative Review (completed by the Administrative Review committee).

The EIM Incident Report is the primary repository of information about the incident. In addition to the Provider Certified Investigator Report and Provider Administrative Review, it explains information that was available when the incident was reported, how it was classified, and the first steps that were taken to promote the health, safety, and well-being of the victim. It also provides follow-up information for all actions that were taken prior to the closing of the incident. The Provider Certified Investigator Report contains the details of the CI's investigation process and how relevant evidence (physical, testimonial, and documentary) was identified, collected, and preserved before, during, and after the investigation. The Provider Administrative Review conveys the organization's review of the CI's investigation and steps taken to prevent future recurrences of the incident. All evidence and documentation related to an investigation should be maintained and preserved in the Provider Investigation File.

Provider Certified Investigator Report

During the investigation process, the CI must enter information relevant to the CI's methodology, how evidence was identified and collected, and other required information in the Provider Certified Investigator Report. The report provides a clear and comprehensive "road map" about the protocols used by the CI, a summary of the evidence that was available to answer the primary investigatory question is used for documentation when conducting investigations, and an analysis of potential issues that need to be considered when reconciling evidence.

Provider Administrative Review

The Provider Administrative Review process is the final stage of the investigation for critical incidents. The Administrative Review committee is responsible for making sure that proper decisions are made regarding the final conclusions and outcomes of the critical incident investigation including:

- Determining the final outcome (i.e. Confirmed, Not confirmed, Inconclusive) based on a Preponderance of Evidence standard;
- Determining how to address concerns that were identified by the CI, during the investigation process; and
- Determining related corrective actions (individual, program, fiscal, personnel, administrative) that must be implemented.

For entities with oversight authority (i.e., ODP, Administrative Entities, the Department of Health, or others with responsibility and/or authority to review an investigation), the entire EIM Incident Report provides a comprehensive picture of the protocols used to manage the critical incident from the time it was initially reported to its conclusion, including the implementation of corrective actions and preventative measures by the provider.

Additional information and training on the role of leadership and others who may be responsible for oversight of the CI's investigation can be accessed at www.myODP.org.

Topics > Incident Management/Risk Management > Documents, Resources, & Training: Incident Management Bulletin 00-21-02 > Leadership's Role in Reporting, Investigating, and Responding to Incidents

Maintaining the Provider Investigation File

Due to the highly confidential nature of the information that is contained in the Provider Investigation File, involving individuals receiving services and employees, organizations must create internal policies and procedures regarding how evidence and related contents of the investigation file are organized, maintained, and secured. Issues such as maintaining files/evidence in a secure location with limited, controlled access is critical to meeting expectations related to the "chain of custody" rules. If an organization contracts with an individual or entity who is not an employee of the organization to conduct a peer review for the organization, explicit language should be included in any letters of agreement/contracts with that individual/entity that the Provider Investigation File is the property of the organization that is responsible for conducting the investigation. In other words, the Provider Investigation File does not belong to the contracted individual/entity. The contracted individual/entity can receive a copy of the Provider Investigation File, but the hiring organization should maintain the original file.

Additional information on maintaining the Provider Investigation file can be found within Incident Management Bulletin 00-21-02, which can be accessed at www.myODP.org.

Professionals > Certified Investigator Program > CI Help & Resources > All Documents > Bulletins

Part IV: CIPR Tool User Guide

In order to complete the CIPR, the following worksheets are to be completed prior to answering the related questions in the CIPR tool:

- **CIPR Form #1: Physical Evidence Log Sheet**
- **CIPR Form #2: Testimonial Evidence Log Sheet**
- **CIPR Form #3: Documentary Evidence Log Sheet**

The CIPR tool and CIPR Forms 1-3 can be found in the Appendices of this manual.

The remainder of this manual focuses on providing step-by-step guidance and interpretive guidelines for reviewing Provider Investigation Files, utilizing CIPR tools, and completing the CIPR process.

Quality Foundation for Certified Investigator's Peer Review Key Indicators Sheet: CI

Item #1: Did the CI develop and document a thorough Investigative Plan?

Guidance: The construction of the Investigative Plan is an important step within the investigation process. An investigation must be systematic, which means it must be planned and not haphazard. Immediately upon assignment, the CI should develop a plan to approach the investigation in an organized way. This will enable the CI to organize their work and will likely result in a thorough investigation. The CI should identify the required tasks that need to be completed (generally in a sequential manner) for the investigation and be aware of how each task in the plan leads to or supports other steps in the process.

The quality of the CI's Investigative Plan can be measured by the CI's documentation of the following:

- Safety measures for the victim,
- The gathering of information about the Initial Incident Report,
- Established ideal timelines for the investigation process (steps to be taken, projected completion dates, etc.),
- The investigatory question,
- The identification of witnesses,
- Chronology of witness interviews,
- Possible evidence to collect, and
- How evidence will be preserved.

It is important to note that the CI's Investigative Plan should be developed shortly after being assigned to the investigation and documented within the Provider Certified Investigation Report.

If a review of the Provider Certified Investigator Report indicates the CI developed and documented a thorough Investigative Plan, select "Yes" for Item #1.

If a review of the Provider Certified Investigator Report does not suggest the CI developed a thorough Investigative Plan, select "No" for Item #1. The reviewer may use the second page of the tool to provide additional guidance to the CI or refer the CI to the appropriate section of the Certified Investigator's Manual for completing the Investigative Plan on the second page of the CIPR tool.

Additional information and resources for the Investigative Plan, including the Investigative Plan Worksheet, can be accessed at www.myODP.org.

Professionals > Certified Investigator Program > CI Help & Resources > All Documents > CI Forms and Templates

Item #2: Did the CI interview or attempt to interview the victim during the investigation or document an investigative reason to explain why the interview did not occur?

Did the CI conduct or attempt to conduct the interview in person or document an investigative reason to explain why?

Guidance: Every effort should be made to interview the victim during the investigation process. It is important that the CI conducts an interview (or attempts to interview) the victim during the investigation process. The victim holds critical details about the incident, and the CI is responsible for giving the victim an opportunity to communicate their memories of the incident. Interviewing the victim in a timely manner allows the CI to check on their safety, improve their chances of accurate recall, and reassure the victim that the incident is being taken seriously.

When possible, the CI must interview the victim in person. An "In-person" interview is conducted by the CI while being face to face in the same room as the victim. Conducting interviews in person allows the CI to collect the victim's testimony, observe body language and other indicators that may be relevant to the victim's testimony, and ensure the health, safety, and wellbeing of the victim. If the victim is interviewed by any means other than an in-person interview, including Zoom, FaceTime, phone, or another source of technology, that interview should be considered as "remote" or "virtual". To analyze the CI's efforts to conduct an (in-person) interview with the victim, Item #2 of the tool is two-fold.

If a review of the Provider Certified Investigator Report indicates the CI interviewed (or attempted to interview) the victim during the investigation process, select "Yes" for the first question of Item #2.

If a review of the Provider Certified Investigator Report does not suggest the CI interviewed (or attempted to interview) the victim and a logical investigative reason was not provided to explain this deviation from the investigation process, select "No" for the first question of Item #2. If "No" is selected for the first question of Item #2, the second question of Item #2 should not be answered.

If "Yes" is selected for the first question of Item #2, the second question of Item #2 must be answered. If a review of the Provider Certified Investigator Report indicates the CI conducted (or attempted to conduct) the victim's interview in person, select "Yes" for the second question of Item #2.

If a review of the Provider Certified Investigator Report does not suggest the CI conducted the victim's interview in person and a logical investigative reason was not provided to explain this deviation from the investigation process, select "No" for the second question of Item #2.

Possible logical investigative reasons for the CI not interviewing the victim during the investigation process may include, but is not limited to, the following:

- The victim's unwillingness to participate in the investigation,
- Additional trauma that may be caused by interviewing the victim,
- A victim's hospitalization which may prevent the CI from interviewing the victim over an extended period of time, and
- An incident of death.

A recorded attempt ***must*** be made to interview the victim or provide an investigative reason for the lack of an interview, even when documentation may suggest the victim is unable to participate in the investigation process. The CI is responsible for assuring the victim is given the opportunity to effectively communicate memories of their experiences/observations during the interview. To do this, a CI may need to provide accommodations to meet the victim's communication needs by providing sign or spoken language interpreters, communication boards, etc. To best provide these accommodations, the CI must research the victim's communication needs before the interview. Information related to the victim's communication needs can be found in the victim's Individual Support Plan (ISP). In preparing to interview the victim, the CI should also coordinate with the victim's team to learn about the victim's communication. The CI must understand that people can communicate without the use of words. Information suggesting the victim does not use words to communicate (is "non-verbal") is not sufficient justification for not interviewing the victim. A valid reason must be documented by the CI in the Provider Certified Investigator Report for Item #2 to be answered "Yes".

Item #3: Did the CI conduct the first interview within 24 hours of being assigned to the investigation or document an investigative reason to explain why the interview did not occur?

Guidance: Speed is one of three critical elements associated with a quality investigation, as lapsed time can create a potential for evidence to be altered. With time, a witness's memory may change and cause an inaccurate report of what occurred during the incident. To heighten the CI's chances of collecting accurate information that is relevant to the events of the incident, the CI should conduct the first witness interview within 24 hours of being assigned to the investigation.

If a review of the Provider Certified Investigator Report indicates the CI conducted the first interview within 24 hours of being assigned to the investigation, select "Yes" for Item #3.

If a review of the Provider Certified Investigator Report does not suggest the CI conducted the first interview within 24 hours of being assigned to the investigation and a logical investigative reason was not provided to explain this deviation from the investigation process, select "No" for Item #3.

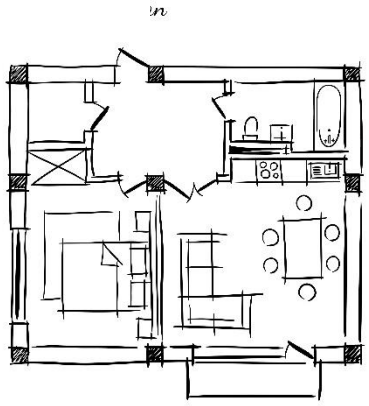
A logical investigative reason for not conducting the first interview within 24 hours may include, but is not limited to, the following:

- The CI documented that they experienced failed attempts to reach the victim, and
- The CI documented that they experienced failed attempts to contact the initial reporter, eyewitnesses, or others who may have information about the incident within 24 hours of assignment.

It is important to note that it is not up to the reviewer to speculate why the first interview was not conducted within 24 hours of the CI's assignment. A valid reason must be documented by the CI in the Provider Certified Investigator Report for Item #3 to be answered "Yes".

Item #4: Did the CI visit the scene or document an investigative reason to explain why they did not?

Guidance: Visiting the scene of an incident is important to the investigation process. A visit to the scene of the incident allows the CI to assess the scene for evidence that may be important to the outcome of the investigation. The CI may find evidence that explains what happened to the victim and/or suggests health and safety hazards that could lead to additional investigations. The CI should always visit (or attempt to visit) the scene of the incident.



If a review of the Provider Certified Investigator Report indicates the CI visited the scene of the incident during the investigation process, select "Yes" for Item #4.

If a review of the Provider Certified Investigator Report suggests the CI did not visit the scene of the incident during the investigation and a logical investigative reason was not provided to explain this deviation from the investigation process, select "No" for Item #4.

A logical investigative reason for the CI not visiting the scene during the investigation process may include, but is not limited to, the following:

- The scene could not be identified,
- The scene is not accessible, and
- Visiting the scene of the incident is a safety risk to the CI.

It is important to note that it is not up to the reviewer to speculate why the CI did not visit the scene of the incident. A valid reason must be documented by the CI in the Provider Certified Investigator Report for Item #4 to be answered "Yes".

Item #5: Did the CI clearly identify the physical evidence necessary to contribute to an accurate final determination by the Administrative Review committee?

Guidance: To provide a thorough and quality investigation, the CI should identify, preserve, and collect all evidence that may be relevant to the investigation. During each investigation, the CI should review the EIM Incident Report and the scene of the incident for any physical evidence that may be relevant to the final determination of the incident. While all physical evidence may not be collected, the CI is encouraged to identify and preserve each piece of relevant evidence during the investigation process. If identified evidence cannot be collected or preserved, a logical investigative reason must be provided to explain why. The ability to conduct a thorough, quality investigation directly relates to the CI's ability to properly identify, preserve, and collect all relevant physical evidence.

> **Physical Evidence:** Things themselves (e.g., an injury, weapon, a piece of furniture, environmental condition, etc.) or the absence of things, as well as the spatial relationship among things that have the potential to describe or explain an incident under investigation.

Prior to completing this item, the reviewer should refer to ***CIPR Form #1***. All relevant physical evidence that was available to the CI should be listed and the form should be completed as directed.

After the form has been completed, the reviewer should determine whether any relevant physical evidence that was available to the CI, but not identified, preserved, or collected, could have affected the final determination and/or the implementation of corrective actions by the Administrative Review committee.

The reviewer should acknowledge that not all physical evidence listed on the form will affect the Administrative Review committee's final determination. Physical evidence that was not identified, preserved, or collected and would not have affected the investigation's outcome can be noted on the second page of the tool.

If a review of the Provider Certified Investigator Report indicates the CI identified, preserved, and collected all relevant physical evidence that was available to the CI during the investigation process, select "Yes" for Item #5.

If a review of the Provider Certified Investigator Report suggests the CI did not identify, preserve, or collect, all relevant physical evidence that was available and would have influenced the outcome of the investigation, select "No" for Item #5 and note the missing evidence on the second page of the tool.

Item #6: Did the CI clearly identify testimonial evidence necessary to contribute to an accurate final determination by the Administrative Review committee?

Guidance: During each investigation, the CI should interview any person, including individuals who are receiving services, who may have had knowledge of the incident to collect testimonial evidence and demonstrate efforts to provide a thorough investigation.

> **Testimonial Evidence:** A witness' communication of memories, to a CI, of observations that may be related to the details of the incident under investigation. The capacity for observation derives from the senses: what the witness saw, heard, tasted, felt, or smelled.

While some witnesses may not have been at the scene of the incident when it occurred, they may be able to provide the CI with a testimony that may be relevant to the Administrative Review committee's final determination and/or the implementation of corrective actions. The CI should use witness statements and CI notes to document each interview. Regardless of the CI's ability, or inability, to collect a witness statement during each interview, a summary of each witness's testimony should always be documented within the Provider Certified Investigator Report. The ability to conduct a thorough, quality investigation directly relates to the CI's ability to properly identify and collect all relevant testimonial evidence.

Prior to completing this item, the reviewers should refer to ***CIPR Form #2***. All relevant testimonial evidence that was available to the CI should be listed and the form should be completed as directed.

After the form has been completed, the reviewer should determine whether any relevant testimonial evidence that was available to the CI, but not identified or collected, could have affected the final determination and/or the implementation of corrective actions by the Administrative Review committee.

The reviewer should acknowledge that not all testimonial evidence listed on the form will affect the Administrative Review committee's final determination. Testimonial evidence that was not identified or collected and would not have affected the investigation's outcome can be noted on the second page of the tool.

If a review of the Provider Certified Investigator Report indicates the CI identified and collected all relevant testimonial evidence that was available to the CI during the investigation process, select "Yes" for Item #6.

If a review of the Provider Certified Investigator Report suggests the CI did not collect all relevant testimonial evidence (that may have been available) and would have influenced the outcome of the investigation, select "No" for Item #6 and note the missing evidence on the second page of the tool.

Item #7: Did the CI clearly identify the documentary evidence necessary to contribute to an accurate final determination by the Administrative Review committee?

Guidance: A key piece of conducting a thorough and quality investigation is measured by the CI's ability to properly identify and collect all relevant documentary evidence.

> **Documentary Evidence:** Any evidence written down, on paper or electronically (i.e., written statements prepared as a result of interviews with the CI, business records of the organization, program and medical records of individuals receiving services, training records of employees, policies and procedures, fiscal records, etc.).

The CI should collect all documentary evidence that may be relevant to the investigation. While all documentary evidence may not be relevant to the Administrative Review committee's final determination, it may be a clear indicator of the need for corrective actions that may be related to enhancing the quality of care that is being provided to individuals who are receiving services. At minimum, a copy of the victim's Individual Support Plan should be collected during the investigation, to ensure the needs of the victim (Communication, Staffing, etc.) are met throughout the investigation process.

Prior to completing this item, the reviewer should refer to ***CIPR Form #3***. All relevant documentary evidence that was available to the CI should be listed and the form should be completed as directed.

After the form has been completed, the reviewer should determine whether any relevant documentary evidence that was available to the CI, but not identified or collected, could have affected the final determination and/or the creation of corrective actions by the Administrative Review committee.

The reviewer should acknowledge that not all documentary evidence listed on the form will affect the Administrative Review committee's final determination.
Documentary evidence that was not identified or collected and would not have affected the investigation's outcome can be noted on the second page of the tool.

If a review of the Provider Certified Investigator Report indicates the CI identified and collected all relevant documentary evidence that was available to the CI during the investigation process, select "Yes" for Item #7.

If a review of the Provider Certified Investigator Report suggests the CI did not collect all relevant documentary evidence that may have been available and would have influenced the outcome of the investigation, select "No" for Item #7, and note the missing evidence on the second page of the tool.

Item #8: Did the CI conduct all other interviews (excluding the victim) in person or document an investigative reason to explain why interviews were not conducted in person?

Guidance: The CI must always consider interviewing all witnesses in person, before considering other methods of conducting each interview. “In-person” interviews are ones in which the CI and witness are face to face in the same room. “Remote” or “virtual” interviews are ones in which the CI and the witness are not in the same room, and which are facilitated by some type of technology, such as Zoom, FaceTime, phone, etc.
In-person interviews allows the CI the capacity to fully use effective interviewing skills and minimize the likelihood that the confidentiality of each witness will be compromised during the interviewing process. In-person interviews also allow the CI to observe the witness’s gestures and body language.

If a review of the Provider Certified Investigator Report indicates the CI conducted all witness interviews, other than the victim’s, in person, select “Yes” for Item #8.

If a review of the Provider Certified Investigation Report does not suggest the CI conducted all interviews, other than the victim’s, in person and a logical investigative reason was not provided to explain this deviation from the investigation process, select “No” for Item #8.

A logical investigative reason for not conducting interviews in person may include, but is not limited to, the following:

- Health concerns,
- Safety concerns,
- A witness does not live locally, and
- A witness is on an extended vacation

It is important to note that it is not up to the reviewer to speculate why interviews were not conducted in person. A valid reason must be documented by the CI in the Provider Certified Investigator Report for Item #8 to be answered “Yes”.

Item #9: Did the CI conduct or attempt to conduct all initial interviews within 10 days of the investigation being assigned or document an investigative reason to explain why this did not occur?

Guidance: It is critical that the CI adheres to conducting interviews within a timely manner during the investigation process. All initial interviews that allow the CI to gain testimonial evidence from each witness should be conducted within 10 days. While some interviews may be conducted after the suggested timeframe, the CI should make documented attempts to ensure initial interviews are conducted within 10 days of being assigned to the investigation.

If a review of the Provider Certified Investigator Report indicates the CI conducted all initial interviews within 10 days of being assigned to the investigation, select “Yes” for Item #9.

If a review of the Provider Certified Investigator Report does not suggest the CI conducted all initial interviews within 10 days of being assigned to the investigation and a logical investigative reason was not provided to explain this deviation from the investigation process, select “No” for Item #9.

A logical investigative reason for not conducting all initial interviews within 10 days of the CI’s assignment may include, but is not limited to, the following:

- The CI documented that they experienced failed attempts to reach witnesses who may have witnessed the incident, and
- Witnesses were unable to meet the CI within the suggested timeframe.

It is important to note that it is not up to the reviewer to speculate why all initial interviews were not conducted within 10 days of the CI’s assignment. A valid reason must be documented by the CI in the Provider Certified Investigator Report for Item #9 to be answered “Yes”.

Item #10: Did the CI present a clear and thorough Summary of Findings to effectively guide a reviewer in understanding what was learned from the relevant evidence?

Guidance: The Summary of Findings should consider all the relevant testimonial, physical, and documentary evidence that was collected/preserved by the CI. The narrative should demonstrate how the CI analyzed and reconciled all the relevant evidence, and how the investigation may have benefited from identified evidence the CI was not able to obtain. The Summary of CI’s Findings section of the Provider Certified Investigator Report should tell a story that is based on facts that were presented through evidence, not the opinions of the CI.

When determining whether the CI provided an accurate Summary of Findings the reviewer should remember to analyze all evidence that was identified, collected, and presented in the both the Provider Certified Investigator Report and Provider Investigation File.

If a review of the Provider Certified Investigator Report indicates the CI presented a clear and thorough Summary of Findings to effectively guide the reviewer in making an accurate final determination, select “Yes” for Item #10.

If a review of the Provider Certified Investigator Report does not suggest the CI presented a clear and thorough Summary of Findings to guide the reviewer in making an accurate final determination, select “No” for Item #10 and note discrepancies and/or information that may be missing from the summary on the second page of the tool.

Item #11: Did the CI document concerns that were observed during the investigation process?

Guidance: During the investigation process, the CI may become aware of issues that have the potential to diminish the quality of life of the victim and other individuals who are receiving services. The CI may identify concerns involving agency practices, policies and procedures, and individual care protocols that were reviewed during the investigation. Concerns may be directly or indirectly related to the investigation. Regardless of the issue's connection to the incident that is being investigated, those issues should be identified as concerns in the Provider Certified Investigator Report.

If a review of the Provider Certified Investigator Report indicates the CI identified concerns that were observed during the investigation, select "Yes" for Item #11.

If a review of the Provider Certified Investigator Report does not suggest the CI identified concerns that were observed during the investigation, select "No" for Item #11. If the reviewer identifies concerns that were not acknowledged by the CI within the Provider Certified Investigator Report, the reviewer should note those concerns on the second page of the tool.

If the CI did not identify concerns in the Provider Certified Investigator Report, and the reviewer agrees that there are no concerns that should be documented within the report, this can also be noted on the second page of the tool.

Item #12: Did the CI provide a thorough response in each section of the Provider Certified Investigator Report?

Guidance: The Provider Certified Investigator Report serves as a tool that is used to articulate how evidence was identified, collected, preserved, and analyzed to determine what happened during the incident. The Provider Certified Investigator Report is presented to the Administrative Review committee to act as a guide for providing an accurate determination for the investigation and relevant corrective actions to ensure the health and safety of all individuals who were involved in the incident. A vital step within the investigation process is the CI's completion of the Provider Certified Investigator Report. The CI should ensure all fields of the Provider Certified Investigator Report are completed with accurate information that conveys the steps that were taken to complete the investigation process.

When considering whether the CI thoroughly completed each section of the Provider Certified Investigator Report, the reviewer should not factor in single components of the investigations that may have already been addressed in other Items of the tool. For example, documentation of the CI's Investigative Plan is address when completing Item #1 of the tool. Therefore, the reviewer would not mark this item as "No" based on the incomplete documentation of the CI's Investigative Plan.

If a review of the Provider Certified Investigator Report indicates the CI completely answered each item of the report, select “Yes” for Item #12.

If a review of the Provider Certified Investigator Report does not suggest the CI completely answered each item of the report, select “No” for Item #12. The reviewer may identify items of the report that were not completed and provide details concerning steps of the CI’s investigation that were not thoroughly documented on the second page of the tool.

Quality Foundations for Certified Investigator's Peer Review Key Indicators: CI Feedback Identifying Strengths and Improvements

Guidance: After the entire Provider Investigation File has been reviewed and the first page of the CIPR tool has been completed, the reviewer must move to the second page of the tool and provide detailed feedback to the CI, concerning the steps that were taken to complete the investigation process. The reviewer should use this page to highlight strengths and opportunities for possible improvements that were displayed throughout the Provider Certified Investigator Report.

To determine areas of strength and areas where improvements are necessary, the reviewer can refer to the first page of the tool. By analyzing the answers provided for each Item on the first page of the tool, the reviewer can conclude steps of the investigation process that were or were not completed as suggested in the Certified
Investigator's Manual.

When providing feedback about the CI's investigative methods, the reviewer should provide detailed comments that can be used to help the CI understand why specific steps that were taken were identified as a strength or improvement. Detailed comments can include, but are not limited to, the following:

- Examples taken from the Provider Certified Investigator Report,
- Examples to show how steps within the investigation process may be completed, and
- Pages that can be referenced in the Certified Investigator's Manual to provide direct guidance on how to improve the investigation process.

If possible, the reviewer should provide 3 Strengths and 3 Improvements on the second page of the tool. The additional comments box can be used to identify additional strengths and improvements and other areas of concern that may have been identified by the reviewer.

Quality Foundations for Certified Investigator's Peer Review Key Indicators: Administrative Review

Item #1: Did the Administrative Review committee make a final determination (Confirmed, Not Confirmed, or Inconclusive) that is supported by the Preponderance of Evidence Standard?

Guidance: The Administrative Review committee is required to provide a determination for each investigation that is based on the Preponderance of Evidence standard. Preponderance of Evidence standard is a tool that allows the Administrative Review committee to make a final determination that considers all evidence that was identified and collected during the investigation process. The Administrative Review committee must review the Provider Investigation File and determine whether at least 51% of the evidence suggests the incident did or did not occur, according to the incident category (abuse, neglect, etc.) that is specified in the Incident First Section of the EIM Incident Report. The Administrative Review committee must select a determination that adheres to the following:

1. **Confirmed**: If there is a majority of evidence (51% or more) that the allegation more than likely occurred, according to the specifics of the allegation in the primary and secondary categories, the Investigation Determination is *Confirmed*.
2. **Not Confirmed**: If there is not a majority of evidence (49% or less) that the allegation more than likely occurred, according to the specifics of the allegation in the primary and secondary categories, the Investigation Determination is *Not Confirmed*.
3. **Inconclusive**: If there is exactly equal evidence supporting the allegation as occurring and not occurring according to the specifics of the allegation in the primary and secondary categories, the Investigation Determination is *Inconclusive*.

If a review of the Provider Administrative Review indicates the Administrative Review committee provided a final determination that was based on the Preponderance of Evidence standard, select "Yes" for Item #1.

If a review of the Provider Administrative Review does not suggest the Administrative Review committee provided a final determination that was based on the Preponderance of Evidence standard, select "No" for Item #1 and provide an explanation in the corresponding comment box at the bottom of the page.

Item #2: Did the Administrative Review committee identify Corrective Actions that will mitigate the risk of reoccurrence for this incident or assist the agency with improving the quality of care being provided to individuals receiving services?

Guidance: Investigations are a part of ODP's *Quality Management* process, which has been designed to advance the quality of life of individuals who are being served and supported. When incidents occur, the need for change within a Provider's processes may become evident. Regardless of the investigation's final determination, the Administrative Review committee must analyze the incident for areas of concern that may require corrective actions that would prevent the incident from recurring and enhance the quality of life of all individuals who may have been involved.

The Administrative Review committee may choose to implement corrective actions that:

- Protect the individual(s) from preventable incidents,
- Involve areas of concerns that were identified by the CI during the investigation process,
- Are related to steps of the investigation process that were not completed by the CI,
- Include protocols that could enhance the level and quality of care and services being provided by the organization, and
- Address other issues that may cause a reason for concern if not resolved appropriately.

If a review of the Provider Administrative Review indicates the Administrative Review committee implemented corrective actions, select "Yes" for Item #2.

If a review of the Provider Administrative Review does not suggest the Administrative Review committee implemented corrective actions, select "No" for Item #2 and provide an explanation in the corresponding comment box at the bottom of the page.

Additional information on the identification and implementation of corrective actions can be accessed at www.myODP.org.

Professionals > Certified Investigator Program > CI Help & Resources > Helpful Links

Item #3: Did the CI document concerns within the Provider Certified Investigator Report?

If yes, did the Administrative Review committee adequately address each concern that was identified?

Guidance: The Administrative Review committee is responsible for developing adequate corrective actions that mitigate risk and ensure the health and safety of individuals that are receiving services. In addition to those initial corrective actions, the Administrative Review committee must acknowledge each concern that has been identified by the CI in the Provider Administrative Review. If the CI has identified a concern, the Administrative Review committee must determine how that concern should be addressed. Concerns may vary in nature (practice, policy, procedure,

etc.) and may or may not be directly involved with the incident. The Administrative Review committee, regardless of the concern's relevance to the incident, must acknowledge the concern and ensure plans to address the concern are documented within the Provider Administrative Review.

If the Provider Administrative Review indicates the CI identified concerns within the report, select "Yes" for the first question of Item #3.

If the Provider Administrative Review does not indicate the CI identified concerns within the report, select "No" for the first question of Item #3. If "No" is selected for the first question of Item #3, the second question of Item #3 should not be answered.

If "Yes" is selected for the first question of Item #3, the second question of Item #3 must be answered. If a review of the Provider Administrative Review indicates the Administrative Review committee adequately addressed each concern that was identified by the CI, select "Yes" for the second question of Item #3.

If the Provider Administrative Review does not suggest the Administrative Review committee adequately addressed each concern that was identified by the CI in the Provider Certified Investigator Report, select "No" for the second question of Item #3 and provide an explanation in the corresponding comment box at the bottom of the page.

Item #4: Were additional Corrective Action(s) that were necessary to mitigate the risk of similar incident(s) or to assist the agency with improving the individual's quality of life, which were not identified by the Administrative Review committee, identified by the reviewer?

Guidance: As the reviewer conducts a CIPR on an investigation, the Provider Certified Investigator Report and Provider Investigation File must be reviewed for indicators that may suggest the need for corrective actions that were not identified by the Administrative Review committee in the Provider Administrative Review. If the reviewer believes additional corrective actions are needed to mitigate risk or assist the agency with improving the individual's quality of life, those corrective actions should be included in the CIPR tool.

If a review of the Provider Administrative Review indicates the reviewer did identify additional corrective actions, select "Yes" for Item #4 and provide a detailed list of additional corrective actions in the corresponding comment box at the bottom of the page.

If a review of the Provider Administrative Review suggests the reviewer did not identify additional corrective actions, select "No" for Item #4.

Additional corrective actions that may be listed by the reviewer can include deviations by the CI and Administrative Review committee that were not explained during the course of the investigation and not acknowledge prior to the closure of the EIM Incident Report.

Item #5: Did the Administrative Review committee verify and document what types of assistance, including Victim Assistance Services, were offered to the victim or provide an investigative reason to explain why assistance was not offered to the victim?

Guidance: Victim's Assistance Services should be offered to every individual that has been identified as a victim of an investigation. Victim's Assistance programs are resources that are available to assist victims physically, emotionally, financially, and legally when they have been abused, neglected, and identified as a victim of a crime. Victims may access many resources within the Commonwealth and have the right to access those services at any time. Support staff are required to offer Victim's Assistance programs directly to the victim, and the victim should be given the opportunity to process the event and decide which supports they wish to access.
Even if the victim chooses to refuse Victim's Assistance services, the Administrative Review committee must ensure Victim's Assistance is offered. Each type of assistance that was offered to the victim must be noted in the Provider Administrative Review.

If a review of the Provider Administrative Review identifies the types of Victim's Assistance that were offered to the victim of the investigation, select "Yes" for Item #5.

If a review of the Provider Administrative Review does not identify the types of Victim's Assistance that were offered to the victim of the investigation, select "No" for Item #5 and provide a list of types of Victim's Assistance that may have been offered to the victim in the corresponding comment box at the bottom of the page.

If a review of the Provider Administrative Review indicates this section of the report was marked "N/A" or "Other" and a logical reason was provided to explain why, select "Yes" and indicate the Administrative Review's response in the corresponding comment box at the bottom of the page. If a valid reason was not provided to explain why "N/A" or "Other" was marked for Victim's Assistance, select "No" and provide an explanation in the corresponding comment box.

Information on the types of Victim's Assistance that can be offered to the victim can accessed at www.myODP.org.

Professionals > Certified Investigator Program > CI Help & Resources > Helpful Links

Item #6: Did the Administrative Review committee provide a thorough response in each section of the Provider Administrative Review?

Guidance: The Administrative Review committee is required to complete each item of the Provider Administrative Review within the EIM Incident Report. Failure to complete each item of the Provider Administrative Review may imply specific steps of the Administrative Review were not completed as directed in the Administrative Review Process Manual.

When considering whether the Administrative Review committee thoroughly completed each section of the Provider Administrative Review, the reviewer should not factor in single components of the Administrative Review that may have already been addressed in other Items of the tool. For example, an incomplete documentation of Victim's Assistance is addressed when completing Item #5 of the tool. Therefore, the reviewer would not mark this item as "No" based on the incomplete documentation of Victim's Assistance.

If a review of the Provider Administrative Review indicates the Administrative Review committee completely answered each item of the report, select "Yes" for Item #6.

If a review of the Provider Administrative Review does not suggest the Administrative Review committee completely answered each item of the report, select "No" for Item #6 and provide details concerning steps of the Administrative Review that were not thoroughly documented in the corresponding comment box at the bottom of the page.

Conclusion

The Peer Review process can be concluded after all items of the CIPR are completed. Feedback that is provided during the Peer Review process should be used as a learning resource for the CI. Feedback can also be used, by management, as an indicator of systematic improvements that may be necessary to protect the health, safety, and well-being of all individuals that may be receiving services. The CI, management, and other entities who may be able to review the feedback that was provided during the Peer Review should consider improvements and strengths that were mentioned throughout the review. While improvements highlight areas where change may be necessary, strengths focus on favorable practice that have been utilized by the CI and the agency's management.

Appendix: CIPR Tool and Supplemental Forms

The following documents will be found in this section of the manual:

1. **The CIPR Tool**
2. **CIPR Form #1: Physical Evidence and Photography/Video***
3. **CIPR Form #2: Testimony and Witness Statements***
4. **CIPR Form #3: Documentary Evidence***
5. **Glossary**

Quality Foundations for Certified Investigator's Peer Review
Key Indicators: CI

EIM Incident ID:	Date of Review:
CI Name:	Reviewer Name:

1. Did the CI develop and document a thorough Investigative Plan?	Yes	No
2. Did the CI interview or attempt to interview the victim during the investigation or document an investigative reason to explain why the interview did not occur?	Yes	No
Did the CI conduct or attempt to conduct the interview in person or document an investigative reason to explain why?	Yes	No
3. Did the CI conduct the first interview within 24 hours of being assigned to the investigation or document an investigative reason to explain why the interview did not occur?	Yes	No
4. Did the CI visit the scene or document an investigative reason to explain why they did not?	Yes	No
5. Did the CI clearly identify the physical evidence to contribute to an accurate final determination by the Administrative Review committee?	Yes	No
6. Did the CI clearly identify testimonial evidence to contribute to an accurate final determination by the Administrative Review committee?	Yes	No
7. Did the CI clearly identify the documentary evidence to contribute to an accurate final determination by the Administrative Review committee?	Yes	No
8. Did the CI conduct all other interviews (excluding the victim) in person or document an investigative reason to explain why interviews were not conducted in person?	Yes	No
9. Did the CI conduct or attempt to conduct all initial interviews within 10 days of the investigation being assigned or document an investigative reason to explain why this did not occur?	Yes	No
10. Did the CI present a clear and thorough Summary of Findings to effectively guide a reviewer in understanding what was learned from the relevant evidence?	Yes	No
11. Did the CI document concerns that were observed during the investigation process?	Yes	No
12. Did the CI provide a thorough response in each section of the Provider Certified Investigator Report?	Yes	No

Please use feedback form to provide responses to any items where deviations may have occurred.

Quality Foundations for Certified Investigator's Peer Review Key Indicators: CI Feedback	
EIM Incident ID:	Date of Review:
CI Name:	Reviewer Name:
List 3 strengths of the CI's investigation.	
1.	
2.	
3.	
List 3 opportunities for possible improvement for the CI's investigation.	
1.	
2.	
3.	
Additional Comments:	

Quality Foundations for Certified Investigator's Peer Review
Key Indicators: Administrative Review

EIM Incident ID:	Date of Review:
CI Name:	Reviewer Name:

1. Did the Administrative Review committee make a final determination (Confirmed, Not Confirmed, or Inconclusive) that is supported by the Preponderance of Evidence Standard?	Yes	No
2. Did the Administrative Review committee identify Corrective Actions that will mitigate the risk of reoccurrence for this incident or assist the agency with improving the quality of care being provided to individuals receiving services?	Yes	No
3. Did the CI document concerns within the Provider Certified Investigator Report?	Yes	No
If yes, did the Administrative Review committee adequately address each concern that was identified?	Yes	No
4. Were additional Corrective Action(s) that were necessary to mitigate the risk of similar incident(s) or to assist the agency with improving the individual's quality of life, which were not identified by the Administrative Review committee, identified by the reviewer?	Yes	No
5. Did the Administrative Review committee verify and document what types of assistance, including Victim Assistance Services, were offered to the victim or provide an investigative reason to explain why assistance was not offered to the victim?	Yes	No
6. Did the Administrative Review committee provide a thorough response in each section of the Provider Administrative Review?	Yes	No

Please provide an explanation for each item where deviations may have occurred, and an investigative reason was not provided. Use the box that corresponds with the question number.

1.
2.
3.
4.
5.
6.

CIPR FORM #1
Physical Evidence and Photography/Video

EIM Incident ID:	Date of Review:
CI Name:	Reviewer Name:

Table 1: Physical Evidence

Relevant Physical Evidence	Identified? (Y/N/NA)	Collected? (Y/N/NA)	Notes

Table 2: Photographs and Video

Relevant Photographs and Video	Identified? (Y/N/NA)	Collected? (Y/N/NA)	Notes

CIPR FORM #2
Testimonial Evidence

EIM Incident ID:	Date of Review:
CI Name:	Reviewer Name:

Table 1: Witness Testimony

Name of Witness	Witness Role (Victim, Target, etc.)	In Person Interview (Y/N)	Date/Time of Interview	Written Statement (Y/N)	Notes

CIPR FORM #3
Documentary Evidence

EIM Incident ID:	Date of Review:
CI Name:	Reviewer Name:

Table 1: Documentary Testimony

Relevant Documentary Evidence	Collected? (Y/N)	Date Collected	Notes

Glossary

Additional Corrective Action: Person-centered corrective action that is focused on the prevention of future incidents that may be similar in nature to the incident under investigation. Additional Corrective actions may include both short and long-term risk mitigation actions and can have expected completion dates beyond the incident closure date.

Administrative Review: The final stage of the investigation process that includes reviewing the competency and quality of an investigation for *Speed, Objectivity,* and *Thoroughness*; weighing evidence to make an investigation determination; ensuring completion of preventative corrective action; determining additional corrective action plans; and completing the Administrative Review section of the EIM Incident Report.

Administrative Review Committee: A group of individuals who will review the Provider Certified Investigator Report, Provider Investigation File, evaluate the quality of the investigation, and provide the final determination of the investigation. Committee members may hold various roles within the organization such as agency management and administration.

Agency Policy: A written statement outlining a principle that an organization and its members are guided by.

Agency Procedure: Written guidelines or steps to be followed by members of an organization in an effort to adhere to rules, regulations and or policies.

Allegation: A unproven claim that someone has done something wrong or that goes against an organization's policy/procedure. An allegation is typically made by the person designated as the "initial reporter".

Background Interview: An interview used to generate evidence considered relevant, but not specifically originating from the incident itself.

Certified Investigator: A person who has been trained and certified to investigate critical incidents, according to the guidelines in the most current Certified Investigator's Manual. Certification is through instructors designated by The Office of Developmental Programs.

Certified Investigator Improvements: A component of the feedback section of the Certified Investigator's Peer Review tool that is used to highlight steps of the investigation process that were not completed as directed in the Certified Investigator's Manual.

Certified Investigator Peer Review: Process of measuring the quality of investigations and incident management practices within an organization or system. The Certified Investigation Peer Review (CIPR) process is an assessment of the quality of investigations from a peer or supervisory prospective, which is intended to give performance feedback directly to the Department Certified Investigator who conducted the investigation. The person conducting the review should have experience and/or training in conducting investigations or managing the investigation process.

Certified Investigator Peer Review Tool: Tool used to measure a Certified Investigator's quality of investigations, during the Certified Investigator Peer Review process. The tool is intended to provide information about the quality of investigations through an assessment of core action steps completed by the Certified Investigator.
Certified Investigator Strengths: A component of the feedback section of the Certified Investigator's Peer Review tool that is used to highlight skills, knowledge, and action steps of the investigation process that were completed appropriately by the CI.

Circumstantial Evidence: Evidence that is not directly from an eyewitness or participant and requires some reasoning to prove the details of the incident.

Critical Incident: A type of incident that has been determined to be a sufficiently serious indicator of risk that it requires an investigation by a Department-Certified Investigator.

Communication Accommodation: Measures taken to ensure witnesses are given the opportunity to effectively communicate memories and observations of an incident. Communication accommodations may include but are not limited to sign or spoken language interpreters, communication boards, or language applications.

Concerns Identified by CI: Actions or items that go against practices, policies, or procedures that are specific to an individual or organization, which were identified by the CI during the investigation process.

Confirmed Determination: Final finding used by the Administrative Review committee when the evidence presented in the Provider Certified Investigator Report and Provider Investigation File suggests there **is** a majority of evidence (51% or more) that the allegation more than likely occurred.

Direct evidence: Evidence in the form of testimony from a witness who was present for the incident and experienced any of the specific details of the incident through sight, hearing, touch, taste, or smell.

Documentary Evidence: Any evidence written down, on paper or electronically.

Enterprise Management System (EIM): Database used to input critical incidents that may have compromised the health, safety, rights, and dignity of individuals receiving services.

Follow-up Interviews: Interviews generally conducted with identified witnesses and used primarily to reconcile conflicting evidence, ask about new evidence emerging in the investigation, or ask questions the CI failed to ask during earlier interviews with a witness.

Incident: An event with potential to adversely impact an individual's health, safety, or rights.

Incident Management: The response to an event intended to ensure adequate, appropriate, and effective protection and promotion of the health, safety, and rights of individuals.

Inconclusive Determination: Final finding used by the Administrative Review committee when the evidence presented in the Provider Certified Investigator Report and Provider Investigation File suggests there is exactly equal evidence supporting the allegation as occurring and not occurring.

Initial Witness Interview: Interviews conducted with people identified as potential witnesses who have either direct or circumstantial evidence about what happened.

Investigation: The process of identifying, collecting, and assessing evidence from a reportable incident in a systematic manner.

Investigation Determination: A finding of *Confirmed, Not Confirmed,* or *Inconclusive* that uses the *Preponderance of Evidence* standard and that is made during the Administrative Review stage of an investigation. It is based on the Administrative Review committee's review of the Provider Certified Investigator Report and the Provider Investigation File.

Investigative Plan (Investigation Plan): A framework to guide the CI to conduct a systematic investigation that is objective, timely, and thorough.

Investigatory Question: A question that provides a general guide to the parameters of the investigation and assists the CI in avoiding tunnel vision. There is generally only one investigatory question per investigation.

Investigative Reason: A valid explanation to be included in the Provider Certified Investigator Report when there is a deviation from the standards and protocols provided in the Certified Investigator's Manual.

Irrelevant Evidence: Evidence that does not have the potential to help describe or explain an incident under investigation.

Law Enforcement Activity: Any activity involving law enforcement that occurs during the provision of service, including instances in which an individual is the subject of a law enforcement investigation that may lead to criminal charges against the individual.

Medical Attention: Any assessment, examination, or treatment by a qualified medical professional, and/or basic first aid.

Not Confirmed Determination: Final finding used by the Administrative Review committee when the evidence presented in the Provider Certified Investigator Report and Provider Investigation File suggests there **is not** a majority of evidence (49% or less) that the allegation more than likely occurred.

Objectivity: The ability to describe or perceive something based on evidence without influence by personal emotions, experiences, bias, or opinion.

Physical Evidence: Evidence in the form of objects or things, spatial relationships between people or things, or the absence of things that otherwise should reasonably be present.

Policy: A written statement outlining a principle that an organization and its members are guided by.

Preponderance of the Evidence: The standard of evidence requiring that the conclusion drawn about the incident be based on what is more likely than not to have occurred, in other words, what 51% or more of the evidence supports.

Preventative Corrective Action: A single immediate corrective action that must be implemented before the Incident Final Section is submitted. A Preventative Corrective action is a person-centered remediation that is related to the underlying cause(s) of the incident. It is focused on preventing future incidents similar in nature to the incident under investigation. If an incident is categorized as Abuse, Sexual Abuse, Neglect, Rights Violation, or Exploitation, and the Investigation Determination is *Confirmed,* a Preventative Corrective action is mandatory.

Procedure: Written guidelines or steps to be followed by members of an organization in an effort to adhere to rules, regulations, and or policies.

Protective Service Entity: A protection agency under the Adult Protective Service Act, Older Adult Protective Service Act, or Child Protective Service Law that has the authority to investigate incidents or complaints of abuse, neglect, and other incident categories related to individuals, if there is probable cause or if incidents or complaints are reported.

Provider Investigation File: A collection of the Provider Certified Investigator Report and all associated evidence that was collected by the CI during the investigation.

Provider Certified Investigator Report: A record that provides the details of the investigation process that was used by the CI to determine what occurred during an incident. Information related to an investigation may be documented in the Provider Certified Investigator Report in the EIM system.

Relevant Evidence: Evidence that potentially helps to describe or explain an event or incident under investigation.

Remote Interview: Any interview with a witness that is not conducted in-person, including those that are conducted over the phone or through the use of electronic video equipment such as Microsoft Teams, Face Time, or Zoom.

Risk Management: The proactive and responsive management of potential risks to an organization, its employees, its clients and customers, and others.

Risk Mitigation: An overall approach to minimize the severity of risk and to reduce the likelihood of occurrence or recurrence of an adverse event.

Speed: A standard of evidence that requires the CI to act in a timely way that considers how evidence may change or disappear over time.

Summary of Findings: A narrative, provided by the CI, which tells the "story" of what more likely than not happened or did not happen, based on the relevant evidence collected during the investigation.

Target: The person or entity who is alleged to have caused the incident to occur.

Testimonial Evidence: Evidence that is a witness' communication to a CI, in verbal form or the equivalent, that expresses their memories of their experiences or observations related to the incident under investigation.

Thoroughness: A standard of evidence that requires the CI to generate details throughout the entire investigation.

Trauma: A psychological, emotional response to an event or an experience that is deeply distressing or disturbing.

Trauma-Informed Interviewing: An approach to interviewing that treats a person in a way that is sensitive to their trauma or possible trauma that has been recently experienced or even experienced in the past.

Victim: The individual for whom the incident occurred or is alleged to have occurred.

Victim's Assistance Programs: Resources that are available to individuals who are victims of abuse, neglect, or crime to assist them medically, physically, emotionally, financially, and legally. There are two main types of victim's assistance programs: system and community-based organizations.

Witness Statement: Document used to preserve intact the witness' communication of their memory of experiences they had or observations they made.