

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

PRINTED: 05/12/2016
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 03/24/2016
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 3/14/16 and completed on 3/24/16. As a result of the complaints: 00014315, 00014469 & 00014314 regulatory violations were identified related to all 3 complaints. Based on information gathered, the hospital was determined not to be in compliance with the Federal Conditions of Participation for Acute Care Hospitals to include: CoP: Patient Rights and Emergency Services.	A 000		
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on interviews and record reviews conducted on days of the on-site complaint survey, from 3/14/16 through 3/16/16 and completed on 3/24/16, the Condition of Participation: Patient Rights was not met as evidenced by the hospital's failure to provide sufficient interventions to assure each patient's rights are protected. Refer to: A 144: Failure to assure that each patient's rights to receive care in a safe setting. A 154: Failure to assure patients' rights by relinquishing patient care to law enforcement. A 164: Failure to discontinue restraints at the earliest possible time. A 167: Failure to ensure restraints were only	A 115		

*See attached -
Account 4.26.16 fm/ed*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Therese [Signature]

TITLE

VPCS

DATE

5/12/16

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 115 Continued From page 1
Imposed to ensure immediate physical safety of the patient and others.
A 169: Failure of a physician to initiate new orders for the application of restraints and the administration of emergency medications.

A 115

A 144 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING

A 144

The patient has the right to receive care in a safe setting.

See Attached pg 1

This STANDARD is not met as evidenced by:
Based on interview and record review the hospital failed to assure that each patient's rights to receive care in a safe setting was maintained when law enforcement personnel were notified of and responded to a patient who required behavioral management in the ED. The hospital also failed to address a potential safety hazard involving furniture in the ED. (Patient #1 & 2)
Findings include:

1. During an ED admission on 1/8/16 at 22:48 a patient seeking treatment for Depression, Anxiety and with suicidal ideation was subjected to physical force when staff summoned police to assist with the behavioral management of Patient #2 without recognition of the individual's Patient Rights. At the time of admission the patient was examined by a ED provider who states in the Physician Clinical Report on 1/8/16: "S/he has felt depressed for a long time and has been taking more xanax than s/he should.... is feeling frustrated as well and wants help. Nothing is making her/him better or worse....Patient is medically stable for psychiatric evaluation and disposition." A HCRS (Health Care Rehabilitation Services) screener was contacted by ED staff to

Mary Leazer *5/17/16*

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A 144 Continued From page 2 -

assist in the evaluation and possible psychiatric hospitalization for Patient #2. The patient was cooperative and staff provided reassurance. During the screening evaluation with HCRS staff, Patient #2 was informed a specific psychiatric facility s/he had requested for admission had no beds available. Patient #2 became angry and informed staff s/he wanted to leave and refused to contract for safety. The police were summoned during 3 attempts at elopements but each time the patient returned to the ED on his/her own and the police did not remain.

Per Clinical Report - Nurses progress note states on 1/9/16 at approximately 02:20 Patient #2's behavior escalates and "...became verbally assaultive to HN (Hunter North Security staff) then used her/his body to push past him (security), attempting to leave. Pt. then redirected to room, with show of numbers. Pt began striking glass door attempting to break glass. BPD (Brattleboro Police Department) officers arrived at our request (the patient) to be escorted to a secure room".

Per review of Brattleboro Police Report, ED nursing staff request assistance with a patient. 2 officers arrive to the ED on 1/9/16 at approximately 0228. The report states police approach Patient #2 who was sitting on stretcher in assigned room, and informed by police s/he is going to be transferred to another room for the patient's safety and the safety of others. Patient #2 refuses and was told by one of the police officers if s/he did not go of her/his own free will hands would be placed on the patient and s/he would be physically escorted to room #10 (safe/seclusion room). The patient again refused but demonstrated no resistance. Per report, the

A 144

See Attached pg 1

Mary Leggett 5/13/16

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<p>A 144 Continued From page 3</p> <p>police officers seized Patient #2 in a "non-compliant escort hold" and pulled the patient off the ED stretcher. Patient #2 resisted the holds and tried to sit on the floor and subsequently tried to kick back at one of the officers. The report states police used a arm-bar takedown resulting in dropping Patient #2 to the floor and pinning the patient's head to the floor by pressing a forearm against the patient's jaw. The patient remained on the floor struggling and head remained pressed to the floor. Eventually Patient #2 was assisted to his/her feet and held in a non-compliant escort hold and then the patient's right wrist was placed in a front-supported wrist lock. Patient #2 was lead into room #10 by the 2 police officers who ordered the patient to lay on the bed and handcuffed the patient's right wrist to the bed.</p> <p>Per review of Clinical Report - Nurses progress note states at 02:55 1/9/16 " Officers escorted Pt to the floor and secured her/him at that time with handcuffs. Pt then brought to room 10 and secured to the cot until calm". After a period of time the police removed the handcuff, and left the ED. The patient was not a prisoner or charged and placed in police custody. After the incident with law enforcement the Physician Clinical Report states "During restraint s/he hit her/his head and c/o wrist pain so x-rays were done, CT head....both negative." It was also determined Patient #2, was in need of psychiatric hospitalization and an involuntary admission occurred on 1/9/16 at 21:28 to a inpatient facility.</p> <p>2. Per record review, Patient #4 arrived in the ED on 12/7/15 at 09:47 with a diagnosis of Bi-Polar/Schizophrenic episode. Patient arrived with family and was described as agitated, confused and hallucinating. Per review of</p>	<p>A 144</p> <p><i>See Attached pg 1</i></p>
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Mary Elizabeth T 5/11/16

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A 144	Continued From page 4 Behavioral Management Precaution/Room Safety Check staff are to remove ALL items that can be picked up and thrown to include trash cans, chairs, stools....". Per Clinical Report - Nurses at 11:45 the patient is restless and remains agitated. While in an assigned room Patient #4 throws a metal chair out of the room, breaking a light switch. The potential for injury was significant, however ED staff, visitors or other patients were not harmed. Per interview on the morning of 3/16/16 the VP of Patient Care Services confirmed a Safety Event report was filed as a result of the incident involving Patient #4 throwing a metal chair. After this event no further evidence of corrective action by ED staff and/or others was initiated to further ensure a safe environment as it relates to furniture which can become projectile objects. A second incident resulted on 1/5/16 a 15:24 involving Patient #1, with a diagnosis of Psychosis, who required psychiatric hospitalization and was awaiting placement. Clinical Report - Nurses states the sheriff's department spent time sitting in the patient's room talking with the patient. When they left the room they failed to take the chair out. Shortly after the patient picked up the chair and was slamming it against the walls, door and window.	A 144		
A 154	482.13(e) USE OF RESTRAINT OR SECLUSION Patient Rights: Restraint or Seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed	A 154		

See Attached pg 1

See Attached pgs 2+3

Wangleyhall 5/13/16

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A 154 Continued From page 5

to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

This STANDARD is not met as evidenced by:
Based on staff interview and record review, the hospital failed to protect the rights of a patient when ED staff relinquished to Law Enforcement the process of a room transfer of a patient resulting in unnecessary force to immobilize the patient to include manual restraints and handcuffs. (Patient #2) The facility also failed to discontinue the use of restraints and seclusion at the earliest possible time for 1 of 4 applicable patients. (Patient #1) Findings include:

1. Per record review, on 1/8/16 at 22:48 Patient #2 arrived to the ED accompanied by a friend with a chief complaint of Depression and a past history of Bipolar and Anxiety. Patient #2 confirmed s/he has had suicidal thoughts. The patient was examined by a ED provider who states in the Physician Clinical Report on 1/8/16: "S/he has felt depressed for a long time and has been taking more xanax than s/he should....is feeling frustrated as well and wants help. Nothing is making her/him better or worse....Patient is medically stable for psychiatric evaluation and disposition." A HCRS (Health Care Rehabilitation Services) screener was contacted by ED staff to assist in the evaluation and possible psychiatric hospitalization for Patient #2. The patient was cooperative and staff provided reassurance. During the screening evaluation with HCRS staff, Patient #2 was informed a specific psychiatric facility s/he had requested for admission had no beds available. Patient #2 became angry and informed staff s/he wanted to leave and refused to contract for safety. The police were summoned

A 154

*See Attached pg's
2+3*

Wayne L. ... 5/13/16

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A 154 Continued From page 6

A 154

during 3 attempts at elopements but each time the patient returned on his/her own. Per Clinical Report - Nurses on 1/9/16 at approximately 02:20 Patient #2's behavior escalates and "...became verbally assault to HN (Hunter North Security staff) then used her/his body to push past him (security), attempting to leave. Pt. then redirected to room, with show of numbers. Pt began striking glass door attempting to break glass. BPD (Brattleboro Police Department) officers arrived at our request (the patient) to be escorted to a secure room".

See Attached pgs 2+3

Per review of Brattleboro Police Report, ED nursing staff request assistance with a patient. Two officers arrive to the ED on 1/9/16 at approximately 0228. The report states police approach Patient #2 who was sitting on stretcher in assigned room, and informed by police s/he is going to be transferred to another room for the patient's safety and the safety of others. Patient #2 refuses and was told by one of the police officers if s/he did not go of her/his own free will hands would be placed on the patient and s/he would be physically escorted to room #10 (safe/seclusion room). The patient again refused but demonstrated no resistance. Per report, the police officers seized Patient #2 in a "non-compliant escort hold" and pulled the patient off the ED stretcher. Patient #2 resisted the holds and tried to sit on the floor and subsequently tried to kick back at one of the officers. The report states police used a arm-bar takedown resulting in dropping Patient #2 to the floor and pinning the patient's head to the floor by pressing a forearm against the patient's jaw. The patient remained on the floor struggling and head remained pressed to the floor. Eventually Patient #2 was assisted to his/her feet and held in a non-compliant escort

Wang, L. 5/12/16

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A 154	<p>Continued From page 7</p> <p>hold and then the patient's right wrist was placed in a front-supported wrist lock. Patient #2 was lead into room #10 by the two police officers who ordered the patient to lay on the bed and handcuffed the patient's right wrist to the bed.</p> <p>By relinquishing the decision making process to police officers for managing the room transfer of Patient #2, the hospital failed to support the patient's right to receive safe and appropriate care in an environment supportive of the patient's physical safety and also failed to follow hospital policy. Per review of policy Restraint /Seclusion last reviewed on 8/2015 states: " IV. PROCEDURE: C. Application of restraints: trained staff are in charge of applying restraints, maintenance staff, Security and Law Enforcement may assist with the application of restraints with the support and direction of the staff ". Patient # 2 was not in police custody, nor a prisoner, but a patient with psychiatric disabilities that required direct management and consistent therapeutic intervention by hospital staff. Once in the ED the police were permitted to make the decisions regarding the immediate management and treatment of this psychiatric patient to include intimidation, specific restraint holds and handcuffing. It was determined Patient #2 was in need of psychiatric hospitalization and an involuntary admission occurred on 1/9/16 at 21:28 to a inpatient facility.</p> <p>2. ED staff failed to discontinue the use of 4 - point restraints at the earliest possible time and the physician failed to appropriately reassess and justify the need for continuation of the use of restraints for Patient #1. On 1/2/16 ED staff were concerned Patient #1 ' s belongings that s/he kept piled on ED bed stretcher should be</p>	A 154	<p>See Attached pgs 2+3</p>

Manlygubert 5/12/16

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<p>A 154</p> <p>Continued From page 8</p> <p>contraband (to assure patient and staff safety). In addition, due the patient ' s increased agitation and aggression toward nursing staff, s/he would be removed from Room #3, to Room #10 (also designated as a seclusion/secure room) for closer observation and monitoring. During this transfer, Patient #1 became more agitated and resistant. Per Physician Orders/Restraints for 1/2/16 at 07:45 ED Physician #1 restraint orders include Chemical, Physical and Seclusion. Patient #1 was placed in Room #10, 4 point restraints were applied and medication was administered to include: Haldol 5 mg & Ativan 2 mg IM (intramuscular injection). Per review of restraint observation flow sheet used by nursing, from 11:15 through 12:45 on 1/2/16 Patient #1 was observed and coded as " 1 " (sleeping) and/or " 2 " (calm), however staff failed to initiate removal of restraints. In addition, ED Physician #1 documents in Physician Clinical Report at 11:37 1/2/16 Patient #1 was: " sleeping, NAD " (no acute distress) but reorders at 11:45 the continuation of 4-point restraints/seclusion noting in the Physician Order/Restraints because: " Pt. shouts out periodically " .</p> <p>3. On 1/4/16 at 13:15 Patient #1 was placed in seclusion in Room #10 due to persistent wandering. Once in seclusion Patient #1 was observed from 14:00 through 14:45 as " 2 " calm. At approximately 15:00 and per Nursing Clinical Report: " Patient found to have picked a scab from her/his right lower thigh and wrote ' xxxx xxx ' in her/his blood on the wall. Site cleaned and antibiotic ointment and band aid applied. Tried to reason with patient the importance of keeping safe and patient was pushing personnel away and started screaming. " Per interview on 3/15/16 at 12:25 PM Nurse #1 stated s/he could not recall the size of the injury or any extent of</p>	<p>A 154</p> <p><i>See Attached PG 2+3</i></p>
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Therapist 5/13/16

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A 154 Continued From page 9

A 154

bleeding from the scab. The patient, although already in seclusion and under 1:1 observation by the Sherriff 's department officer, Nurse #1 stated s/he and other staff had been pushed by Patient #1 when the patient was approached to treat the open area on right lower thigh. If staff had left the seclusion room, the threat of imminent safety risk to them would have been resolved. However, it was determined as a result of the patient 's resistance to receiving first aid and threats to staff, the application of 4 point restraints and chemical restraints was warranted. There was no evidence least retrictive methods were attempted prior to the application of restraints. The Physician Orders/Restraint states purpose of Chemical restraint was for " self-injury " and " threatening others ". Patient #1 was not threatening staff until confronted by staff who wanted to put a band aid on the small open area on patient 's right lower thigh. The patient remained in 4 point restraints and seclusion for 2.25 hours.

4. Staff failed to discontinue the use of 4 -point restraints at the earliest possible time on for Patient #1. Per Nursing Clinical Report for 1/4/16 at 19:15 Patient #1 was described as " ...unruly and disruptive and would not stay in room. " Patient #1 refused redirection and began yelling in ED hallway. During the process of escorting Patient #1 back to room #10, Patient #1 grabbed a nurse 's arm, kicked and assaulted nurse with fingernails. 4 point restraints were ordered and applied and emergency medications to include Haldol 10 mg. & Ativan 2 mg. IM were administered. There was a failure by staff to discontinue the restraints and/or seclusion at the earliest possible time as evidenced by review of the restraint observation flow sheet. With the exception on 1/4/16 at 21:30 & 21:45 when staff

See attached pg 2+3

Thanghachar T 5/13/16

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A 154	Continued From page 10 assessed Patient #1 as " 3 " restless, from 20:00 to 23:45 Patient #1 was observed by staff to be either " 1 " sleeping and/or " 2 " calm, however there was no evidence of reduction nor removal of the 4 point restraints. Per interview on 3/15/16 at 2:45 PM the ED Medical Director confirmed staff failed to release Patient #1 at the earliest possible time when s/he was demonstrating no further imminent threat of harm to self and/or staff. Per review of the hospital ' s Restraint/Seclusion policy last reviewed 8/2015 states: " III H. Discontinuation: Restraint/Seclusion shall be discontinued by an RN once the behaviors or situations that prompted are assessed and no longer are harmful to the safety of the patient, staff members or others and treatment may be accomplished through less restrictive means. " The policy further states: " Patients have the right to be free from restraint or seclusion of any form that is not clinically necessary for the safety of the patient. Whenever possible, the use of restraint/seclusion is to be avoided due to its potential to be physically and mentally harmful to the patient and to protect the patient ' s dignity, rights and well-being " .	A 154	<i>See attached pg 2+3</i>		
A 164	482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. This STANDARD is not met as evidenced by: Based on observation, interview and record review the hospital failed to assure restraints used on 1 of 4 applicable patients were	A 164	<i>See Attached pg 4</i>		

Wingbozherdt 5/13/16

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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 03/24/2016
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)

A 164 Continued From page 11

discontinued at the earliest possible time and the application of restraints were only imposed to ensure immediate physical safety of the patient and others. (Patient #1) Findings include: Per record review, Patient #1 was admitted to the ED on 12/31/15 at 22:19 after exhibiting a behavior change which included increased agitation, self-inflicted injury and delusions. Upon physician exam the clinical impression was Psychosis. It was subsequently determined Patient #1 was in need of psychiatric hospitalization, however due to the lack of availability for a psychiatric admission bed, Patient #1 remained in the ED until 1/6/16. During this time period Patient #1 was restrained, administered emergency medications and placed in seclusion. Staff failed during the use of restraints to discontinue the restraints at the earliest possible time and failed to demonstrate the patient was a continued immediate physical safety concern to self and/or others.

1. On 1/2/16, ED staff were concerned Patient #1's belongings that s/he kept piled on ED bed stretcher should be contraband (to assure patient and staff safety). In addition, due the patient's increased agitation and aggression toward nursing staff, s/he would be removed from Room #3, to Room #10 (also designated as a seclusion/secure room) for closer observation and monitoring. During this transfer, Patient #1 became more agitated and resistant. Per Physician Orders/Restraints for 1/2/16 at 07:45 ED Physician #1 restraint orders include Chemical, Physical and Seclusion. Patient #1 was placed in Room #10, 4 point restraints were applied and medication was administered to include: Haldol 5 mg & Ativan 2 mg IM (intramuscular injection). Per review of restraint observation flow sheet used by nursing, from

A 164

See attached pg 4

Mangalaghar 5/12/16

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A 164 Continued From page 12

11:15 through 12:45 on 1/2/16 Patient #1 was observed and coded as "1" (sleeping) and/or "2" (calm), however staff failed to initiate removal of restraints. In addition, ED Physician #1 documents in Physician Clinical Report at 11:37 1/2/16 Patient #1 was: "sleeping, NAD" (no acute distress) but reorders at 11:45 the continuation of 4-point restraints/seclusion noting in the Physician Order/Restraints because: "Pt. shouts out periodically".

2. On 1/4/16 at 13:15 Patient #1 was placed in seclusion in Room #10 due to persistent wandering. Once in seclusion Patient #1 was observed from 14:00 through 14:45 as "2" calm. At approximately 15:00 and per Nursing Clinical Report: "Patient found to have picked a scab from her/his right lower thigh and wrote 'xxxx xxx' in her/his blood on the wall. Site cleaned and antibiotic ointment and band aid applied. Tried to reason with patient the importance of keeping safe and patient was pushing personnel away and started screaming." Per interview on 3/15/16 at 12:25 PM Nurse #1 stated s/he could not recall the size of the injury or any extent of bleeding from the scab. The patient, although already in seclusion and under 1:1 observation by the Sheriff's department officer, Nurse #1 stated s/he and other staff had been pushed by Patient #1 when the patient was approached to treat the open area on right lower thigh. If staff had left the seclusion room, the threat of imminent safety risk to them would have been resolved. However, it was determined as a result of the patient's resistance to receiving first aid and threats to staff, the application of 4 point restraints and chemical restraints was warranted. The Physician Orders/Restraint states purpose of Chemical restraint was for "self-injury" and "threatening others". Patient #1 was not threatening staff until

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See Attached sheet pg 4

Wang, Elizabeth 5/17/16

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A 164

Continued From page 13
confronted by staff who wanted to put a band aid on the small open area on patient's right lower thigh. The patient remained in 4 point restraints and seclusion for 2.25 hours. There was no clear indication least restrictive interventions were attempted after the initial encounter with the patient who was already in seclusion.
3. Per Nursing Clinical Report for 1/4/16 at 19:15 Patient #1 was described as "... unruly and disruptive and would not stay in room." Patient #1 refused redirection and began yelling in ED hallway. During the process of escorting Patient #1 back to room #10, Patient #1 grabbed a nurse's arm, kicked and assaulted nurse with fingernails. 4 point restraints were ordered and applied and emergency medications to include Haldol 10 mg. & Ativan 2 mg. IM were administered. There was a failure by staff to discontinue the restraints and/or seclusion at the earliest possible time as evidenced by review of the restraint observation flow sheet. With the exception on 1/4/16 at 21:30 & 21:45 when staff assessed Patient #1 as "3" restless, from 20:00 to 23:45 Patient #1 was observed by staff to be either "1" sleeping and/or "2" calm, however there was no evidence of reduction nor removal of the 4 point restraints during this time period. Per interview on 3/15/16 at 2:45 PM the ED Medical Director confirmed staff failed to release Patient #1 at the earliest possible time when s/he was demonstrating no further imminent threat of harm to self and/or staff.
Per review of the hospital's Restraint/Seclusion policy last reviewed 8/2015 states: " III H. Discontinuation: Restraint/Seclusion shall be discontinued by an RN once the behaviors or situations that prompted are assessed and no longer are harmful to the safety of the patient, staff members or others and treatment may be

A 164

See attached pg 4

Therapy begun 5/12/16

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A 164 Continued From page 14
accomplished through less restrictive means. " The policy further states: " Patients have the right to be free from restraint or seclusion of any form that is not clinically necessary for the safety of the patient. Whenever possible, the use of restraint/seclusion is to be avoided due to its potential to be physically and mentally harmful to the patient and to protect the patient ' s dignity, rights and well-being "

A 164 *see attached p 94*

A 167 482.13(e)(4)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION

A 167

[The use of restraint or seclusion must be--]
(ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.

see attached p 95

This STANDARD is not met as evidenced by:
Based on staff interview and record review the hospital failed to assure staff consistently implemented the use of restraints in accordance with policy and procedures when involving Law Enforcement for 1 of 4 applicable patients. (Patient #2) Findings include:

Per review of policy Restraint /Seclusion last reviewed on 8/2015 states: " IV. PROCEDURE: C. Application of restraints: trained staff are in charge of applying restraints, maintenance staff, Security and Law Enforcement may assist with the application of restraints with the support and direction of the staff." However, on 1/9/16 ED staff relinquished the direction for the application of restraints when the police were summoned by nursing staff to assist with a transfer of a patient from one room to another. Although ED staff have received training in CPI (Crisis Prevention

Therapy Logsheet 5/13/16

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A 167 Continued From page 15

Intervention/ Non-violent Crisis Intervention) and additional training in the application of restraints, they failed to follow hospital policy when allowing the police to use physical force, manual restraint and the application of handcuffs to a patient requiring psychiatric hospitalization who was not under arrest or in police custody.

Patient #2, with a history of Depression, Anxiety and suicidal ideation was brought to the ED requesting treatment for his/her mental illness and demonstrated significant anxiety as s/he awaited determination of a psychiatric hospital admission. Per review of Brattleboro Police Report, ED nursing staff request assistance with a patient. 2 officers arrive to the ED on 1/9/16 at approximately 0228. The report states police approach Patient #2 who was sitting on stretcher in assigned room, and informed by police s/he is going to be transferred to another room for the patient's safety and the safety of others. Patient #2 refuses and was told by one of the police officers if s/he did not go of her/his own free will hands would be placed on the patient and s/he would be physically escorted to room #10 (safe/seclusion room). The patient again refused but demonstrated no resistance. Per report, the police officers seized Patient #2 in a "non-compliant escort hold" and pulled the patient off the ED stretcher. Patient #2 resisted the holds and tried to sit on the floor and subsequently tried to kick back at one of the officers. The report states police used a arm-bar takedown resulting in dropping Patient #2 to the floor and pinning the patient's head to the floor by pressing a forearm against the patient's jaw. The patient remained on the floor struggling and head remained pressed to the floor. Eventually Patient #2 was assisted to his/her feet and held in a non-compliant escort

A 167

See attached pg 5

Mary Lambert 5/17/16

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A 167 Continued From page 16

hold and then the patient's right wrist was placed in a front-supported wrist lock. Patient #2 was lead into room #10 by the 2 police officers who ordered the patient to lay on the bed and handcuffed the patient's right wrist to the bed.

Per review of Clinical Report - Nurses progress note states at 02:55 1/9/16 " Officers escorted Pt to the floor and secured her/him at that time with handcuffs. Pt then brought to room 10 and secured to the cot until calm". After a period of time the police removed the handcuff, and left the ED. The patient was not a prisoner or charged and placed in police custody. After the incident with law enforcement the Physician Clinical Report states "During restraint s/he hit her/his head and c/o wrist pain so x-rays were done, CT head... both negative." It was also determined Patient #2, was in need of psychiatric hospitalization and an involuntary admission occurred on 1/9/16 at 21:28 to a inpatient facility.

Patient # 2 was not in police custody, nor a prisoner, but a patient with psychiatric disabilities that required direct management and consistent therapeutic intervention by hospital staff. As a result of the incident on 1/9/16 staff also failed to adhere to, the hospital policy Restraint /Seclusion which further states: I. Policy: " Patients have the right to be free from restraint or seclusion of any form that is not clinically necessary for the safety of the patient. Whenever possible, the use of restraint/seclusion is to be avoided due to its potential to be physically and mentally harmful to the patient and to protect the patient's dignity, rights and well-being ".

A 169 482.13(e)(6) PATIENT RIGHTS: RESTRAINT OR

A 167

A 169

See attached pg 5

over

Mary Maguire 5/12/16

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A 169 Continued From page 17
SECLUSION

A 169

Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).

This STANDARD is not met as evidenced by:
Based on record review and staff interview a ED Physician failed to initiate new orders for the application of restraints and the administration of emergency medications for 1 of 4 applicable patients. (Patient #1) Findings include:
Per review of Physician Orders/Restraints dated incorrectly as "12/4/16" (later acknowledged by Nurse #2 who completed date and time on order sheet that correct date was "1/4/16") ED Physician #2 signed orders for seclusion for Patient #1 at 13:15. Approximately 2 hours later, restraints and emergency involuntary medication is now ordered for Patient #1 and at some point added to the original restraint order sheet for 1/4/16 at 13:15. However, per review of Medication Order Sheet Physician #2 prescribed Geodon (antipsychotic) 20 mg. IM & Ativan (benzodiazepine/sedative) 2 mg. IM at 15:14 and nursing administered the medication at 15:20 to Patient #1. Around the same time Patient #1 was placed in 4 - Point restraints per Nurse Clinical Report note stating at 15:19 on 1/4/16 Patient #1 is safely placed in restraints. A new Physician Orders/Restraints form was not utilized or an appropriate assessment conducted to justify the reason for the new episode requiring the application of restraints and medication administration. In addition, orders for restraints can not be left as PRN (as needed) and then utilized 2 hours later when considered by staff to then be necessary.

See attached pg 6

Therapist 5/13/16

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A 286 Continued From page 18
A 286 482.21(a), (c)(2), (e)(3) PATIENT SAFETY

A 286
A 286

(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.

See attached pg 7+8

This STANDARD is not met as evidenced by:
Based on staff interview and record review, the hospital's Quality Assurance/Performance Improvement (QA/PI) failed to effectively analyze and evaluate the appropriateness of restraint/seclusion use in the ED; the interactions and use of Law Enforcement when called to the ED to augment staffing and assurance Patient Rights are maintained. As a result, there was a

Henry Boyerhead 5/1/16

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A 266 Continued From page 19
failure of QA/PI to identify additional opportunities for improvement. Findings include:

A 286

Per interview on 3/15/16 at 3:45 PM the Executive Director for Quality, Utilization & Care Management confirmed multiple meetings, retraining and education have been provided to staff, specifically evaluating the care, services and management of Patient #1 during his/her stay in the ED from 12/31/15 - 1/6/16. Treatment plans were reviewed, the patient's record was audited and opportunities for improvement had been identified to include the correct positioning of patients during the application of restraints.

However, review of Patient #1's ED record additional opportunities for improvement were not identified by the QA/PI program or ED management to include a delay in releasing Patient #1 from restraints when it was evident there was no longer an immediate threat of physical safety of the patient, a staff member or others. Review of restraint documentation for 1/2/16 and 1/4/16 demonstrated on both occasions the patient was either "calm" or "sleeping" for extended periods of time from 1.5 hours to 3 hours. There was a failure of ED physicians and nurses to document that the restraint intervention was the least restrictive. There was also discrepancies in the documentation pertaining to the Room Safety Checklist for Patient #1. Nursing progress notes state the patient had been changed into a hospital gown on 12/31/16 and safety checks conducted. However, the patient was confronted by staff during the morning of 1/2/16 during escalation of patient behaviors to be contraband and to have street clothes removed.

*See attached
Pg 7+8*

Wang, L. J. 5/12/16

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A 286 Continued From page 20

There was a failure to recognize the need to review if staff coverage was sufficient and available at all times in the ED to provide essential services and able to respond to emergent events or procedures and to be sufficient to meet the needs of patients demonstrating psychosis or other behavioral symptoms.

A 286

See attached pg 7+8

A 392 482.23(b) STAFFING AND DELIVERY OF CARE

The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient.

A 392

See attached pg 9

This STANDARD is not met as evidenced by:
Based on staff interview and record review, the hospital failed to assure sufficient staff coverage was available at all times in the ED to provide essential services and able to respond to emergent events or procedures and to be sufficient to meet the needs of patients demonstrating psychosis or other behavioral symptoms. Findings include:

Per interview on 3/18/16 at 2:10 PM the ED Manager stated "...night staff resources are slim" and law enforcement are used as "back-up" and can provide "a show of force". Also noting there is generally only 4 staff members on during the night shift in the ED. The use of Law Enforcement was evident on 1/9/16 at 02:30 when summoned to the ED by nursing staff to assist with a transfer of a patient from one room to another. Although

Mary Lagerhaug 5/12/16

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A 392	Continued From page 21 ED staff have received training in CPI (Crisis Prevention Intervention/ Non-violent Crisis Intervention) and additional training in the application of restraints, sufficient staff was not made available to assist with the behavioral management of Patient #2 for the transfer of the patient from one ED room to the safe/secure room. However, upon arrival to the ED, police officers were given charge of Patient #2 which resulted in the patient being subjected to police holds, forced to the floor and restrained by handcuffs by police officers.	A 392	See attached pg 9		
A 438	482.24(b) FORM AND RETENTION OF RECORDS The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the hospital failed to assure medical records were accurately written and complete for 2 of 11 applicable patients. (Patients #1 & 11) Findings include: 1. Based on record review the hospital failed to maintain an accurately written medical record for Patient #11. Per review, on 3/15/16, of the medication administration record, physician orders, and nursing progress notes; the patient received 10 units (measure of dosage) of insulin (medication used to treat elevated blood sugar)	A 438	See attached pg 10		

Wendy Longhart 5/13/16

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A 438	<p>Continued From page 22</p> <p>intravenously (into the veins) at 16:59 and 6 units of insulin intravenously at 19:53. Per review of the hospitalist 's consultation note written on 1/8/16, " The patient received IV normal saline in the Emergency Room and 10 units of subcutaneous insulin. " Per interview with the Nurse Practitioner who has clinical oversight of the Emergency Department on 3/16/16 at 9:58 AM, he/she stated that the patient received 10 units of insulin IV at 16:59 and 6 units of insulin at 19:53.</p> <p>2. Per review of Physician's Orders/Restraints for 1/4/16 the facility failed to maintain an accurate record for Patient #1. During Patient #1's stay in the ED physicians at various times ordered Patient #1 to be held in seclusion, 4-point restraints and/or emergency medications were also ordered. Restraint orders for 1/4/16 were dated 12/4/16. The discrepancy was confirmed by Nurse #2 who stated on 3/15/16 at 10:26 s/he had completed the date on the restraint order form. The ED Physician who ordered Patient #1 to be placed in restraints, seclusion and to receive emergency medications at 13:15 on 1/4/16, renewed the order with the incorrect date of 1/5/16 for restraints ordered on 1/4/16. This was confirmed by Physician #2 on 3/15/16 at 2:45 PM.</p> <p>3. Per review of the Behavioral Management Precaution/Room Safety Check dated 12/31/15 at 2300 utilized by ED staff upon admission of Patient #1. The check list noted all items that can be picked up and thrown were removed and all patient personal items are secured and kept outside of room. A Nursing Progress Note further states on 12/31/15 at 23:00 "Patient gowned....a safety sweep of the room has been completed". However, on 1/2/16 at 07:15 handwritten Progress Notes states "Patient remains in street</p>	A 438	<p><i>See attached pg 10</i></p>	
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Wendy Longbrake 5/12/16

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

PRINTED: 05/12/2016
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 03/24/2016
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)
A 438	Continued From page 23 clothes" and had not been in a gown. Per interview on 3/15/16 at 2:45 PM Physician #2 who was working on the morning of 1/2/16 recalls concerns were raised when Patient #1's behaviors were escalating and s/he was sitting on a stretcher with piles of belongings and had not been contraband by staff for articles/objects that could be considered harmful to self and or others. "I was frightened with that". Eventually, paper scrubs were provided to Patient #1 and the street clothes were removed along with certain items considered unsafe.	A 438	<i>see attached pg 10</i>
A1100	482.55 EMERGENCY SERVICES The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. This CONDITION is not met as evidenced by: Based on interviews and record reviews conducted on days of the on-site complaint survey, from 3/14/16 through 3/16/16 and completed on 3/24/16, the Condition of Participation: Emergency Services was not met as evidenced by: Based on interview and record review the hospital failed to effectively meet the needs of a patient with a psychiatric emergency condition by demonstrating a failure to provide appropriate health care intervention and behavioral management and utilizing law enforcement to augment staff for assistance with patient care. (Patient #2) Findings include: Per record review, on 1/8/16 at 22:48 Patient #2 arrived to the ED accompanied by a friend with a chief complaint of Depression and a past history	A1100	<i>see attached pg 11 & 12</i>

Mary Kuperherst 5/13/16

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

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A1100 Continued From page 24

A1100

of Bipolar and Anxiety. Patient #2 confirmed s/he has had suicidal thoughts. The patient was examined by a ED provider who states in the Physician Clinical Report on 1/8/16: " S/he has felt depressed for a long time and has been taking more xanax than s/he should.....is feeling frustrated as well and wants help. Nothing is making her/him better or worse....Patient is medically stable for psychiatric evaluation and disposition." A HCRS (Health Care Rehabilitation Services) screener was contacted by ED staff to assist in the evaluation and possible psychiatric hospitalization for Patient #2. The patient was cooperative and staff provided reassurance. During the screening evaluation with HCRS staff, Patient #2 was informed a specific psychiatric facility s/he had requested for admission had no beds available. Patient #2 became angry and anxious and informed staff s/he wanted to leave and refused to contract for safety. The police were summoned during 3 attempts at elopements but each time the patient returned on his/her own. Per review of police report for 1/9/16, Patient #2 was informed by a police officer that due to the patient's suicidal threats s/he was in protective custody, and hospital staff could not let the patient elope/leave. The patient remained in the ED, was not placed in police custody, and the police left the ED. Patient requested and received medication for sedation at 01:57 on 1/9/16 to include Zyprexa 10 mg and Benadryl 25 mg orally.

*See attached
Pg 11+12*

Per Clinical Report - Nurses on 1/9/16 at approximately 02:20 Patient #2's behavior escalates and "...became verbally assaultive to HN (Hunter North Security staff) then used her/his body to push past him (security), attempting to leave. Pt. then redirected to room.

Henry [unclear] 5/13/16

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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A1100 Continued From page 25

with show of numbers. Pt began striking glass door attempting to break glass. Per review of Brattleboro Police Report, ED nursing staff request assistance with a patient. 2 officers arrive to the ED on 1/9/16 at approximately 0228. The report states police approach Patient #2 who was sitting on stretcher in assigned room, and informed by police s/he is going to be transferred to another room for the patient's safety and the safety of others. Patient #2 refuses and was told by one of the police officers if s/he did not go of her/his own free will hands would be placed on the patient and s/he would be physically escorted to room #10 (safe/seclusion room). The patient again refused but demonstrated no resistance. Per report, the police officers seized Patient #2 in a "non-compliant escort hold" and pulled the patient off the ED stretcher. Patient #2 resisted the holds and tried to sit on the floor and subsequently tried to kick back at one of the officers. The report states police used a arm-bar takedown resulting in dropping Patient #2 to the floor and pinning the patient's head to the floor by pressing a forearm against the patient's jaw. The patient remained on the floor struggling and head remained pressed to the floor. Eventually Patient #2 was assisted to his/her feet and held in a non-compliant escort hold and then the patient's right wrist was placed in a front-supported wrist lock. Patient #2 was lead into room #10 by the 2 police officers who ordered the patient to lay on the bed and handcuffed the patient's right wrist to the bed.

Per Clinical Report - Nurses progress note also states at 02:55 1/9/16 " Officers escorted Pt to the floor and secured her/him at that time with handcuffs. Pt then brought to room 10 and secured to the cot until calm." Staff failed to

A1100

See attached pg 11+12

Mary Legerhart 5/11/16

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A1100 Continued From page 26

document the length of time the patient was held in a handcuff restraint. After a period of time the police removed the handcuff, left the ED without the patient who was not determined to be in police custody and who remained as a patient in need of psychiatric services requiring hospitalization. Subsequently, as a result of the physical takedown the Physician Clinical Report states "During restraint s/he hit her/his head and c/o wrist pain so x-rays were done, CT head....both negative."

Per review of hospital policy Restraint /Seclusion last reviewed on 8/2015 states: " IV. PROCEDURE. C. Application of restraints: trained staff are in charge of applying restraints, maintenance staff, Security and Law Enforcement may assist with the application of restraints with the support and direction of the staff ". However, staff direction was limited to requesting assistance from Law Enforcement and permitted the patient to be subjected to excessive force and restraint. Once in the ED, the police were permitted to make the decisions regarding the immediate management and treatment of this psychiatric patient to include intimidation, specific restraint holds and handcuffing.

Per interview on 3/16/16 at 2:10 PM the ED Manager stated "...night staff resources are slim" and police are used as "back-up" and can provide " a show of force". Also noting there is generally only 4 staff members on during the night shift. Subsequent to this event it was determined Patient #2 was in need of psychiatric hospitalization and an involuntary admission occurred on 1/9/16 at 21:28 to a inpatient facility.

A1100

*See attached
pg 11+12*

May Leguina 5/3/16



Brattleboro Memorial Hospital

Brattleboro Memorial Hospital

Plan of Correction for survey conducted March 24, 2016

Originally submitted 4/22. Approved 4/27 cur

482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING

The patient has the right to receive care in a safe setting.

A144

This STANDARD is not met as evidenced by: Based on interview and record review the hospital failed to assure that each patient's rights to receive care in a safe setting was maintained when law enforcement personnel were notified of and responded to a patient who required behavioral management in the ED. The hospital also failed to address a potential safety hazard involving furniture in the ED (Patient # 1 & 2).

A144 POC

ED nursing staff and providers received individual instruction regarding the completion of: (completed 3/28/16-4/1/16)

- Seclusion/Restraint;
- Behavioral Management;
- Room Safety Check
- Patient Search/Contraband Packets

In addition, reviewed contraband and room safety with HCRS Crisis personnel. Education and reviews done by ED Director and ED RN Liaison. (3/28/16-4/1/16)

100% concurrent auditing of packet completion and room safety compliance to be done by ED Director and ED RN Liaison for 6 months. (started 4/4/16 - end date 10/4/16)

One to one observer chairs being maintained outside of room allowing for view into room and unrestricted movement of the patient. Visitor chairs being provided on basis of patient assessment. Assessments to be done by ED Staff Nurses. (4/4/16)

Mary Hughes 5/12/16
POC cur 4-26-16 fm/sj

482.13 (e) USE OF RESTRAINT OR SECLUSION

A154

Patient Rights: Restraint or Seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.

Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to protect the rights of a patient when ED staff relinquished to Law Enforcement the process of a room transfer of a patient resulting in unnecessary force to immobilize the patient to include manual restraints and handcuffs. (Patient #2) The facility also failed to discontinue the use of restraints and seclusion at the earliest possible time for 1 of 4 applicable patients (Patient #1).

A154 POC

Education provided to staff nurses and nursing supervisors regarding the appropriate interactions between hospital staff and law enforcement staff on the BMH campus. Training focused upon the hospital's responsibility for appropriate assessment and the provision of safe, appropriate care of a patient and during situations when law enforcement may act including: imminent danger, detention and public safety reasons. Begun by ED Director on 4/25/16. Multiple modalities for instruction through 5/25/16.

Modified policy (Code Green) regarding use of law enforcement personnel in the management of patient behavior in the Emergency Department. Modification done by ED Director. Education of changes to staff by ED Director at monthly staff meetings 4/16 through 6/16.

Collaborative meetings occurred with the Windham County Sheriff's Department, the Department of Mental Health, and the BMH Quality (Quality Director/Care Management) and Emergency Departments (ED Director and Medical Director), regarding law enforcement's role in the Emergency Department as it relates to the CoP. Additionally, the Department of Mental Health completed a GAP analysis of the BMH restraint policy and the Windham County Sheriff's Department's restraint policy and gave recommendations for interagency alignment. (Initial meeting 3/8/16, Follow-up meeting 3/31/16)

Collaborative meeting with ED Director and Brattleboro Police Department discussing roles and interactions within the hospital. (4/28/16)

Ulrich/Logan 5/17/16

*POC aunt 4-26-16
f m/SL*

The Vice-President of Patient Care Services will conduct a series of educational sessions and will submit pertinent information to Brattleboro Memorial Hospital newsletters regarding the rights of health care workers assaulted while engaged in official duties as described in 13 V.S.A. §1028 & §1028(a).

This newsletter will also address the role of BMH Senior Administration in supporting nursing personnel through the process of filing charges and the felony's adjudication. (5/2/16)

Ungluebert 5/13/16

PDC unit 42616 FM/62

482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION

A164

Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.

This STANDARD is not met as evidenced by: Based on observation, interview and record review the hospital failed to assure restraints used on 1 of 4 applicable patients were discontinued at the earliest possible time and the application of restraints were only imposed to ensure immediate physical safety of the patient and others (Patient #1).

A164 POC

Quarterly Case Review:

Review documentation guidelines, management principles and clinical care standards for restrained and secluded patients. (5/2/16)

Review 100% concurrent cases and Cases #1 and #4 with involved staff. Focus educational efforts on the continued need for restraints, behavior to be in evidence for restraint removal and alternatives to the use of restraints. (4/4/16-4/4/17)

Address the need to remove restraints when patients are able to contract for safety, sleeping, compliant with verbal requests or display calm demeanor. Education to be done concurrently with staff during audit process by ED Director or ED RN Liaison.

A post evaluation instrument created to be used as appropriate by ED staff nurses after incidences of restraint/seclusion. (5/2/16)

Data will be reviewed monthly at the Emergency and Quality Department Leadership Meetings (4/27), quarterly at the Risk Management Meeting (June 23) and then quarterly at Quality Council (June 2)

Therese L. ... 5/13/16

Doc am J 4-26-16 f m /sd

482.13(e)(4)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION

A167

[The use of restraint or seclusion must be--] (ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.

This STANDARD is not met as evidenced by: Based on staff interview and record review the hospital failed to assure staff consistently implemented

the use of restraints in accordance with policy and procedures when involving Law Enforcement for 1 of 4 applicable patients (Patient #2).

A167 POC

As of April 4, 2016 100% occurrences of Seclusion/ Restraint have been concurrently reviewed by the Director of Emergency Services and the Emergency Department Nursing Liaison. (4/4/16-4/4/17)

From concurrent audits by ED Director, omissions, errors and/or deficits in documentation and clinical practice to be reviewed with involved personnel and corrective action strategies developed. To be done by ED Director and ED RN Liaison. Improvements in practice have been realized through coaching and completion of a Seclusion Restraint Use Review Form. (5/2/16-5/2/17)

Henry Longstreet 5/13/16

Dee Ann 4.26.16
fm fsd

482.13(e)(6) PATIENT RIGHTS: RESTRAINT OR SECLUSION

A169

Orders for the use of restraint or seclusion must never be written as a Continued From page 7 standing order or on an as needed basis (PRN).

This STANDARD is not met as evidenced by: Based on record review and staff interview a ED Physician failed to initiate new orders for the application of restraints and the administration of emergency medications for 1 of 4 applicable patients (Patient #1).

A169 POC

With concurrent audits by ED Director, individual educational sessions with nursing personnel to review documentation guidelines, patient assessment, need for restraint application and alternatives to their use. (5/2/16-5/2/17)

The Director of Emergency Services, ED Medical Director and the ED RN Liaison presented a review of patient's rights, the BMH Restraint Policy, Physician orders and requirements for patient assessment following orders for Seclusion/Restraints at the ED Providers Meeting.(3/31/16)

*Therapists 5/13/16
POC audit 4.26.16
fm. sl*

482.21(a), (c)(2), (e)(3) PATIENT SAFETY

A286

(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 Continued From page 8 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 of 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: Based on staff interview and record review, the hospital's Quality Assurance/Performance Improvement (QA/PI) failed to effectively analyze and evaluate the appropriateness of restraint/seclusion use in the ED; the interactions and use of Law Enforcement when called to the ED to augment staffing and assurance Continued From page 9

Patient Rights are maintained. As a result, there was a failure of QA/PI to identify additional opportunities for improvement.

A286 POC

Based on the concurrent audits done by the ED Director, in the above mandatory Quarterly Case Review meetings, the Director of Emergency Services and the Director of Quality Care Management will review the process and parameters for law enforcement's involvement as outlined in 42CFR §482.13(e). Will insure clarity of role definition and the process of a transfer of a patient's care and custody. Will review documentation guidelines and clinical responsibilities and relay areas of question to Leadership.
(4/4/16-4/4/17)

Results and analysis of Restraint/Seclusion audits will be presented in a series of Quality forums involving clinical staff, medical professionals and Board members. See below for forums.

Data will be reviewed monthly (starting at April and May meetings) at the Emergency and Quality Department Leadership Meetings (4/27/16), quarterly at the Risk Management Meetings (6/23/16)

Thuy Leung 5/13/16
POC complete 4.26.16
for 6/23

and then quarterly at Quality Council (6/2/16) The results and analysis of Restraint/Seclusion audits will be presented quarterly at the Board-level Quality Patient Safety Committee.(5/4/16)

Therapy/Behavior 5/13/16

PC audit 4.26.16
fm/sd

482.23(b) STAFFING AND DELIVERY OF CARE

A392

The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient.

This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure sufficient staff coverage was available at all times in the ED to provide essential services and able to respond to emergent events or procedures and to be sufficient to meet Continued From page 10 the needs of patients demonstrating psychosis or other behavioral symptoms.

A392 POC

The Directors of Emergency Services and Quality/Care Management to develop a plan for a multidisciplinary team to respond to incidences of Code Green. This team will provide for a safe response and compliance with CoP when incidences of physical aggression and/or self-directed violence occur. (Plan completed 5/5/16)

Ongoing education will be provided at subsequent staff meetings for multidisciplinary team members. (Initial distribution of education 5/5/16-5/6/16) (Ongoing education 5/2/16-7/2/16)

Wang, L. 5/13/16
AC unit 4.26.16 5/2/16

482.24(b) FORM AND RETENTION OF RECORDS

A438

The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.

This STANDARD is not met as evidenced by: Based on record review and staff interviews, the hospital failed to assure medical records were accurately written and complete for 2 of 11 applicable patients. (Patients # 1 and 11).

A438 POC

100% concurrent review and auditing of incidence of restraint was initiated by ED Director in April 2016 to insure compliance with established policies and CoP. 100% auditing will continue through 4/17. (4/4/16-4/4/17)

Therese Lambert 5/12/16
POC count 426/16
FM LSU

482.55 EMERGENCY SERVICES

A1100

The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice.

This CONDITION is not met as evidenced by: Based on interviews and record reviews conducted on days of the on-site complaint survey; from 3/14/16 through 3/16/16 and completed on 3/24/16, the Condition of Participation: Emergency Services was not met as evidenced by:

Based on interview and record review the hospital failed to effectively meet the needs of a patient with a psychiatric emergency condition by demonstrating a failure to provide appropriate health care intervention and behavioral management and utilizing law enforcement to augment staff for assistance with patient care (Patient #2).

A1100 POC

Regional Psychiatric Strategy Meeting

After meetings with local psychiatric providers, the Brattleboro Retreat and Healthcare and Rehabilitative Services of Southeastern Vermont (HCRS), BMH chaired a collaborative meeting of health care and behavioral health providers. The goal of this quarterly collaborative meeting is to improve the quality of behavioral health care along the continuum of care delivery. Areas to be addressed include: information sharing, care planning/care transitions, tele-medicine. (4/19/16)

ED nursing staff and providers received individual instruction regarding the completion of: (3/28/16-4/1/16)

- Seclusion/Restraint;
- Behavioral Management;
- Room Safety Check
- Patient Search/Contraband Packets

In addition, reviewed contraband and room safety with HCRS Crisis personnel. Education and reviews done by ED Director and ED RN Liaison. (3/28/16-4/1/16)

100% concurrent auditing of packet completion and room safety compliance to be done by ED Director and ED RN Liaison one year. (4/4/16- 10/4/16))

Therese Loggins 5/13/16
for unit 4-26-16
fm JSD

One to one observer chairs being maintained outside of room allowing for view into room and unrestricted movement of the patient. Visitor chairs being provided on basis of patient assessment. Assessments to be done by ED Staff Nurses. (4/4/16)

Education provided to staff nurses and nursing supervisors regarding the appropriate interactions between hospital staff and law enforcement staff on the BMH campus. Training focused upon the hospital's responsibility for appropriate assessment and the provision of safe, appropriate care of a patient and during situations when law enforcement may act including: imminent danger, detention and public safety reasons. Begun by ED Director on 4/25/16. Multiple modalities for instruction through 5/25/16.

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Collaborative meetings occurred with the Windham County Sheriff's Department, the Department of Mental Health, and the BMH Quality and Emergency Departments, regarding law enforcement's role in the Emergency Department as it relates to the CoP. Additionally, the Department of Mental Health completed a GAP analysis of the BMH restraint policy and the Windham County Sheriff's Department's restraint policy and gave recommendations for Continued From page 4 inter-agency alignment. (Initial meeting 3/8/16, Follow-up meeting 3/31/16)

Collaborative meeting with ED Director and Brattleboro Police Department discussing roles and interactions within the hospital. (4/28/16)

Marilyn Leggett 5/12/16

*POC unit 4-26-16
FM/Sd*