



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

# 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

It is recommended that the [PDF form](#) be used. HCA's online [Incident Report Form](#) can also be used, but PDF is easier to use.

- Pages 1 & 2 of the [PDF](#) 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 a copy of the completed report to them at [dlriskmanagement@phs.org](mailto:dlriskmanagement@phs.org)

**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 PDF Form

Page 1 of [PDF](#) 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)

Case #: \_\_\_\_\_

**Fields in red are required**

**SECTION 1 – CONSUMER INFORMATION**

Name of Consumer	<b>First:</b> <input type="text"/>	Middle: <input type="text"/>	<b>Last:</b> <input type="text"/>
Social Security #	<input type="text"/>	<b>Gender</b> <input checked="" type="radio"/> <b>Male</b> <input type="radio"/> <b>Female</b>	<b>DOB:</b> <input type="text"/>
Residence Address	<b>Street Address:</b> <input type="text"/>	<b>City:</b> <input type="text"/>	<b>Zip:</b> <input type="text"/> <b>Phone:</b> <input type="text"/>
<b>Consumer Competency Level</b>	<b>ADLs (Resident Needs Assistance With) Check All That Apply</b>		
<input checked="" type="radio"/> <b>High</b> <input type="radio"/> <b>Moderate</b> <input type="radio"/> <b>Low</b>	<input type="checkbox"/> <b>Walking</b>	<input type="checkbox"/> <b>Wheelchair</b>	<input type="checkbox"/> <b>Bathing</b> <input type="checkbox"/> <b>Eating</b> <input type="checkbox"/> <b>Transfer</b>
	<input type="checkbox"/> <b>Total Care</b> <input type="checkbox"/> <b>None</b>	<b>Verbal</b> <input checked="" type="radio"/> <b>Yes</b> <input type="radio"/> <b>No</b>	
<b>Diagnosis(es):</b>	<input type="text"/>		
<b>Name of Consumer's Doctor:</b>	<input type="text"/>	<b>Doctor's Phone:</b>	<input type="text"/>

# Step 1, continued

**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:       Title:       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:**

**During the Incident:**

**After the Incident:**

**Person Completing Sections 1 & 2**

Confidentiality Desired:	Name:	Agency:	Title/Relationship:	Phone:	Date Completed:	Time Completed:
<input checked="" type="radio"/> YES <input type="radio"/> NO	<input type="text" value="Your Name"/>	<input type="text" value="Your Facility"/>	<input type="text" value="Your Job Title"/>	<input type="text" value="Your Phone"/>	<input type="text"/>	<input type="text"/>

**THIS FORM WILL NOT BE SUBMITTED UNTIL YOU HAVE COMPLETED ALL THE REQUIRED FIELDS ON EACH PAGE.**

## 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."

## Step 2: Submit Completed 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
<b>SECTION 6 – ADDITIONAL INFORMATION</b> Information to be provided in cases of medical emergency services.					
<input type="radio"/> YES <input checked="" type="radio"/> NO		Hospital Admission Required? If Yes/Discharge Date: <input type="text"/>			
<input type="radio"/> YES <input checked="" type="radio"/> NO		Medical Records FAXED to DHI on (Date): <input type="text"/>			
<input type="radio"/> YES <input checked="" type="radio"/> NO		Diagnosis(es) given at Emergency Intervention:			
Comments: <input type="text"/>					
Does this consumer have an existing medical diagnosis that may be related to this incident? <input type="radio"/> YES <input checked="" type="radio"/> NO If yes, provide DX: <input type="text"/>					
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: <input type="checkbox"/> Abuse <input type="checkbox"/> Neglect <input type="checkbox"/> Financial Exploitation					
What measures have been put in place to remedy the situation and to ensure the health and safety of the consumer? <input type="text"/>					
Additional Information that may be pertinent to this incident? <input type="text"/>					
Authorized by:					
Last Name:	First Name:	Title:	Agency:		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		

**THIS SECTION IS OPTIONAL**

## 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/suspicious 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](mailto:Incident.Management@hca.nm.gov)

**Report the event via HRP**

**UNANTICIPATED 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 [Unanticipated 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.

# Optional: Completing Online Form

- **IT IS RECOMMENDED THAT YOU USE THE [PDF FORM](#)**
- IF, however, you use HCA's [Online Form](#), still **contact PHS Risk Management Department** at (505) 923-8801 **FIRST**.
  - When completing the online form, only the blanks with an asterisk (\*) are required.
  - When completing the online form, **MAKE SURE** you include your email address in this box at the bottom of the form, **BEFORE** you submit:

Email Copy of Report To

Enter your email address if you want a copy of the report emailed to you.

- **FORWARD** that email to Risk Management
- Contact Risk Management at (505) 923-8801 with any questions.

# Questions?

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

**Presbyterian Risk Management Dept.**

**(505) 923-8801**

