De-Escalation Awareness

De-escalation is a behavior that is intended to prevent conflicts from developing into a greater issue.

It may also refer to approaches in conflict resolution.

People may become committed to behaviors that tend to escalate conflict, so specific measures must be taken to avoid such escalation.

DON’T LET AGITATION REACH ITS BOILING POINT. IDENTIFY IT PROMPTLY TO HELP PREVENT FURTHER POTENTIAL ESCALATION.

- For patients with bipolar disorders or schizophrenia Agitation Assessment Tool Agitation presents along a spectrum from mild to severe, displaying a diverse range of both physical and verbal behavioral signs.

- The Positive and Negative Syndrome Scale-Excited Component (PEC) represents a simple tool for evaluating agitation that utilizes 5 symptom categories for assessment—excitement, tension, poor impulse control, uncooperative, and hostility.

- Look for physical and verbal signs of agitation to help determine the rating.

REGARDLESS OF THE SEVERITY OF AGITATION, PROMPT ACTION IS NEEDED TO HELP THE PATIENT REGAIN CONTROL SAFELY AND COOPERATIVELY

- Each category is rated on a scale of 1 (not present) to 7 (extremely severe).
- The total PEC score determines the severity of agitation: mild moderate, or severe.
- Use this tool to help identify and assess the spectrum of agitation in clinical practice.
- Rate each PEC category on a scale of 1 (not present) to 7 (extremely severe).
- Take the sum of the individual PEC scores to calculate the total score. Look for physical and verbal signs of agitation to help determine the rating.7 REGARDLESS OF THE SEVERITY OF AGITATION, PROMPT ACTION IS NEEDED TO HELP THE PATIENT REGAIN CONTROL SAFELY AND COOPERATIVELY

For patients with bipolar disorders or schizophrenia

DON'T LET AGITATION REACH ITS BOILING POINT. IDENTIFY IT PROMPTLY TO HELP PREVENT FURTHER POTENTIAL ESCALATION.[1-3]

Agitation presents along a spectrum from mild to severe, displaying a diverse range of both physical and verbal behavioral signs.[1,3,4] The Positive and Negative Syndrome Scale-Excited Component (PEC) represents a simple tool for evaluating agitation that utilizes 5 symptom categories for assessment—excitement, tension, poor impulse control, uncooperative, and hostility.[3,5,6] Each category is rated on a scale of 1 (not present) to 7 (extremely severe). The total PEC score determines the severity of agitation: mild (5–13), moderate (14–19), or severe (20–35). Use this tool to help identify and assess the spectrum of agitation in clinical practice.[3,6]

Agitation Assessment Tool

Rate each PEC category on a scale of 1 (not present) to 7 (extremely severe).[3,6] Take the sum of the individual PEC scores to calculate the total score. Look for physical and verbal signs of agitation to help determine the rating.[7]

PEC CATEGORY	SIGNS OF MILD AGITATION	SIGN OF MODERATE AGITATION	SIGNS OF SEVERE AGITATION
EXCITEMENT Hyperactivity displayed as increased motor behavior, response to stimuli, hypervigilance, or excessive mood lability[8] Rating: 1 2 3 4 5 6 7 (circle one)	• Rocking[9] • Hand wringing[4] • Hair pulling[4] • Fiddling with clothes or objects[4] • Slightly pressured speech[8] • Foot tapping[4]	• Throwing objects[9] • Pointing fingers[9] • Pacing[1]	• Screaming[3] • Shouting[9] • No attention span[3] • Incoherent speech[3]
TENSION Overt physical manifestation of fear, anxiety, or agitation[8] Rating: 1 2 3 4 5 6 7 (circle one)	• Slight apprehensiveness[8] • Restlessness[1,8] • Rapid hand tremor[8]	• Nervous mannerisms[8] • Nervous shaking[8] • Clenching jaw[8,10] • Clenching fists[8,10] • Profuse sweating[8]	• Suffering[3] • Behaviors relating to combat and escape[3] • Rapid restless pacing[8]
POOR IMPULSE CONTROL Disordered regulation and control of action on inner urges[8] Rating: 1 2 3 4 5 6 7 (circle one)	• Easily angered[8] • Repetitive thoughts exhibited by vocalization[4] • Inappropriate behavior without clear purpose[2]	• Episodes of verbal abuse[8] • Angered with minimal provocation[8]	• Threatening[8] • Demanding[8] • Destructive[8]
UNCOOPERATIVENESS Active refusal to comply with the will of others (such as hospital staff or caregiver)[8] Rating: 1 2 3 4 5 6 7 (circle one)	• Impatient[8] • Stubborn[8]	• Frequently incompliant[8] • Silence or refusal to communicate[2,8] • Defensive or negative attitude[8]	• Belligerent[8] • Outright refusal to comply[8]
HOSTILITY Verbal and nonverbal expressions of anger and resentment[8] Rating: 1 2 3 4 5 6 7 (circle one)	• Angry facial gestures[3,8] • Defiant and/or prolonged visual contact[2,8] • Sarcastic[8]	• Occasionally verbally abusive or threatening[8] • Exaggerated gesturing[2,8] • Raised tone of voice[2,8] • Frequent irritability[8]	• Physical/verbal aggressiveness[2,8] • Violent and destructive behaviors[8] • Self injury[1]
Total PEC Score: _____ (The sum of the individual PEC scores)	PEC score range: 5–13	PEC score range: 14–19	PEC score range: 20–35

REGARDLESS OF THE SEVERITY OF AGITATION, PROMPT ACTION IS NEEDED TO HELP THE PATIENT REGAIN CONTROL SAFELY AND COOPERATIVELY[3,4]

References: 1. Rappolo LP, Morris DW, Khan F, et al. *J Am Coll Emerg Physicians Open.* 2020;1(5):898–907. doi:10.1002/emp2.12138 **2.** Vieta E, Garriga M, Cardete L, et al. *BMC Psychiatry.* 2017;17(1):328. doi:10.1186/s12888-017-1490-0 **3.** Martinez-Raga J, Amore M, DiSciascio G, et al. *Front Psychiatry.* 2018;9:54. doi:10.3389/fpsyt.2018.00054 **4.** Richmond JS, Berlin JS, Fishkind AB, et al. *West J Emerg Med.* 2012;13(3):17–25. doi:10.5811/westjem.2011.9.6864 **5.** Kay SR, Fiszbein A, Opler LA. *Schizophr Bull.* 1987;13(2):261–276. doi:10.1093/schbul/13.2.261 **6.** Montoya A, Valladares A, Lizan L, et al. *Health and Qual of Life Outcomes.* 2011;9(18):1–11. doi:10.1186/1477-7525-9-18 **7.** Zeller S, Zun L, Cassella JV, Spyker DA, Yeung PP. *BJPsych Open.* 2017;3(6):285–290. doi:10.1192/bpo.bp.117.005363 **8.** Kay SR. Appendix E: PANSS manual of definitions. In: *Positive and Negative Syndromes in Schizophrenia: Assessment and Research. Clinical and Experimental Psychiatry Monograph No. 5.* New York, NY: Brunner/Mazel; 1991:232–245. **9.** Cummings J, Mintzer J, Brodaty H, et al. *International Psychogeriatrics.* 2015;27(1):7–17. doi:10.1017/s1041610214001963 **10.** Foley GN, Gentile JP. *Psychiatry (Edgmont).* 2010;7(6):38–44.

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TEAM APPROACH

T – Techniques can be verbal as well as non-verbal. Using simple commands and non-threatening body language reduces hostility and tension.

E - Environmental and supportive modifications such as soothing your voice, dimming the lights, or reducing the number of individuals making commands or directives.

A- Avoidance of restraints and coercive measures, such as using threats in order to have patient accept a request to comply.

M - Medications that are noninvasive, noncoercive, and taken voluntarily.

HUMAN FACTOR IN USE OF FORCE

- There is a societal focus on the use of force.
- The use of Body Camera’s
- The public use of cellphone video and still photography
- Viewing any type of violence is difficult, calls for the public to cry for change

How do you see the above factors effecting emergency responders and the ability to perform their jobs?

To properly learn and prepare for these events, emergency responders need to know the human factors that critically affect the incident and behaviors.

Significant **factors** include past experiences
a variety of cognitive biases
an **escalation** of commitment and sunk outcomes
individual differences, including age and socioeconomic status
and a belief in personal relevance.

These things all impact the decision-making process and the decisions made.

Individual characteristics

These are differences that are specific to the person you are working with.

Individual characteristics are part of the reason why two people can perceive and respond to a situation differently.

Individual characteristics include things like knowledge, belief systems, personality characteristics, and general disposition.

This also includes things like the person’s learning history specifically as it relates to experiences with reinforcement and punishment.

Interpersonal factors

These are factors that relate to a person's social interactions.

Examples of interpersonal factors include a person's social support network, relationships with other people, and a person's religious or spiritual relations.

Rule-governed behavior may be influenced by social expectations.

Institutional factors

These are factors that relate to the rules, regulations, and informal structures that exist within an organization or community that the client works or lives.

Institutional factors can influence a person's behavior through the rules and expectations placed on them such as how to dress, how to interact with others, and expectations related to appropriate habits and behaviors.

Rule-governed behavior as well as behavior that is impacted by direct consequences may be influenced by institutional factors.

Community factors

This relates to the environment where your client lives.

People’s behavior can directly or indirectly be influenced by the available resources in their community as well as by the norms placed upon them by society.

Public policy

This refers to factors that relate to the regulations and laws that influence a person's behaviors and lifestyle.

This can influence behaviors in a variety of ways from parenting strategies used to views on disabilities and much more.

Consider these various factors that can play a role in how your clients behave and how they experience day to day life. Some factors may be like the influences that impact your behavior while other factors may be different.

Human behavior is complex. Many of the factors discussed can interact in complex ways leading to different influences on your clients' behaviors.

Conflict

Conflict is common in all parts of society.

Conflict is present at an individual level, between two people. It is also present on a larger scale such as between small or large groups of people.

You can see that conflict is present in that people most often are looking to access their own reinforcement. Sometimes this creates conflict between them and someone else.

Try to assess the nature of the conflict and what each person is experiencing within that conflict and what resolution they would both ideally like to have in order to create an effective

Rational choice

People often behave in ways that align with an effort to obtain something that achieves some sort of goal.

A parent may want less noise in the home therefore they may behave in ways to decrease tantrums their child exhibits.

A child may want more leisure time so they may behave in ways that are an attempt to access more leisure and demand-free time.

While considering the goal-directed nature of human behavior, we can also explore how people tend to exchange resources, such as attention, time, information, and physical acts in order to obtain or give a certain outcome. People generally want to maximize their reinforcement and minimize punishment experiences.

People engage in interactions to obtain or give reinforcement or punishment.
When an individual, even a child, is not provided with enough reinforcement, they may experience a "power struggle" in which it seems that one party has more control over the other. Of course, parents are naturally designed to have some "control" over their children. However, it is still helpful to consider in what ways the parents are allowing some child-directed interactions and dynamics within the home.

Social Constructionist

Being culturally competent is important in all human services including in parent training.

A person's way of viewing things and then behaving on how they perceive their experiences is, in part, based on traditions, culture, and historical contexts of the society in which they live or that in which they identify as being a part of.

Developmental

Human behavior is influenced by development. Development is influenced by the way in which a person follows through a set of stages.

These stages are often experienced in a certain order although there is some flexibility in that some people may not follow the expected stage order exactly.

Social behavioral

From a social behavioral perspective, people behave in ways that are based on what they have learned through social experiences.

Primarily, people learn in the context of their interactions with the environment. They can learn through pairing multiple stimuli. They can learn through the process of reinforcement or punishment. And they can learn through imitation of stimuli, including other people, in their environment.

Classical and operant conditioning is the primary method of changing human behavior when looking strictly through a social behavioral lens.

Humanistic

Through a humanistic lens, people behave in ways that help them to align with meaningful goals. They are motivated to behave in ways that help them to live according to their true selves or their true values.

Although, from this perspective, private events play a role in a person's behavior, this can still connect with an applied behavior analysis approach because a person's private events can motivate them to behave in particular ways.

For instance, a person who experiences a private event related to having the value of family may be motivated to behave in a way that leads to spending more time with their family. This behavior can then be reinforced by the experience they have with their family and the additional private events that may occur such as a personal thought that says they enjoyed or are glad that they spent time with family.

Ways of Looking at Human Behavior

Consider how the above perspectives can help you to better understand the parents you are working with in your ABA parent training services. Although these perspectives may have been developed as individual approaches to understanding human behavior, they can be used in combination to help you better understand the experience of your clients.

In summary, people are generally driven to obtain reinforcement. They want to live a meaningful life that is true to who they are. Their behavior is influenced by the interactions they have with other people and the rules and expectations placed upon them. Their behavior is guided by general developmental stages and then reinforced or punished by their interactions with the environment.

People learn and behave within the systems they are part of, reinforcement they experience, interacting with their environment, and aligning themselves with their true values and goals.

Briefly

When there are signs of anger or verbal aggression it is important to remember that:

- you need to stay calm
- anger may be a sign that the person is in distress, experiencing fear or frustrated
- it is not possible to reason, or problem solve with someone who is enraged
- effective communication skills are the key to settling, resolving and de-escalating a situation.

Use the strategies below to de-escalate a situation:

LOWLINE

- **L**isten to what the issue is and the person's concerns.
- **O**ffer reflective comments to show that you have heard what their concerns are.
- **W**ait until the person has released their frustration and explained how they are feeling.
- **L**ook and maintain appropriate eye contact to connect with the person.
- **I**ncline your head slightly, to show you are listening and give you a non-threating posture.
- **N**od to confirm that you are listening and have understood.
- **E**xpress empathy to show you have understood.

In a situation like this, workers can panic because they don’t know how to “stop” the anger, and they need to know that periods of intense anger do not last. … intense feelings like anger naturally dissipate as time passes.

It is not your job to stop the person being angry, but these steps may help to make the person feel calmer. It is only then that you can look at how to deal with the situation and their concerns.

Times are tough.

No doubt about it.

Lots of people are hurting right now as a result of the global pandemic.

But even before COVID-19, our first responders encountered an increasing number of people experiencing mental health issues or crises.

These contacts are different from traditional calls for service.

They may not involve a crime to investigate.

And sometimes a person experiencing a mental health crisis exhibits the same symptoms as a person under the influence of drugs or alcohol.

This requires first responders to take a slightly different approach while still being vigilant and maintaining our safety.

There are several possible signs of mental illness.

Disorientation, hallucinations or delusions, withdrawal, anxiety, and paranoia.

Public safety professionals are on the front lines when it comes to those in crisis.

How we respond to these situations is extremely important.

Consider turning off bright or flashing lights.

Move and speak in a non-threatening manner.

Ask disruptive people to leave the area, including family members.

Most of all, have patience.

Remember that the person you're dealing with might have an altered reality.

Do your best to communicate with the person.

It's a careful balancing act between your personal safety and theirs.

With limited resources at your disposal, you may be the only one who can get them the help they need.

Remember, our primary goal in these encounters is helping those in crisis get the proper care.

Whether that means a civil commitment or simply a friendly conversation, you can have a big impact on mitigating any crisis.

People get upset about their situation and tend to take it out on those of us emergency responders.

Here are a couple of tips on how to develop rapport with angry patients and de-escalate the patient's anger so you can do your job.

KNOW YOUR PATIENT

Blue Personality. A person with a Blue personality type is a people person, one who is outgoing, socially engaging, and interpersonally skilled. The person with a Blue personality type values harmony, relationships, and honesty. It has been posited that individuals with Blue personality types comprise 15% of the American population.

Green Personality. Green personalities are analytical in their approach to the world; they like logic and explanations, and they value learning and problem-solving. Green personality types comprise 35% of the American population.

Gold Personality. A person with a Gold personality is known for their practicality, dependability, organizing abilities, list-making, responsibility and accountability. Gold personalities value hierarchies, rules, regulations, order and structure. Almost 50% of the American population are Gold personalities.

Orange Personality. A person with an Orange personality is known to act on impulse; he or she needs a lot of freedom, action, challenge, change, and independence. The Orange personality type person seeks action, excitement, and risks, and loves competition. there are about 30% of Oranges in the American population.

How does understanding of personality types help me?

So ok, now, what to do with this information? How to help ourselves and our patient?

First, we need to find out what personality we are as well as our patient. Only this way we know what our strengths and weaknesses are and finally understand why ‘some others’ are how they appear in our eyes.

Second, try to accommodate the different personality types. The truth , we’re doing it already, all the time. We talk differently to different people, and we adjust our style and language with friends, leaders, patients, and colleagues.

Third, remember that different personality types make this world an inspiring place to live. A colorful world. Imagine if the world would be only blue? Or yellow?

What can I do with my color, and with other personality types?

Instead of focusing on how annoying it is dealing with the details rolled out by the **Blue personality**, take a breath, step back for a minute if you need to. Acknowledge that, if he or she would not have been the person they are, the success they have achieved would not have occurred. Precision may not be your forte, but he or she has it, so use it, take advantage of the fact they work in a team sense of achievement.

Help the **Yellow personality** to focus on his or her tasks and learn to be as daring and enthusiastic as they are. If they can talk, why not allow them to try?

Admire the strength and charisma of **the orange**: they are verbally articulate, direct, and they want to bring things forward. Don't get offended by their rude manners, work with them, try to adapt the speed of your work to theirs, they may not think it's enough, but they will appreciate the effort.

As for **the Greens** in the room, try to find out what they think, encourage them to honestly express their opinion, without fear, push them to challenge themselves. In return, from the Greens, you can learn to relax, to show more empathy, hence, to develop better patient outcomes.

Conclusion:

The next time around, let’s welcome our differences, observe and learn from each other rather than getting frustrated and irritated.

We are all a lovely, nuanced mix of many colors, all to be discovered.

Besides, remember that if everyone agrees, development is impossible.

The Yellows produce the ideas, the Orange say ‘great, let’s do it,’ the Greens carry it out, and the Blues evaluate it.

And voilà!

The perfect group dynamic!

I. POLICY: Abuse, Neglect & Domestic Violence Report Mechanisms & Expectations

II . PURPOSE:

To provide a consistent approach for reporting to the appropriate authority suspected or actual victim abuse, neglect, and/or domestic violence.

III. DEFINITIONS:

The following definitions of abuse and neglect apply to this policy.

1. Abuse: Willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. This includes staff neglect or indifference to infliction of injury or intimidation of one patient by another.
2. Physical: Physically harming a person through such actions as slapping, bruising, cutting, burning, physically restraining, improper use of restraint, force feeding, rushing, pushing, shoving or rough handling; using chemical or physical restraint for punishment or convenience.
3. Financial: Stealing, exploiting, or improperly using the money, property or other assets of another person; charging for unnecessary services, or services not rendered.
4. Psychological Abuse: Emotionally harming a person by demeaning, frightening, humiliating, intimidating, isolating, insulting, scolding, or using verbal aggression; taking something away from a patient as punishment or for retaliation.
5. Sexual Abuse: Sexual contact that results from threats, force, or the inability of the person to give consent and involving a range of activities including but not limited to assault, rape or sexual harassment.
6. Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.
7. Financial Neglect: Failure to use available resources to sustain and/or restore health.
8. Psychological Neglect: Failure to provide social stimulation, changes in routine, companionship, links to the outside world or ignoring, leaving alone, or giving “silent treatment”. Infliction of anguish, pain or distress that results in mental or emotional suffering.
9. Violation of Rights: Violation of the patient’s rights to privacy, dignity, and individual freedom.
10. Abandonment: The desertion of an individual receiving services by any person who has assumed responsibility for providing care or by a person who has physical custody of the individual.
11. Domestic Abuse: Any form of abuse or neglect of an individual receiving services by someone with whom he/she has a personal relationship.
12. Institutional Abuse: All forms of abuse and neglect of an individual that occurs in an institutional setting, specifically a residential setting.

13. Self-Abuse or Self-Neglect: Characterized as a behavior of the individual receiving services that threatens his/her own safety.
14. SIGNS AND SYMPTOMS: (Examples of possible indicators of abuse/neglect)
a. Bruises, black eyes, welts, lacerations, rope marks, imprint injuries.
b. Fractures.
c. Open wounds, cuts, and punctures.
d. Sprains or dislocations.
e. Unexplained venereal disease or genital infections.
f. Unexplained vaginal or anal bleeding.
g. Bruises around the breast or genital area.
h. Malnutrition or dehydration that is not a result of terminal illness or end-stage disease
i. Contractures that become fixed, even in an individual with certain neurological conditions, due to lack of consultation or active management.
j. Pressure ulcers without evidence of predisposing medical conditions that may increase risk of pressure sore development of evidence of preventive measures or intervention
k. Unexplained restlessness.
l. Beneficiaries appear inexplicably timid; shy, reticent, or withdrawn.
m. Beneficiaries are nervous or exhibit aimless wandering without provocation
n. Lack of interaction between individuals and staff.
o. Beneficiaries avoid staff attention and appear fearful, angry, stressed, defensive, anxious, or worried.
p. Tearfulness or crying.
q. Unexplained poor personal hygiene.

IV. GUIDELINES/PROCEDURES

1. Directors and/or managers are to ensure upon hire and annually that education is provided for hospital staff covering the following topics:

a. Definitions of abuse and neglect, domestic violence

b. Signs of abuse and neglect, domestic violence

c. Recognition of stress factors for caregivers

d. Dealing with stressful situations with elderly population

e. Proper response to abuse and neglect, domestic violence, or suspected abuse and neglect and domestic violence situations

f. Prevention of abuse and neglect

g. Reporting requirements

2. Any hospital administrator, agent, employee, or medical staff member who has reasonable cause to believe that there is a possible situation of abuse, neglect or domestic violence to a patient is to report this immediately to their Supervisor or in their absence to the House Supervisor. Upon receiving information from any staff member that a patient is a suspected or actual victim of abuse, neglect and/or domestic violence, the following actions are taken:

a. The Director/House Supervisor and/or designee ascertains if there is immediate danger to the patient and intervenes to protect the patient.

b. The Director/House Supervisor and/or designee conducts an internal investigation of the allegations, working together with the Director of Human Resources, Risk Manager, and on-call Administrator as appropriate. The Director/House Supervisor and/or designee supervises the completion of a record of the supportive documentation and files this with an incident report.

c. The Director/House Supervisor and/or designee evaluates disciplinary action in conjunction with the Director of Human Resources if an employee is implicated.

d. In instances where the alleged abuse took place while that patient was in the hospital, the Director/House Supervisor and/or designee should immediately report the issue to the CEO and/or designee. CEO and/or designee shall submit a report to IDPH within 24 hours of receiving the report. The report shall include:

a. The name of the patient;
b. The name and address of the hospital treating the patient;
C. The age of the patient;
d. The nature of the patient's condition, including any evidence of previous injuries or disabilities; and
e. Any other information that the reporter believes might be helpful in establishing the cause of the reported abuse and the identity of the person believed to have caused the abuse.

e. For patients admitted or discharged by the Emergency Department, who are admitted for 23-hour observation, are DOA or go AMA, who have been sexually assaulted or who have injury suspected or alleged to result from domestic violence or child abuse, the Director/House Supervisor and/or designee ensures the Emergency Department Guideline for reports to IDPH are completed. The Director/House Supervisor and/or designee ensures that Emergency Department patient reporting is completed, according to regulation, regardless of patient disposition.

f. For the Elderly:

i. In the case of the elderly inpatient or outpatient, contact the Director/House Supervisor and/or designee then the Registered Nurse is to contact CHELP 422-9888 (Macon County) or the Elder Abuse Hotline 1-800-252-8966 within 24 hours.

ii. In the case of a new admission from a nursing home, when suspicion of abuse and neglect by the facility occurs, the Registered Nurse must call the Nursing Home Hotline 1-800-252-4343 and ensure an incident report is completed.

iii. Local Law Enforcement is to be called by the Department Director or House Supervisor in the following situations:

a) Physical abuse involving physical injury inflicted on a resident/patient by a staff member or a visitor;

b) Physical abuse involving physical injury inflicted on a resident/patient by another resident, except in situations where the behavior is associated with dementia, psychiatric or developmental disability;

c) Sexual abuse of a resident/patient by a staff member, another resident, or a visitor;

d) When a resident/patient death has occurred other than by disease processes.

g. For Children

i. The Director or House Supervisor or Registered Nurse (if delegated to do so) immediately calls the Illinois Department of Children & Family Services (“DCFS”) at 1-800-252-2873 and reports the name, address of child and parents or other persons having custody, the child’s age, the nature of the child’s condition including any evidence of previous injuries or disabilities; any other information that might be helpful in establishing the cause of such abuse or neglect; and the identity of the person believed to have caused such abuse or neglect.

ii. The Director and/or designee ensures the completion of the “Written Confirmation of Suspected Child Abuse/Neglect Report: Medical Professional” Registered Nurses are to complete the “Written Confirmation of Suspected Child Abuse/Neglect Report: Medical Profession” and submit accordingly. A copy of the completed document will be forwarded to the Quality/Risk Management Director.

iii. Within 48 hours of the initial telephone report, the Director and/or designee ensures the original report is mailed to:

The Illinois Department of Children and Family Services
2900 North Oakland
Decatur, IL 62526
And a copy to:
State Central Register
Illinois Department of Children & Family Services
406 East Monroe Street
Springfield, IL 62701

iv. The Director/House Supervisor and/or designee ensures no one undertakes an investigation. DCFS has a duty to investigate.

v. For cases involving newborns in the Nursery, the Director/House Supervisor and/or designee ensures a referral is sent to DCFS for follow up services.

vi. If needed, call the Case Manager for consultation regarding problems in reporting.

vii. The attending physician, law enforcement officer or designated employee of DCFS may take temporary custody if:

a. There is reason to believe circumstances or conditions of the child are such that continuing in the place of residence or in the care and custody of the person responsible for the child's welfare presents an imminent danger to that child's life or health; or

b. The person responsible for the child's welfare is unavailable or has been asked and does not consent to the child's removal from his custody; and

c. There is not time to apply for a court order for temporary custody of the child.

viii. The Director/House Supervisor and/or designee ensures that if temporary custody is taken by a physician that notification is given to the DCFS, the person responsible for the child's welfare and administration.

ix. Photographs/X-rays.

DCFS employee may, at their expense, take or cause to be taken color photographs and X-rays of the area of trauma on a child who is the subject of a report. A hospital employee, at the direction of the attending physician, may take photographs of a child only after a reasonable attempt has been made to inform the parent. Medical photographs are the property of the hospital and become a part of the medical record. Law enforcement agencies may take photographs only with proper written consent of the patient or person responsible for the patient's welfare. Photographs taken by DCFS or law enforcement agency are the property of that agency.

h. For Domestic Violence

i. If there is suspected domestic violence, ensures the Director/House Supervisor and/or designee that the following is completed:

a) Assessment of patient on admission to the facility or to the Emergency Room includes an assessment of signs and symptoms of possible domestic violence/abuse.

Note: Presence of symptoms indicates need for further investigation and does not prove the presence of domestic abuse.

ü Injuries to the face, neck, throat, abdomen, genitals (i.e. welts, bruises, discoloration, swelling, etc.)

ü Signs of dehydration or malnutrition without illness related causes.

ü Injuries during pregnancy (often directed toward the woman's abdomen).

ü Poor hygiene, soiled clothing or bedding.

ü Injuries inconsistent with explanation by patient, or a caregiver.

ü Repeated use of emergency room services.

ü Evidence of drug or alcohol abuse.

ü Inappropriate sexual behavior among family members.

ü Social isolation, patient being blamed for needing care.

ü Lack of necessary equipment, heat, food, water, or unsafe housing conditions.

ü Evidence of inappropriate use of medication.

ü Patient is unable/unwilling to answer questions. or looks to a person who has accompanied them prior to answering. Family member/significant other answers all questions and does not allow patient to answer.

ii. Documentation occurs of injuries in the medical record, including photographs. Obtain consent for photography. Photos become part of the medical record.

iii. Patients are provided information about community resources, as identified in 4.

iv. Contact is made with the following agencies, if appropriate for shelter or assistance:

a. Dove, Inc.

b. Growing Strong

c. Macon County Health Department Case Management

3. Ensure documentation of actions is recorded in the Medical Record.

4. Legal Immunity

Any person acting in good faith who participates in making a report or subsequent investigation is immune by law from any liability, civil, criminal or otherwise which might result by his/her participation.

5. Consult with a Quality Representative and/or a Chaplain as appropriate to situation.

6. Suspicious activities or individuals visiting nursing units or patients are to be reported to the Director/House supervisor and security. An incident report is to be filed.

7. No individual who lawfully and in good faith makes a report under this policy will be subject to retaliation.

8. Specific incidents of abuse/neglect are reviewed for “lessons learned”, are discussed with staff if appropriate and are considered in policy/procedure review and revision.