Abuse and Neglect Prevention and Intervention

Purpose:

To establish for North Country Healthcare (NCH) and its affiliates, criteria that focus on objective evidence to identify possible victims of abuse throughout the organization, initiate appropriate action for the patient who is a suspected victim of abuse or neglect, to maximize patient safety, and define specific and unique responsibilities for safeguarding evidentiary material in accordance with Standards for Privacy of Individually Identifiable Health Information Public Safety and Welfare Chapter Child Protection Act, and Elderly and Adult Services.

Definitions:

Any reference to "NCH" or "Facility" refers to the affiliates of North Country Healthcare - Androscoggin Valley Hospital, North Country Home Health & Hospice Agency, Upper Connecticut Valley Hospital, Weeks Medical Center and their related clinics and delivery sites.

Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.

Involuntary Seclusion: Separation from other patients or from his or her room against the patient's will, or the will of the patient's legal guardian or representative. *Note: Temporary monitored separation from other patients will not be considered involuntary seclusion and may be permitted when used as a therapeutic intervention to reduce agitation as determined by the attending provider, and such action is consistent with the patient's plan of care.

Mental Abuse: Defined as, but not limited to, humiliation, harassment, threats of punishment, or withholding of treatment or services; Failure to respect professional relationship boundaries; bullying.

Misappropriation of Patient Property: The deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a patient's belongings or money without the patient's consent.

Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

Physical Abuse: Defined as hitting, slapping, pinching, rough handling, kicking, etc. It also includes controlling behavior through corporal punishment.

Sexual Abuse: Includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.

Verbal Abuse: Defined as any use of oral written, or gestured language that includes disparaging and derogatory terms to patient or their families, or within their hearing distance, to describe patients, regardless of their age, ability to comprehend, or disability.

Workforce Members: Workforce members are the officers, board members, employees, volunteers, trainees, credentialed professionals (including Medical Staff members and other individuals granted clinical privileges), and other health care practitioners and their staff of NCH and its Affiliates, whether or not they are paid by NCH or an Affiliate.

General:

NCH is committed to protecting the patient's right to be free from abuse, neglect, misappropriation of property, corporal punishment and involuntary seclusion and will not condone patient abuse by any of its employees, guests, contractors, etc. Note, it is acknowledged that at times, restraints are appropriate and should be used in accordance with the NCH Restraint Use in Personal Safety Emergencies policy.

An employee shall not knowingly:

a. Attempt, with or without threats or promises of benefit, to induce another to fail to report an incident or suspected incident of abuse.
b. Fail to report an incident or suspected incident of abuse.

c. Alter, change, destroy, or render unavailable (without proper authorization) a report made by another.
d. Screen report or withhold information to reporting agencies.

Infractions will lead to disciplinary action which will be taken as outlined in the NCH Discipline policy.

Prevention and Intervention

NCH will not knowingly employ any individual who has been found guilty of abusing, neglecting, or mistreating patients by a court of law, or has had a finding entered into the State nursing aide registry concerning abuse, neglect, or mistreatment of patients or misappropriation of their property. The Human Resources Department will conduct employment background screening checks, reference checks, and criminal conviction investigation checks on individuals making application for employment with this facility.

a. For any licensed professional applying for a position that may involve direct contact with patients, their respective licensing board will be contacted to determine if any sanctions have been assessed against the applicant's license.
b. Should the background investigation disclose any misrepresentation on the application form or information indicating that the individual had been convicted of abuse, neglect, mistreatment of individual, and/or theft of property, the applicant will not be employed, or, if already employed, will be terminated from employment.
c. Information (e.g., court actions) discovered through the course of the background investigation that indicates the applicant is unfit for duty will be provided to the individual's appropriate licensing boards.
d. Prior convictions of offenses other than abuse, neglect, mistreatment of individuals, and/or theft of property may not necessarily disqualify an applicant from employment with the facility. Serious consideration will be given to the position applied for, the type and seriousness of the offense, how recently the offence was committed, and whether there is any pattern or recurrences.
e. The facility will report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other hospital personnel to the state nurse aide registry or licensing authorities.

Employee Training

All employees will receive training on policies and procedures prior to having any patient contact through orientation programs and periodically on an ongoing basis.

a. The facility's patient rights, and abuse and neglect prevention/intervention educational training programs include but are not limited to:
    1. A review of patient rights published by the state.
    2. A review of the facility's abuse and neglect prevention/intervention and reporting policies and procedures, including what constitutes abuse, neglect, and misappropriation of property.
    3. Recognizing signs and symptoms of abuse.
    4. Dealing with aggressive or catastrophic patient behaviors/reactions.
    5. How and to whom incidents of suspected abuse, neglect, and mistreatment should be reported.
    6. Other training programs that may be helpful in preventing patient abuse.
b. Mandatory competency assessment includes patient rights, abuse and neglect prohibition, prevention, and reporting policies and procedures.
c. When changes in regulations or facility practices occur that affect patient rights, education will be provided to inform Hospital personnel of such changes.

Identification and Assessment of Potential Victims

Any person having reason to believe that an individual, **specifically a child under 18 or an incapacitated adult**, has been subjected to abuse, neglect, or exploitation is obligated to report such to the appropriate agency. Victims of alleged or suspected abuse or neglect may present through various settings or services.

Appropriate care cannot be provided unless suspected or alleged victims are identified.

Assessment Criteria:

Abuse of Children

a. Hospital personnel should be alert for:
    1. An explanation of an injury to a child which seems inconsistent with the nature and/or extent of that injury.
    2. A delay in seeking medical attention for a serious injury to a child.
    3. Multiple injuries at different stages of healing.
b. Injuries often associated with physical abuse are:
    1. Bruises found in unexpected or in unusual places, especially when they do not match the explanation of how they occurred.
    2. Multiple and severe bruises, especially bruises which may have been inflicted with an object, e.g., a strap or paddle.
    3. Fractures in bones of a child less than 6 months of age.
    4. Multiple fractures at different stages of healing.
    5. Joint injuries confirmed by x-rays, secondary to twisting or pulling of a child's limbs.
    6. Injuries secondary to shaking, squeezing, or throwing of a child, e.g., internal bleeding, subdural hematoma, retinal hemorrhage.
    7. Cigarette burns which may be found in unusual places and be at different stages of healing.
    8. Scald type burns, especially if these do not match the explanation of how the injury occurred.
c. Be alert for a history of repeated or suspicious injuries.
d. Observe for evidence of sexual abuse. This should be considered in the following circumstances when the complaints center on:
    1. Stains or blood on underwear.
    2. Pain in anal or genital area.
    3. Vaginal or penile discharge or bleeding.
    4. Genital inflammation or penile swelling or bruises.
    5. Sexually transmitted infections appearing on genitals, anus, or throat.
    6. Pain on urination in the male patient.
e. Be aware of other historical indicators which may reflect child abuse syndrome such as:
    1. Multiple accidental injuries or ingestions.
    2. Child removed from Hospital against medical advice.
    3. Parental fear of being left alone with child.
    4. Failure to return for follow-up care.
    5. Criticism about treatment of the child by neighbors or family.
    6. Parent(s) who were abused themselves.
f. Observe for an unexplained growth failure, e.g., non-organic, in a child.
g. Be alert for evidence of gross neglect including:
    1. Lack of adequate food, clothing, and/or shelter.
    2. Lack of nurturing and affection, e.g., gross emotional neglect.
    3. Lack of adequate supervision which has led to a serious accident involving a child.
    4. Lack of appropriate medical care or use of inappropriate medical care which jeopardizes a child's health.
h. Note the child's behavior. Observe the demeanor of the child, e.g., withdrawn, fearful of parents or caregiver, distrustful.
i. Assess the child's understanding of the situation.
j. Observe the emotional state of the caregiver, e.g., caring, concerned/unconcerned, angry with child, staff, or agent of abuse. Is caregiver supportive? Does caregiver have unrealistic expectations for the child based on the child's current developmental level?

Abuse, Neglect, and/or Exploitation of an Incapacitated Adult

("Incapacitated" means that the physical, mental, or emotional ability of a person is such that he/she is unable to manage personal, home, or financial affairs in their own best interest, or they are unable to act or unable to delegate responsibility to a responsible caretaker or caregiver.)

a. Review the reason for the visit, admission, or appointment for evidence of non-accidental injury. Data sources include a physical examination, x-ray findings, and/or review of the medical chart and other records.
b. Hospital personnel should be alert for:
    1. An explanation of an injury which seems inconsistent with the nature and/or extent of that injury.
    2. A delay in seeking medical attention for a serious injury.
    3. Multiple injuries at different stages of healing.
c. Injuries often associated with physical abuse in adult, elderly and/or mentally impaired patients are:
    1. Bruises found in unexpected or unusual places, especially when these do not match the explanation of how they occurred.
    2. Presence of multiple untreated or poorly treated decubiti.
    3. Presence of hip and proximal femur fractures. Although common after accidental falls, identical injuries can occur if the patient has been pushed or tripped intentionally.
    4. Multiple and severe bruises, especially bruises which appear to have been inflicted with an object.
    5. Burns resulting from:
        i. Cigarettes or cigars.
        ii. Splashes.
        iii. Friction (being dragged on the ground).
    6. Injuries secondary to shaking, squeezing, or throwing, e.g., internal bleeding, subdural hematoma, retinal hemorrhage.
    7. Evidence of sexual abuse, e.g., blood stains on underwear, pain or discharge in anal or genital area.
    8. Skull fracture.
    9. Stab wounds.
    10. Scalp and facial lacerations.
    11. Oral mucosa lacerations.
    12. Facial or nose contusions or fractures.
    13. Patterned bruises.
    14. Torso injuries:
        i. Breast contusions.
        ii. Fractured ribs.
        iii. Abdominal contusions, especially during pregnancy.
        iv. Back or spine injuries.
    15. Neurologic impairment:
        i. Altered consciousness from strangulation attempts.
        ii. Intracranial hemorrhage.
        iii. Post-concussion symptoms.
        iv. Visual impairment resultant from corneal abrasion or retinal detachment.
    16. Miscarriages.
d. Be alert for a history of repeated or suspicious injuries.
e. Be alert for evidence of gross neglect including:
    1. Malnourished and/or dehydration.
    2. Subtherapeutic or toxic drug levels.
    3. Lack of affection and emotional support, e.g., gross emotional neglect.
    4. Lack of appropriate medical care or use of inappropriate medical care which jeopardizes patient health.
    5. Prolonged lack of attendance to hygienic needs, e.g., strong body odor, filth, infestation with lice or scabies.
f. Obtain a weight if nutritional neglect is suspected.
g. Note demeanor of the patient; be alert for signs indicating fear of spouse, family member or significant other. Note if the patient seems untrusting of caregiver/ spouse.
h. Assess the patient's understanding of the situation.
i. Observe the emotional state of the caregiver or spouse, e.g., caring, concerned/unconcerned, angry with patient, staff, or agent of abuse. Is the caregiver/spouse supportive, or overly supportive?

Patient-to-Patient (or Family Member, Visitors, or Hospital Personnel) Abuse

All forms of patient-to-patient (or family members, visitors, or Hospital Personnel) abuse and neglect will be reported immediately to manger/supervisor. Anyone reporting an incident of abuse or neglect, or suspected abuse or neglect, will be protected from retaliation.

a. Facility staff will monitor patients for aggressive/inappropriate behavior toward other patients, family members, visitors, or to Hospital personnel. Occurrences of such incidents must be promptly reported to Management.
b. Should a person be observed/accused of abusing another patient, family members, visitors, or Hospital personnel, the facility will implement the following actions:
    1. Provide care and safety for the abused patient, family members, visitors, or Hospital personnel;
    2. Remove the aggressor from the situation if the aggressor is still in the area in which the incident occurred;
    3. Temporarily separate the aggressor from other patients as a therapeutic intervention to help lower the agitation until the interdisciplinary care planning team can develop a plan of care to meet the needs of the patient;
    4. Counsel the patient to determine the cause of the behavior;
    5. Notify each patient's representative and attending provider;
    6. Evaluate the circumstances/events leading up to the incident;
    7. Develop a care plan that includes interventions to prevent the recurrence of such incident;
    8. Inform all Hospital personnel involved in the care of the patient of the care plan and to promptly report behavioral changes to the charge nurse, as appropriate;
    9. Document in the patient's clinical records all interventions and their effectiveness;
    10. Consult psychiatric services for assistance in assessing the patient and developing a care plan for intervention and management as necessary or as may be recommended by the attending provider or interdisciplinary care planning team;
    11. Complete an incident/occurrence report and document the incident, findings, and any corrective measures taken in the patient's medical record;
    12. Transfer the patient for psychiatric evaluation if deemed by the interdisciplinary care planning team and medical director as being a danger to themself or to others; and
    13. Report incidents, findings, and corrective measures to appropriate agencies as outlined in the facility's abuse reporting policy.

Allegation of Abuse of a Patient by Staff

Upon learning from a patient, staff member or other party of an allegation of abuse of a patient, rough handling or inappropriate touching/sexual conduct by staff, the employee shall confer with their manager/supervisor.

The Manager/Leadership will:
a. Provide care and safety for the abused patient;
b. Remove the aggressor from the situation if the aggressor is still in the area in which the incident occurred;
c. Notify the attending provider caring for the patient who in turn will perform a physical assessment as appropriate;
d. Implement actions such as placing affected staff member on administrative leave pending an investigation;
e. Recommend that the affected staff member not be reassigned to another unit/position/location until the conclusion of the investigation;
f. Should law enforcement be called in by the patient, the patient's legal representative or the facility, the leadership team will allow them to investigate without any interference;
g. Determine who will conduct the investigation if law enforcement is not involved or has concluded their investigation;
h. Obtain a list of all involved parties (including alleged victim, witnesses, name of attending, family, etc.);
i. Obtain patient name, dates of admission/service and diagnosis;

Communication/Notification
a. Contact Risk Management;
b. Ensure that other departments where patient may need care while the investigation is underway are notified of the allegation of abuse;
c. Perform additional notifications to providers, leadership, legal and public relations with periodic updates as investigation progresses;

d. Risk Management to support leadership or designee in the investigation; verify the incident/event report is submitted and ensure a thorough and credible documentation trail is created;
e. Diffuse the situation as needed with other staff;
f. Identify one person to serve as primary contact to the patient and family;

Investigation/Reporting Requirements
a. Leadership will interview patient with manager present and they will involve law enforcement early as needed;
b. Interview accused staff member and other identified staff;
c. Interview witnesses;
d. Risk Management/senior leadership/human resources will determine if the incident will require a report to regulatory, licensing and/or law enforcement agencies;
e. Return impacted staff to duty or take progressive steps as needed.

Responsibilities for Safeguarding Evidentiary Material and Reporting the Situation

a. The employee will confer with their manager/supervisor. Manager/supervisor will notify Risk Management. The patient's statements or medical, physical, or social facts will be documented in the medical record. Personnel will be especially alert to preserve evidence.
b. A report to Division of Child, Youth & Families or Bureau of Elderly and Adult Services must be made by the individual witnessing and/or suspecting abuse, neglect, or exploitation.
    1. The patient, parent, or guardian must be promptly informed that such a report has been or will be made, except if it is believed that informing them would place the patient at risk of serious harm; or it is reasonably believed that the personal representative is responsible for abuse, neglect, or other injury, and that informing this person would not be in the best interests of the patient as determined by the staff.
    2. The individual disclosing protected health information shall immediately report such disclosure to the Hospital Coordinator if Monday-Friday during the day shift.
c. Care Management will be notified of inpatient reports to the Division of Child, Youth, & Families or Bureau of Elderly and Adult Services. Care Management will be involved in formulating a discharge plan in cooperation with the appropriate Division as needed.
d. Report suspected child abuse/neglect to the New Hampshire Division of Children and Youth Services at 1-800-894-5533, for all children under the age of 18, including “emancipated” minors. Proof of abuse and neglect is not required to make a report.
e. If requested, a written report should be completed and mailed to the New Hampshire Division of Welfare within 48 hours. A copy of the Emergency Department record may also be requested.

Division of Child, Youth & Families
129 Pleasant Street
Concord, NH 03301
603-271-6562 or 1-800-894-5533 (In state only)

*Call the local police department or dial 911 if there is concern for immediate safety of the child.

f. Report suspected child abuse/neglect to the Vermont Department of Children and Families at their St. Johnsbury office at 802-748-8374 or at their Newport office at 802-334-6723. Caseworkers will interview families and victims within 72 hours.

Department of Children and Families
1016 US-5
St. Johnsbury, VT 05819
802-748-8374
*24-hour Emergency Number: 802-626-8303
Areas Covered: Lunenburg, Guildhall, Gilman, and Granby.

Department of Children and Families

100 Main Street, #230
Newport, VT 05855
802-334-6723
*Areas Covered: Maidstone to Canaan.

*Call the local police department or dial 911 if there is concern for immediate safety of the child.

g. Report cases of suspected abuse, neglect, and/or exploitation of the elderly, or incapacitated adult to:

1. For individuals who live independently in their own homes, with relatives or friends, in boarding homes, or who live or participate in homes/programs administered by or affiliated with the Division of Mental Health and Developmental Services, or who are temporarily in other community settings, contact:

Berlin District Office
650 Main Street, Suite 200
P.O. Box B
Berlin, NH 03570
603-752-7800 or 1-800-972-6111

Littleton District Office
80 N Littleton Road
Littleton, NH 03561
603-444-6786

2. If you are unable to reach the appropriate District Office indicated above, contact the following:

Administrator
Office of Community Services
New Hampshire Bureau of Elderly and Adult Services
105 Pleasant Street
Concord, NH 03301
603-271-9203 or 1-800-351-1888

3. For individuals who live in nursing homes, residential care facilities, or sheltered care facilities contact:

Long Term Care Ombudsman
Office of the Commissioner
NH Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301
603-271-4375 or 1-800-442-5640

h. Elderly mentally impaired or physically impaired patients should be protected from accidental injury while at the hospital. It may be necessary for a staff member or support person to remain with the patient.
i. For the elderly person who is alert, oriented, and competent, shelters or alternate family members may be an option.
j. Report abuse, neglect or exploitation which occurs in the Hospital and is allegedly perpetrated by a staff member, volunteer or any individual in the employ or under supervision of the facility to Central Office of the Bureau of Elderly and Adult Service tel. # 1-800-351-1888.
    1. An advocate will come to the Hospital.
    2. The advocate is offered opportunity to meet with victim.
    3. If the victim agrees to meet with advocate, a private location with complete confidentiality is needed.
    4. If victim refuses, advocate will provide literature and referral material to victim.

Responsibility of Reporting of Adult Abuse

a. Mentally competent individuals have a right to choose whether or not to return to the abusive home. If the abused person chooses to return to the abusive situation, it should be ensured that the patient has emergency referral numbers.
b. Ensure that abused adults are aware of shelter and referral agencies such as RESPONSE at 1-800-662-4220, 24-hour crisis line, Berlin office at 603-752-5679 or Groveton office at 603-636-1747.
c. In some circumstances, an abuse of an adult is exempted from the reporting provisions. Reporting is not required if the person seeking or receiving treatment or other assistance:
    1. Is 18 years of age or older,
    2. Has been a victim of sexual assault offense or abuse as defined in RSA 173-B:1,
    3. Objects to the release of any information to law enforcement officials, and
    4. Is not being treated for a gunshot wound or other serious bodily injury.

Documentation

All patients are screened during the nursing assessment process:
a. Complete documentation is imperative in suspected abuse, neglect, or exploitation cases, even if not reportable.
b. Record a comprehensive history, any observations, interventions, treatment, and patient care measures including:
    1. Name of professionals accompanying the patient.
    2. Informant.
    3. Date, time, and place of the abuse incident.
    4. How the abuse occurred.
    5. Who allegedly abused the victim.
    6. Any history of past abuse.
c. The following should be considered when documenting physical exam findings and/or describing the injury or injuries:
    1. List the injuries by site, e.g., head, arms, legs, back, buttocks, chest, abdomen, genitalia.
    2. Describe each injury by size, shape, color, etc.
    3. If the injury identifies the object that caused it, always say so, e.g., strap mark, cigarette burn.
    4. Use non-technical terms like "cheek" instead of "Zygoma", "bruise" instead of "ecchymosis".
    5. Use direct quotations of statements of threat/abuse.
d. Document circumstances that brought the patient to the facility.
e. Document the presence of fresh and old injuries.
f. Document any x-rays, laboratory tests, and/or other diagnostic studies done.
g. Record any follow-up instructions and/or appointments made.
h. Document any referrals to counseling or social services.

Bibliography:

NH RSA 169-C: 29-31, 1979; 161-F: 46-57, 2002; 45 CFR 164.512:C1-C2.

Sheehy's Emergency Nursing Principles and Practices, 7th Edition, 2019, pgs. 174-185.

Sheehy's Manual of Emergency Care, 7th Edition, 2013, pgs. 521-546.

CMS Conditions of Participation, Critical Access Hospitals and Swing Beds in CAHs, Rev 137, 4/1/15.

Rescission:

This policy is new and therefore does not rescind or replace any other.

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