AMERICAN NURSES ASSOCIATION VERMONT

TO: Sen. Ginny Lyons
Senate Committee on Health and Welfare

FROM: Betsy Hassan, DNP, RN, NEA-BC, CPPS
American Nurses Association – Vermont

RE: Written Testimony Regarding H. 171, An act relating to adult protective services

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The American Nurses Association – Vermont strongly supports the need to report abuse and neglect of vulnerable adults. Nurses appreciate the importance of their role as mandatory reporters. However, H. 171 dramatically expands the scope of mandatory reporting that could negatively impact every nurse in the state as either a reporter or a person subject to a report.

The expansion of mandatory reporting, to include "negligence" within the definitions of abuse and neglect including the "negligent failure or omission by a caregiver," "to carry out a plan of care" will adversely affect all nurses in the largest part of the nursing workforce – acute care. The definition of a vulnerable adult could encompass almost every adult admitted as an inpatient in a hospital who is temporarily "disabled" and requires "assistance" with "personal care," or who have "some impairment" in their ability to protect themselves from abuse or neglect. These expansive definitions will confront nurses in their everyday work as they assume the care of a patient from a co-worker who missed a schedule dose of medication, or scheduled treatment. A busy nurse, who is a mandatory reporter, has no ability to gather the facts to determine if the missed does was due to professional negligence, or caused by a medical record systems error, or was due to a need to prioritize other patients. They will only know that they have an obligation to report their co-worker's failure to follow a plan of care.

Neither a busy staff nurse, nor a layperson investigator from Adult Protective Services (APS) have the ability to conduct a root cause analysis to determine if the missed dose was the result of professional negligence, that a reasonably prudent nurse could have avoided, or that it was caused by a flawed process, short staffing, or the needs of other patients. A root cause analysis, and an assessment of professional negligence takes time (longer than the two business days), and requires transparency, and expertise to determine if a reasonably prudent health care provider could, or should have avoided the deviation from a plan of care. Health care organizations are required to have quality assurance improvement programs (QAPIs) that enhance patient safety through the development of a Just Culture that require input from all relevant staff to identify the systems issues that cause most adverse events. In addition, there is extensive oversight of adverse events that includes reporting serious adverse events as part of the Patient Safety Surveillance and Improvement System to the Vermont Program for Quality in Health Care, the rigorous and frequent federal regulatory reviews performed by licensed nurses on behalf of CMS, and for licensing matters, the expertise of the Board of Nursing, and their knowledge of nursing practice and the provision of health care.

As an example, in my time as a Chief Nursing Officer/Vice President of Patient Care Services of a Vermont community hospital, the Patient Safety Department received over 6,000 event reports annually. A significant portion of these could be attributed to omissions of medications or medication errors. It should be noted that a culture of reporting potential and real adverse events is a health care industry best practice established in the 2000 seminal report from the Institute of Medicine, *To Err Is Human: Building a Safer Health System*. It is an essential component of building a culture that does not demonize and punish health care workers for events created by a failing system – **we want our staff to tell us the barriers in their work to patient safety**. Thorough investigation through a root cause analysis can take days to weeks to fully appreciate the contributing factors or causes of an adverse event. Through this event reporting system, reports to APS are made when there is any reason to suspect deliberate or reckless behavior. Nurses and health care providers when under investigation for potential or suspected abuse are typically removed from the care environment until the investigation is completed. With the expansion of abuse to include 'negligence,' many of these 6,000 adverse events would be reported to APS for review, thus pointing the finger at health care workers for failures in the system, and removing them from the workforce until APS completes the investigation.

Lowering the standard of abuse and neglect from a nurse or person that is **acting with purpose, knowledge and reckless behavior** to a nurse or person that makes a mistake that could have many contributing factors, not only adds fear, and will deter transparent reporting but will overburden agencies who should focus on investigations of perpetrators who engage in purposeful and reckless abuse and neglect of vulnerable adults in less regulated settings.

The ANA-Vermont urges the Legislature to be cautious in considering the proposed expansion of the abuse and neglect to include negligence, especially for highly regulated health care workers where such a change could have significant systemic impacts on the health care workforce, employers, professionals, and patients.

ANA-Vermont requests the following changes to H. 171:

Sec. 1

Page 2, line 9

- Strike the word "negligently" from the definition of abuse.

Page 8, line 9

- Strike the word "negligent" from the definition of neglect.

Page 13, lines 8-9

- Revise the definition of vulnerable adult to include " . . . has a physical, mental, or developmental disability<u>, not caused by an acute illness or injury</u>, infirmities as a result of . . ."