PRESBYTERIAN

Process for Reporting Patient Abuse, Neglect or Exploitation / Theft of Property to the NM Health Care Authority

Last updated December 2024

How to Report

If you become aware of a possible situation of patient abuse, neglect or theft of property:

1. **Ensure Patient is Safe:** Always make sure the patient is safe first.
2. **Notify:**
   - **The operations person in charge**: (such as the medical social worker, house supervisor, clinical lead, practice administrator, on-call administrator or charge nurse), *and*
   - **The Risk Management Department** at (505) 923-8801
3. **Complete Report Form:** Work with your supervisor and the Presbyterian Risk Management Department to complete a report to the State Health Care Authority (instructions on following pages).

Remember

New Mexico state law is very specific that the individual who has a **direct knowledge** of an incident of or signs of abuse, neglect or exploitation must be the one to fill out **the first page** of the Health Care Authority Incident Report Form.

- You will have help and assistance available to you from your manager and the Presbyterian Risk Management Department.
- The law is specific, however, that you must supply the information for the report form about what happened.

Health Care Authority Incident Report Form Instructions

The Health Care Authority (HCA) Incident Report Form consists of **3** pages:

- Pages 1 & 2 are required; page 3 is optional.
  - You must provide the information to complete sections 1 and 2 on page 1.
  - Your supervisor may assist you in completing sections 3 through 5 on page 2 as needed.
- If you have never filled out this form, or need assistance:
  - Contact the Presbyterian Risk Management Department at (505) 923-8801.
- If you are comfortable completing the form yourself:
  - Be sure to inform the Risk Management Department when you send a report.
  - Email or Fax a copy of the completed report to them at (505) 923-8134.

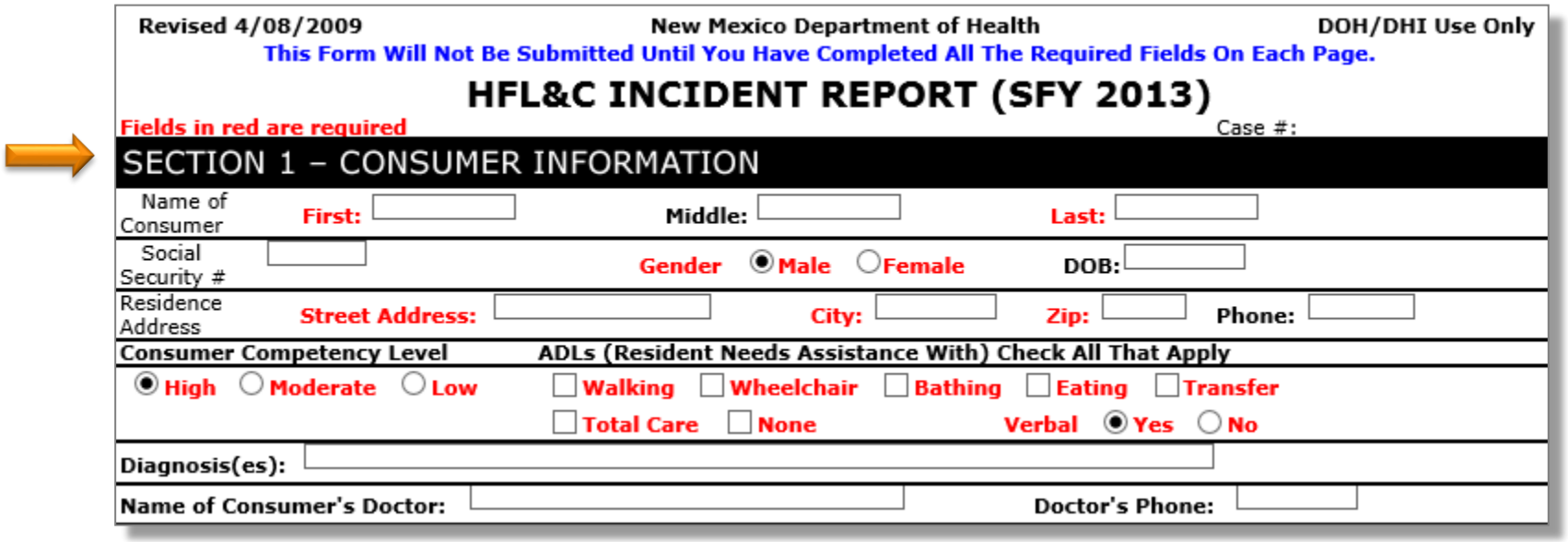
NOTE: In these instructions, we will only discuss how to fill out Page 1. If you need assistance in completing page 2, please contact the PHS Risk Management Department at (505) 923-8801.

Step 1: Complete HCA Incident Report Form

Page 1 has two sections to be completed by the person with direct knowledge of the incident:

The first section on page 1 is *Consumer Information*:

- Complete as much demographic information about the "consumer" – that is the potential victim - as possible.
- Required fields are shown in **red**.
- Date of birth and/or social security number are critical identifiers if you have them, but are not required fields.



Revised 4/08/2009 — New Mexico Department of Health — DOH/DHI Use Only

This Form Will Not Be Submitted Until You Have Completed All The Required Fields On Each Page.

HFL&C INCIDENT REPORT (SFY 2013)

Fields in red are required — Case #:

SECTION 1 – CONSUMER INFORMATION

Name of Consumer — First: — Middle: — Last:

Social Security # — Gender ◉ Male ○ Female — DOB:

Residence Address — Street Address: — City: — Zip: — Phone:

Consumer Competency Level: ◉ High ○ Moderate ○ Low

ADLs (Resident Needs Assistance With) Check All That Apply: ☐ Walking ☐ Wheelchair ☐ Bathing ☐ Eating ☐ Transfer ☐ Total Care ☐ None

Verbal: ◉ Yes ○ No

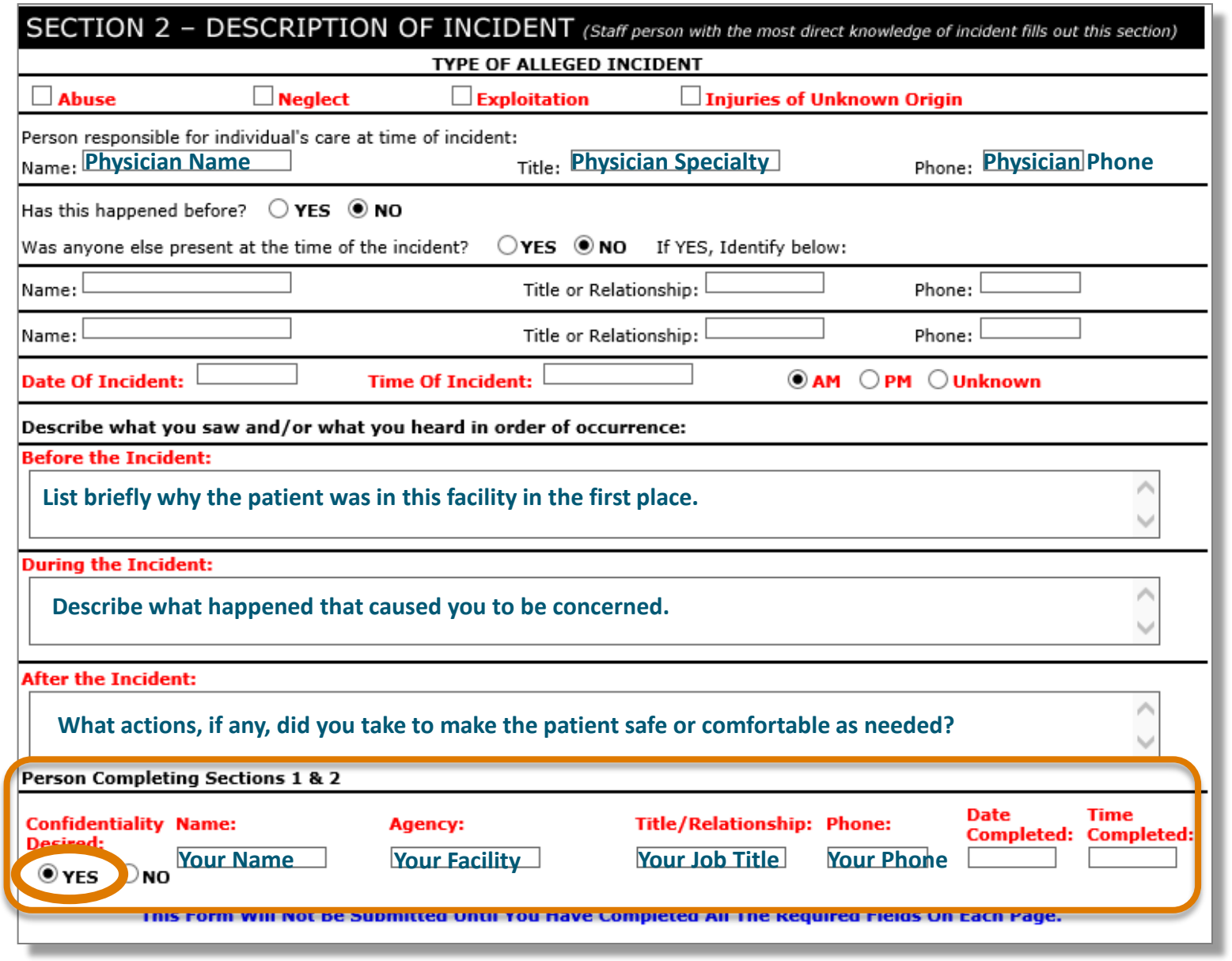
Diagnosis(es):

Name of Consumer's Doctor: — Doctor's Phone:

Step 1, continued: HCA Incident Report Form

NOTE about Confidentiality: List your name & contact info on the bottom of this page.

If you want your name to remain confidential, click "Yes" by "Confidentiality Desired."



SECTION 2 – DESCRIPTION OF INCIDENT *(Staff person with the most direct knowledge of incident fills out this section)*

TYPE OF ALLEGED INCIDENT

☐ Abuse ☐ Neglect ☐ Exploitation ☐ Injuries of Unknown Origin

Person responsible for individual's care at time of incident:
Name: Physician Name Title: Physician Specialty Phone: Physician Phone

Has this happened before? ○ YES ◉ NO

Was anyone else present at the time of the incident? ○ YES ◉ NO If YES, Identify below:

Name: Title or Relationship: Phone:

Name: Title or Relationship: Phone:

Date Of Incident: Time Of Incident: ◉ AM ○ PM ○ Unknown

Describe what you saw and/or what you heard in order of occurrence:

Before the Incident:

List briefly why the patient was in this facility in the first place.

During the Incident:

Describe what happened that caused you to be concerned.

After the Incident:

What actions, if any, did you take to make the patient safe or comfortable as needed?

Person Completing Sections 1 & 2

Confidentiality Desired:	Name:	Agency:	Title/Relationship:	Phone:	Date Completed:	Time Completed:
◉ YES ○ NO	Your Name	Your Facility	Your Job Title	Your Phone		

This Form Will Not Be Submitted Until You Have Completed All The Required Fields On Each Page.

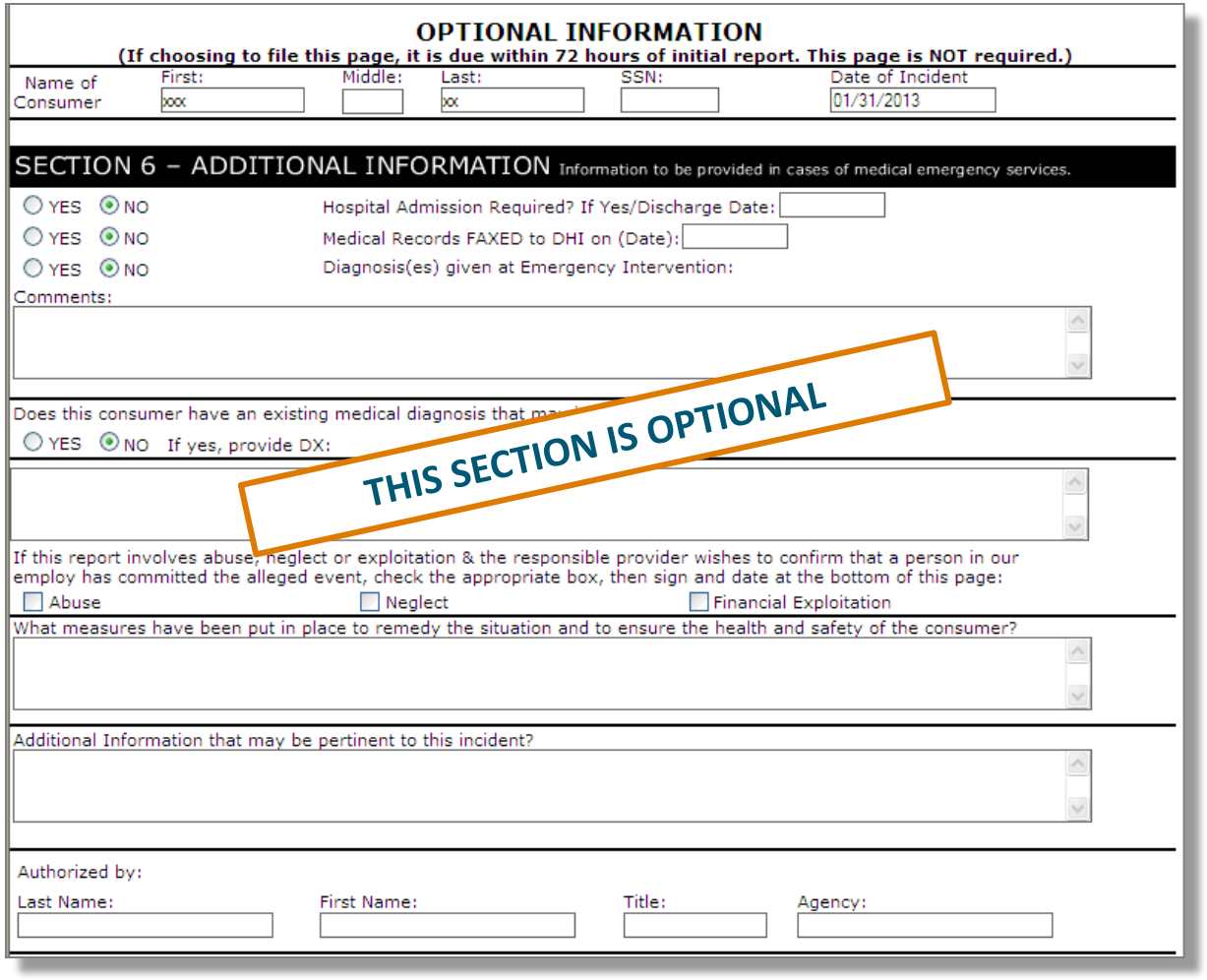
Step 2: Submit HCA Incident Report Form

Sections 1 through 5 of the report are ***required***. They are on Pages 1 and 2.

Section 6 on Page 3 is optional.

Once you have filled in the required sections, save a completed copy to your computer.

NOTE: If unable to save, then print several copies before closing the document.



OPTIONAL INFORMATION

(If choosing to file this page, it is due within 72 hours of initial report. This page is NOT required.)

Name of Consumer | First: xxx | Middle: | Last: xx | SSN: | Date of Incident 01/31/2013

SECTION 6 – ADDITIONAL INFORMATION Information to be provided in cases of medical emergency services.

YES NO Hospital Admission Required? If Yes/Discharge Date:

YES NO Medical Records FAXED to DHI on (Date):

YES NO Diagnosis(es) given at Emergency Intervention:

Comments:

Does this consumer have an existing medical diagnosis that ma

YES NO If yes, provide DX:

THIS SECTION IS OPTIONAL

If this report involves abuse, neglect or exploitation & the responsible provider wishes to confirm that a person in our employ has committed the alleged event, check the appropriate box, then sign and date at the bottom of this page:

☐ Abuse ☐ Neglect ☐ Financial Exploitation

What measures have been put in place to remedy the situation and to ensure the health and safety of the consumer?

Additional Information that may be pertinent to this incident?

Authorized by:

Last Name: First Name: Title: Agency:

Step 3: Submitting and Filing Copies of the Report

Once you have completed the report, save it on your computer and send or attach copies to the following:

1. **The NM Health Care Authority**, Incident Management Bureau:
   (Copy to Risk Management)
2. **Protective Service Agency** (depending on age of victim):
   - ***Under age 18:*** Child Protective Services
   - ***Age 18 or older:*** Adult Protective Services
     (Copy to HIM for scanning into the record)

Contact information detail is on next page

Report Contact Information

Allegations/suspicions of abuse unrelated to PHS care

Report to *ONE* of the following:

Alleged Victim is under 18 years of age:
Child Protective Services:

- Call first: 1-855-333-7233 *and*
- Fax the HCA Incident Report form to 505-841-6691

– or –

Alleged Victim is 18 or older:
Adult Protective Services:

- Call first: 1-866-654-3219 *and*
- Fax the HCA Incident Report form to 1-855-414-4885

Allegations of abuse/neglect at PHS

Report to the NM Health Care Authority (HCA):

- Contact Risk Management for help
- Make a copy of the completed form and send to Risk Management
- Submit the HCA Incident Report form via fax or e-mail:
  Fax: 1-888-576-0012
  Email: Incident.Management@hca.nm.gov

Report the event: MIDAS risk events

RISK EVENT REPORTING

Call Risk Management for assistance if needed

Supervisor / Charge Responsibilities

The supervisor, clinical lead, charge nurse or administrator is responsible for:

- ✓ **Reviewing the policy(ies)** – the relevant policies are in the PEL. You should review these carefully to ensure that the appropriate steps are followed
- ✓ **Ensuring the event was reported** – via the Risk Event Reporting link on the PresNet Homepage
- ✓ **Ensuring that the appropriate individuals and agencies are notified within 24 hours** (individuals and agencies are listed in the policy and in these instructions)
- ✓ **Notifying the patient's attending physician** or other licensed provider

Related Presbyterian Policies

Some key policies that you can refer to for more specific information about responding to patient abuse or neglect, or theft of patient property are:

- **Abuse, Neglect and Misappropriation of Property - Recognition, Identification, Reporting and Follow-up Policy** (PC.PDS.129) – reporting process
- **Workplace Violence** (HR.PHS-E.322) – what to do in emergency situations
- **Patient Grievance and Complaint Management** (PC.PDS.171) – how to handle patient complaints in general, and in particular complaints about misappropriation of property

NOTE: All of these policies are available on the Presbyterian Electronic Library (PEL). If you do not have access to the PEL, you may contact the PHS Compliance Department to obtain copies.

Questions?

If you have questions or need assistance with this process, contact:

Presbyterian Risk Management Dept.

(505) 923-8801