

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

July 23, 2015

Mr. Steven Gordon, Ceo, Administrator
Brattleboro Memorial Hospital
17 Belmont Ave
Brattleboro, VT 05301-3498

Dear Mr. Gordon, Ceo:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 24, 2015**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Suzanne Leavitt, RN, MS
Assistant Division Director
Director State Survey Agency



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/24/2015
NAME OF PROVIDER OR SUPPLIER BRATTLEBORO MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 17 BELMONT AVE BRATTLEBORO, VT 05301	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 6/22/15 through 6/24/15. The following regulatory violation was identified regarding Quality Assurance and Performance Improvement related to complaint #13522.	A 000		
A 286	482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by:	A 286		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		07/14/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 286	<p>Continued From page 1</p> <p>Based on staff interviews and record review the facility failed to utilize their established event reporting system to collect information related to an adverse patient outcome and analyze the cause in an effort to identify opportunities for improvement and implement preventative actions. (Patient #1). Findings include:</p> <p>Per record review Patient #1, whose medical problems included a condition that placed the patient at high risk during pregnancy, was evaluated in the Birthing Center for onset of labor on the evening of 3/23/15. The patient was initially examined by a CNM (Certified Nurse Midwife), and subsequently remained on observation status for a period of approximately 3 and a half hours during which contractions became less frequent and of shorter duration. An exam by an RN (Registered Nurse) determined no cervical change, the CNM was notified and ordered a discharge with specific instructions for the patient to contact the provider if she experienced any further contractions or other signs or symptoms of labor. The patient returned to the ED (Emergency Department) approximately 12 hours later, on the morning of 3/24/15, following an unanticipated home delivery with serious complications and harm resulting. Despite the negative outcome for the patient, staff failed to complete an event report and conduct an RCA (Root Cause Analysis) to investigate the incident in accordance with the hospital's Incident Reporting policy. The policy, which had last been reviewed on 8/15/14, stated: '....IV. Procedure:....B. incident reporting is to identify processes and systems that need improvement...C. The data collected is used to identify opportunities for performance improvement. If the incident is at a level where</p>	A 286			

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A 286	Continued From page 2 serious harm may have occurred a RCA should be performed to ensure all steps and issues of the process are examined...V. RESPONSIBILITIES....C...1. Sentinel events [defined in the policy as an unanticipated outcome resulting in death or serious physical or psychological injury] have a root cause analysis (RCA) performed and are referred to the Peer Review Committee....D....The employee or member of the medical staff most closely involved with the incident or having special information is responsible for initiating the report.' During interview on the afternoon of 6/24/15 the Risk Manager and the Director of Quality both confirmed that although an event report should have been completed it had not been done. In addition, they also confirmed that, although it had been 3 months since the event occurrence, no internal investigation had yet occurred to review care and services in an effort to identify any possible opportunities for improvement, as they were waiting for the completion of a peer review before conducting an RCA. The CMO (Chief Medical Officer) stated, during interview on the morning of 6/24/15, that s/he had experienced difficulty in locating a source, outside the hospital, to conduct a peer review of the case and confirmed that although a source had recently been identified a peer review had not, to date, been conducted.	A 286			

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A 286	482.21 (a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measureable improvement in indicators for which there is evidence that it will...identify and reduce medical errors. (2) The hospital must measure, analyze and track....adverse patient events...		RCA performed on adverse outcome case (attended by CMO, VPPCS, Providers) RCA performed on response to adverse event (Quality Dept., VPPCS, CEO, VP Physician Practice, Practice Directors) Case reviewed in Peer Review Committee Revised the Incident Reporting Policy to ensure reporting and tracking of adverse events. (Director of Risk Mgt/Pt Safety) Revised RCA policy to require Quality Department responsibility for all RCAs. Plan for education level 2 to Leadership in August 2015. (CMO)	6/29/2015 7/8/2015 7/14/2015 To Policy Council for approval 8/10/2015 7/13/2015
	(c) Program Activities... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventative actions and mechanisms that include feedback and learning throughout the hospital.		Risk Management Plan revised to include a new Risk Management committee. Director of Risk Mgmt. to chair. Will include trending data and review areas of risk for analysis and planning. (Director of Risk Management/Pt Safety)	7/10/2015

*Post comment 7/22/15
Hmc/hwt*

		<p>Plan going to Senior Leadership for approval. 7/21/2015</p> <p>Plan distributed to Quality/Patient Safety Committee for review. 7/24/2015</p> <p>On Agenda for discussion and approval of next Quality/Patient Safety meeting. 9/2/2015</p> <p>First Risk Management Committee meeting to be held. 9/2015</p> <p>7/10/2015</p> <p>Revise Performance Improvement Plan to include more tools for monitoring, RCA utilization and oversight of OPPE, FPPE and Peer Review process. Heightened responsibility for Quality Department Management and Quality reviews. (CMO) 7/21/2015</p> <p>Plan going to Senior Leadership for approval. 7/24/2015</p> <p>Plan distributed to Quality/Patient Safety Committee for review. 9/2/2015</p> <p>On Agenda for discussion and approval of next Quality/Patient Safety meeting.</p> <p>Root Cause Analysis policy reviewed and revised. Plan for education level 2 to Leadership in August 2015 (CMO) 7/13/2015</p> <p>Reviewed and revised Chart location policy. Level 2 education to Leadership in August 2015 (Director Risk Mgmt/Pt Safety) 7/13/2015</p> <p>Review and revised Chain of Command Policy, presented to Nursing Leadership. Nursing directors to share with staff. (VPPCS) 7/13/2015</p> <p>Reorganization of Risk Management duties to allow for more oversight. Presented to Senior Leadership and new position posted (Senior Leadership) 7/14/2015</p>	
	(e) Executive Responsibilities. The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following:	<p>Revise Performance Improvement Plan to include more tools for monitoring, RCA utilization and oversight of OPPE, FPPE and Peer Review process. Heightened responsibility for Quality Department Management and Quality reviews. (CMO) 7/10/2015</p>	

(3) That clear expectations for safety are established.	Plan going to Senior Leadership for approval.	7/21/2015
	Plan distributed to Quality/Patient Safety Committee for review.	7/24/2015
	On Agenda for discussion and approval of next Quality/Patient Safety meeting.	9/2/2015
	Case presented to Quality Patient Safety Committee (CMO)	7/1/2015
	Scope of Practice for Certified Nurse Midwives presented to Med Exec. Committee (CEO)	6/28/2015
	Scope of Practice revised and sent to OB Department for review	7/29/2015
	On agenda for approval at OB/Pedi Department Meeting	9/14/2015
	Assessment of Peer Review process by Greeley Consultants and incorporation of recommendations for change to strengthen the process. (CMO) Process begun by phone conference. Will continue through the month of July.	7/2/2015 7/30/2015
	Peer review chair, Med. Staff President and CMO revised Peer Review process for OB/Pedi and timeliness of peer review.	7/2/2015
	Discussed with OB/Pedi Committee	7/6/2015
	Revisions to be further reviewed by Med Exec. (CMO)	9/24/2015

*Rec count 5/23/15
done/kurt*