Julian F. Keith Alcohol and Drug Abuse Treatment Center

SUBJECT:	Human Rights: Reporting Patient Abuse, Neglect or Exploitation	SECTION:	Clinical APM II – 43A
APPROVAL DATE:	3/12/2020	DATE OF ORIGIN:	6/4/2003

APPROVED BY: ________________________________ DATE: ______________

PURPOSE:

The purpose of this policy is to assure that patients being served by JFK-ADATC are protected, appropriate reports are made and thorough investigations are promptly initiated when there are allegations or suspicions of rights infringements (including but not limited to abuse, neglect and exploitation).

POLICY:

Abuse, neglect, exploitation and other rights infringements of patients served at JFK-ADATC are strictly prohibited. The staff of JFK-ADATC are responsible for responding promptly and appropriately to protect patients in the event that abuse, neglect, exploitation or other rights infringements occur. All known or suspected rights infringements will be reported, investigated and documented in accordance with this policy. For definitions of terms pertaining to this policy refer to Attachment A.

PROCEDURES:

A. Initial Intervention and Notification

1. Upon observing, discovering, learning of, or hearing about a confirmed or suspected incident of abuse, neglect, exploitation or other rights infringement, or the falsification of the records of patients, facility staff will immediately intervene, within the scope of their ability, to protect the health and safety of the patient(s) involved. In instances where an injury is suspected, APM II-66 (Patient Safety Incident (Injury) Response and Reporting) will be followed as well to ensure that individuals served receive immediate medical assessment and treatment. As soon as possible, but no later than the end of the current shift, staff who become aware of the incident shall report the incident to the designated supervisory staff on duty and to the Patient Advocate/designee. In the event that the designated supervisory staff on duty is suspected or known to have infringed upon the rights of a patient in the present case, the next level supervisor/manager and the Advocate/designee will be contacted. Failure to make these required reports will result in appropriate disciplinary action.

2. In the event that a patient makes an allegation of abuse, neglect, exploitation or other rights infringement, the designated supervisory staff on duty and the Advocate/designee will be contacted immediately. In the event that the designated supervisory staff on duty is alleged to have infringed on the rights of the patient making the allegation, the next level supervisor/manager and the Advocate/designee will be contacted. It is the responsibility of the staff member to whom an allegation is made to assist the patient in contacting the Advocate/designee or making the contact on the patient's behalf.

3. Staff who report a confirmed or suspected incident of abuse, neglect, exploitation or other rights infringement, or the falsification of the records of patients served, will document that a report has been made. This documentation will be made in the record of the patient(s) served and will include: (1) time the report was made, (2) the name and title of the staff to whom the report has been made, and (3) a brief description of the incident that was reported. The name(s) of the person(s) allegedly responsible and specific details about the incident should not be included in this brief description. When staff who have made a report do not have authority to document in the patient's record or do not consent to have their identity disclosed, the supervisor who receives the initial report will ensure that the required documentation is made in the record. If the supervisor has authority to document in the patient's record, the supervisor will write the note. If the supervisor does not have authority to document in the patient's record, the supervisor will have the nurse/manager in charge of the unit write the note. If the nurse/manager has allegedly participated in the reported incident, the Director of Nursing or Management Designee will write the note. When reporting staff have indicated they do not consent to have their identity disclosed, the note will be written without disclosing the identity of the reporting employee, for example: "It has been reported to this writer that….".

4. Upon receiving a report of alleged or suspected abuse, neglect, exploitation or other rights infringement, the Advocate/designee will immediately notify the designated facility management staff regarding the known circumstances and the need for an investigation.

5. Legally responsible persons will be notified regarding investigations that involve the patient(s) they represent. This notification will occur as soon as possible by telephone, with a prompt confirmation in writing. Each Facility Director will establish a protocol to ensure this notification and documentation thereof.

6. When investigations involve legally competent individuals, notifications will be made as soon as possible to family or significant others as requested and authorized by the legally competent individual. This notification shall be promptly confirmed in writing. Each Facility Director will establish a protocol to ensure this notification and documentation thereof.

7. Designated facility management staff will report to the Health Care Personnel Registry (HCPR) when investigations involve unlicensed facility staff who have direct access to patients served, or their property, and one of the following allegations is made against them:

- abuse,
- sexual abuse,
- neglect,
- misappropriation of an individual's property,
- misappropriation of a facility's property,
- diversion of drugs belonging to an individual served,
- diversion of drugs belonging to the facility,
- fraud against an individual served, and/or
- fraud against the facility.

Initial reports will be made to the HCPR within 24 hours of the facility becoming aware of the allegation as required by law (GS § 131E-256). DHSR/HCPR Form No. 4501 (Attachment C) will be used to make these reports. Designated facility management staff will notify an employee if his/her name is submitted to the HCPR.

8. When allegations name, as the “accused”, facility staff who are certified, licensed or registered by a professional board which requires notification of allegations, the responsible facility manager(s), after consultation with the facility’s Human Resources Manager, will assume responsibility for filing the required reports to the appropriate professional boards.

9. An immediate report will be made to the County Department of Social Services, in accordance with the requirements of DHHS Directive III-5, whenever there is reason to believe that a juvenile under 18 years of age or a disabled adult who is in need of protective services and who is in the custody of or served by the facility has been abused, neglected or exploited.

Subsequent to a report being made to a County Department of Social Services, designated staff will complete and submit a Directive III-5 form (Attachment D) to the Facility Director’s Office for review and transmittal to the Director of State Operated Services. This communication will occur no later than the business day following the initial report to DSS.

10. The Facility Director is responsible for ensuring that any suspected serious abuse/crime is reported to the appropriate law enforcement agency immediately and promptly confirmed in writing. This includes such incidents as reported rape or any other sexual abuse, suspected assault, etc. Alleged abuse/crimes are to be reported regardless of who allegedly committed the crime. If it is unclear if a suspected abuse/crime should be reported to law enforcement for investigation, facility management will consult with law enforcement to make a determination. In the case of less serious incidents, such as alleged theft of personal property of nominal value or physical assault without injury, the facility will inform the victim (or guardian if the patient is a minor or an adult who has been adjudicated incompetent) of his/her right to file criminal charges.

11. Facility staff will be expected to cooperate with any external agency that is authorized to conduct independent investigations. Confidential Information will be shared with those agencies in accordance with State and Federal law, and DHHS policies. If questions arise, the Facility Director will be consulted prior to the release of any confidential information or records to external agencies. The Human Resources Manager will be consulted prior to the release of any confidential personnel information to external agencies.

B. Handling of Evidence

1. Facility staff who witness or suspect an incident of abuse, neglect, exploitation or other rights infringement, including sexual abuse, will consult with supervisory staff prior to:

- Disturbing or cleaning up any environmental evidence that may be critical to an investigation, and
- Bathing or changing the clothes of any patient.

2. The integrity of the evidence should be maintained until the designated facility manager, Advocate/designee and law enforcement officer (if applicable) have observed the patient and the environment, and the patient has been checked by medical staff. As soon as practical after an alleged incident of abuse, neglect, exploitation or other rights infringement has been disclosed, any and all available video recordings of the incident from surveillance cameras will be secured for possible use in an investigation of the incident.

3. The collection of evidence and information, including interviewing witnesses and others involved, will be the responsibility of the investigative team.

C. Internal Investigation Process

1. The Investigative Team will include at a minimum an Advocate/designee and a designated facility manager. Other staff may be included in the Team if they are deemed critical to the interview process. Investigative proceedings will take precedence over all other regularly scheduled activities. Disruption of the treatment, work and/or living environments will be as minimal as possible.

2. The Investigative Team will discuss the need for continued protective measures to safeguard the alleged victim(s) or other potential victims. Examples of protective measures include but are not limited to: medical treatment, reassignment of staff, placement of the staff member(s) on investigatory leave with pay, or any other special provisions to ensure that individuals served are protected.

3. Any person, including other patients served by the facility (as appropriate), having knowledge of or information relevant to an allegation may be interviewed. Guardian consent is not necessary prior to interviewing minors or adult patients who have a guardian.

4. Facility staff being interviewed will be required to sign Statements of Confidentiality and Disclosure and will be asked to provide a written statement (Attachment E) regarding their knowledge of or involvement in the incident being investigated.

5. Those being interviewed who are not staff will also be asked to provide a written statement regarding their knowledge of or involvement in the incident being investigated. Anyone who is unable to produce a written statement can dictate their statement to an investigative team member and then sign and date the statement.

6. Investigation interviews governed by this policy are for informal, administrative purposes and recording devices will not be allowed.

7. Whenever there is an injury or trauma to a patient, a medical report will be obtained through interview of medical staff and/or review of records or reports. This report will include any information that is helpful to derive factual evidence related to the investigation.

8. Additional consultations or diagnostic assessments by professionals may be requested by the Investigative Team if such assessments are considered to be in the best interest of the patient or if such information may be helpful to complete the investigation. Such requests shall be subject to approval by the Program Director or the Facility Director/designee.

9. Internal investigations will be completed within five working days from the time the incident was reported, unless an extension has been granted by the Facility Director/designee.

D. Follow-up Notifications and Response

1. The investigative team will report their findings of facts to the Facility Director. Additional staff may be requested to participate in this process at the discretion of the Facility Director. In cases where members of the investigative team have differing views of the facts, the facts in dispute will be shared in a meeting with the Facility Director. The facility's final determination in the investigation is the responsibility of the Facility Director. If the Facility Director's determination is in conflict with the determination of the Advocate/designee, the case will be brought to the attention of the Director of State Operated Services and the Chief of the Advocacy & Customer Service Section of the Division for further review and a final determination by the Division Director/designee.

2. At the request of the Advocate II/Senior Advocate, a confidential face to face meeting will occur with the Facility Director to review and discuss investigation findings and recommendations.

3. Upon completion of the investigation, the Advocate/designee or designated facility staff will notify the alleged victim, when he/she is a competent patient served, or the legally responsible person, when the victim has been adjudicated incompetent. This notification will be in writing and will include information concerning the investigation and its results as appropriate. The identity of facility staff or other patients served will be kept confidential. Timeframes for this notification will adhere to all regulatory standards for the specific facility.

4. The Advocate/designee will notify the State Facility Advocate Team Leader of any investigation that results in substantiated findings. This notification should occur as soon as a substantiated determination is made.

5. Designated facility management staff will make a second report to the Health Care Personnel Registry (HCPR) at the conclusion of all investigations that required an initial 24 hour report to the HCPR (see requirements in Procedures A.7 of this policy). This report will be made within five working days of the initial, 24 hour notification of the allegation as required by law (GS § 131E-256). DHSR/HCPR Form No. 4500 (Attachment F) will be used to make this report. In the event that an investigation extension has been granted by the Facility Director/designee, a Five Working Day Report will be submitted to the HCPR documenting the current status of the investigation. At the conclusion of the investigation, designated facility management staff will make another report to the HCPR, using the Five Working Day Report form, to notify them of the final status of the investigation.

6. Once all information has been gathered, the Advocate/designee will prepare the investigation file. The investigation file will contain, at minimum, a written investigation report (refer to Attachment B), statements from all witnesses, statement(s) from the "accused", copies of written correspondence to the patient(s) served or guardian(s) as applicable, copies of the reports sent to the HCPR (if applicable), copy of the Directive III-V form (if applicable) and any other relevant information/documentation. The Advocate/designee and the designated facility management staff will sign the final investigation report.

7. Documentation of any actions that have been taken as a result of the investigative findings, including the date of completion or projected completion, will be sent from the responsible facility manager to the Advocate/designee. This excludes information of specific disciplinary actions taken, if any.

8. Documentation of disciplinary action(s) will be forwarded directly to Human Resources by the responsible facility manager(s) and filed in the personnel file(s). The confidentiality of personnel information will be maintained in accordance with State Law.

E. Aggregate Data

1. The Advocate/designee will compile a written report of investigations to present to the facility's Human Rights Committee at each scheduled meeting. This report will include all allegations and investigative findings that have occurred since the last report that the committee received. The identity of patients and facility staff will be kept confidential in all reports to the Human Rights Committee. Upon the Human Rights Committee's request, the Facility Director/designee shall verbally report to the committee the actions that have been

taken subsequent to each investigation. In making this report, the Facility Director/designee shall ensure compliance with State Personnel Laws and all rules of confidentiality.

2. Each Facility Director will establish procedures for aggregating and reviewing investigation data as indicated by individual and facility needs. These procedures will ensure that appropriate follow-up action is implemented regarding observed/noted trends, including more specific evaluation and corrective action as indicated/required.

RESPONSIBILITY:

The Facility Director is responsible for enforcement of this policy.

EXCEPTIONS:

Any exception to the above policy must be approved and granted by the Director, State Operated Services or designee in consultation with the Chief of Advocacy and Customer Service Section or designee.

REFERENCES:

- APM II-43A, Attachment A, Definition Glossary for Rights Infringement Response Policy
- APM II-43A, Attachment B, Investigation Reports – Required Elements
- APM II-43A, Attachment C, HEALTH CARE PERSONNEL REGISTRY INVESTIGATIONS BRANCH
- APM II-43A, Attachment D, Reporting Abuse, Neglect or Exploitation
- APM II-43A, Attachment E, STATEMENTS of CONFIDENTIALITY & DISCLOSURE