Testimony on H.171
To the Senate Health and Welfare Committee
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Howard Center
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Thank you for the opportunity to share my thoughts on H.171, which addresses updates to the act relating to Adult Protective Services.

I am the Senior Director of Nursing at Howard Center in Burlington, and I am testifying on behalf of Vermont Care Partners, and other health trade associations representing hospitals, home health agencies, long term care facilities, physicians, and federally qualified health centers.

I am here to share my feedback on H.171, specifically the inclusion of caregiver negligence in the definitions of abuse and neglect. I advise removal of the word negligently from the definition of Abuse, and removal of the word negligent from the definition of Neglect.

Rationale:

The use of the words negligent and negligently expands the scope of the mandatory reporting to include unintentional errors or omissions, and the potential ramifications of this are significant.

In Vermont, there are thousands of adults who are considered vulnerable due to serious mental illness, intellectual and developmental disabilities, acquired brain injuries, or disabled from causes related to aging and other conditions. No responsible caregiver ever wants to make a mistake, forget a medication, or otherwise jeopardize another human's health or wellbeing; and no parent, child or guardian ever wants to hear that a mistake has been made when it comes to the care that a vulnerable adult should be receiving. Most importantly, no vulnerable adult would ever choose to be the victim of an error or omission that causes or has the potential to cause harm.

Some of the caregivers working with these vulnerable adults are employed by agencies as direct support professionals, some are contracted by agencies as Shared Living Providers, and some are hired as independent contracted supports (meaning in home supports, community support workers, and respite providers), through a variety of community-based programs and service organizations. As I'm sure you are already aware, there is a significant shortage of available caregivers to meet the needs of the vulnerable adults in our State. Many people in Vermont also provide care to a vulnerable adult (such as a parent or other family member), not as an occupation, but in addition to their primary employment, household management, or childrearing.

Paid or unpaid, one thing all caregivers have in common is that they are human beings, and even the most well-trained or experienced of providers (including nurses, physicians, therapists, and many other disciplines in the healthcare profession) make mistakes. This work is mentally, physically, and emotionally challenging, and they may be doing this work during very stressful or unpredictable

circumstances, such as when their residential program is short-staffed, covering an overnight shift when they weren't scheduled, or trying to support a vulnerable adult who is disoriented, agitated, or combative.

If the scope of the mandatory reporting is expanded to include unintentional errors or omissions based on the proposed definitions, this would have a detrimental impact on an already strained workforce. Concern for being reported to Adult Protective Services if an adverse event were to occur may cause people to turn away from caregiving roles out of fear for their own well-being or concerns for their personal liability or reputation.

In the Designated Agencies and Specialized Service Agencies in Vermont, nursing staff delegate medication administration and other routine medical procedures to unlicensed personnel on a daily basis to support our vulnerable adults to live in the community. The act of delegation is a transfer of authority to perform the task, but the nurse retains accountability for supervising the delegation and evaluating the effectiveness of the delegation. When a mistake is made, such as medications being forgotten or given at the wrong time, we count on the caregivers to uphold their responsibilities and let us know when something has gone wrong, even if there was no actual harm to the vulnerable adult. We review the error, the contributing factors, look for unexpected variables, review the training the person received when they were delegated, and refer to applicable policies and procedures. We work collaboratively to get to the root of the error, improve trainings, provide additional oversight, and identify ways we can prevent similar errors from occurring in the future. Since the nurse is often not onsite when the error or omission occurred, we can only work to improve the safety of medication administration when we are aware of the incident that took place.

What would happen when a caregiver makes an error, or harm is caused to a vulnerable adult due to an omission, under this new language? As a nurse, I would be concerned that the error may not get reported at all. I would worry that mistakes would continue, because we can't fix a problem if we don't know there is one. I would worry that staff would feel pressure to cover-up an error, especially if the program is already short-staffed or if they feel there might be retaliation by their co-worker or supervisor. I know as a nurse that I can, and quite honestly have, made errors in my 18-year career. I also know that I can't learn from my mistakes if I'm stuck in a shame-cycle, and I would never want to impose shame or assign blame on others, especially when there hasn't been a chance to review the situation in depth. Even with that background, I also know that as the delegating RN, this language makes me feel more hesitant to delegate medication administration or special care procedures to unlicensed personnel.

I want to point out that we take our roles as Mandatory Reporters seriously, and we do make reports for medical errors or omissions when necessary, including but not limited to when the person responsible for providing care acts in a way that purposefully deviates from the medical plan of care or demonstrates reckless behavioral choices to consciously disregard a substantial risk when performing a medical procedure or administering medication. This is already occurring, and the addition of the language around negligence would not change anything in that regard.

The word negligence in the context of this bill expands the mandatory reporting requirements to a degree that is impossible to comply with, and fear of being reported could perpetuate harm if the caregivers who are responsible for the vulnerable adult are afraid of speaking up. On the other side of the spectrum, an employee's fear of missing something reportable could lead to over-reporting of minor infractions because a caregiver may be more worried about disciplinary action if they failed to report something. Either way, staff morale, efficiency, and effectiveness would not be enhanced, and our vulnerable adults will still be at risk. It is only by knowledge of errors and near miss events, in a learning-oriented context, that allows organizations to examine the situation, identify systemic factors that contributed to the error or event, and make improvements or corrections to prevent similar errors from occurring in the future. Reporting someone to APS for an error or omission related to a client's plan of care points judgment to the caregiver and detracts from the many other factors that contribute to medical mistakes.

Recommendations:

- Strike the word negligently from page 2, line 9, under § 6902. DEFINITIONS, 1 (A), "Abuse", and retain the words "purposefully, knowingly, and recklessly."
- Strike the word negligent from page 8, line 9, under § 6902. DEFINITIONS, 21 (A), "Neglect", and retain the words "purposeful, knowing, and reckless."