

Division of Licensing and Protection
103 South Main Street, Ladd Hall
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

May 8, 2014

Ms. Judy Tarr-Tartaglia, Administrator
Central Vermont Medical Center
Box 547
Barre, VT 05641

Provider ID #: 470001

Dear Ms. Tarr-Tartaglia:

The Division of Licensing and Protection completed a survey at your facility on **April 15, 2014**. The purpose of the survey was to determine if your facility met the conditions of participation for Acute Care Hospitals found in 42 CFR Part 482.

Following the survey, your facility submitted a Plan of Corrections (POC) which was found to be acceptable on **May 8, 2014**.

Sincerely,



Frances L. Keeler, RN, MSN, DBA
Assistant Division Director
State Survey Agency Director

FK:jl

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

PRINTED: 04/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2014
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NAME OF PROVIDER OR SUPPLIER CENTRAL VERMONT MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE BOX 547 BARRE, VT 05641
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(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 survey was conducted by the Division of Licensing and Protection on 4/14/14 through 4/15/14, as authorized by the Centers for Medicare and Medicaid Services. It was determined at the time of the complaint survey the Condition of Participation for Patient Rights and Nursing Services were not met. The following regulatory violations were identified related to Complaint # 00011469.	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: The Condition of Participation: Patient Rights was not met as evidenced by the hospital's failure to recognize concerns brought by a patient's family to be a grievance, and failed to follow hospital policy and process to effectively investigate the grievance to determine if opportunities for improvement existed as result of the grievance.	A 115	See Plan of Correction	5/30/14
A 118	Refer to Tags: A-0118 & A-0130 482.13(a)(2) PATIENT RIGHTS: GRIEVANCES The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. This STANDARD is not met as evidenced by: Based on family and staff interview and record review, the hospital failed to recognize concerns brought by a patient's family to be a grievance, and failed to follow hospital policy and process to	A 118	See Plan of Correction POC accepted F McIntosh / F Kulu	5/30/14 RN MSN OBA 5/8/14

ABOVE SIGNATURE OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Commie Theriault, VP Quality Management
TITLE
DATE
5/15/14

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 118	<p>Continued From page 1</p> <p>effectively investigate the grievance to determine if opportunities for improvement existed as result of the grievance for 1 applicable patient. (Patient #1) Findings include:</p> <p>Per hospital policy Resolution of Patient or Visitor Complaint Grievance last revised 12/16/11 states: "When a patient care complaint cannot be resolved at the time of the complaint by staff present, is postponed for later resolution, is referred to another staff member for later resolution, requires investigation, and/or requires further actions for resolution then the complaint is a grievance." The policy also states regarding processing a grievance: "All formal and informal grievances will be investigated to determine if opportunities exist to improve processes and systems related to issues reported."</p> <p>Per interview on 4/14/14 at 10:30 AM the Quality Improvement Consultant who provides oversight and receives Patient/Visitor complaints and/or grievances acknowledged s/he was made aware of an incident involving a patient who was inappropriately discharged to home from the Medical/Surgical Unit on 3/17/14. The Quality Improvement Consultant stated on 3/18/14 s/he received a telephone call from Patient #1's family representative regarding the failure of nursing staff to remove both an indwelling urinary catheter and a saline lock (peripheral intravenous catheter device) prior to discharging Patient #1 from the hospital on 3/17/14. Nursing Staff on the Medical/Surgical unit involved in the incident had not informed the Quality Improvement Consultant of a complaint raised by the family representative shortly after the patient arrived home on 3/17/14. Upon investigation and discussion of the event on 3/18/14 with nursing staff about the omissions at</p>	A 118		

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A 118	<p>Continued From page 2</p> <p>the time of discharge, it was determined by both nursing staff and the Quality Improvement Consultant the issues were discussed and resolved. The Quality Improvement Consultant stated s/he felt no further action was necessary to determine if opportunities existed to improve processes and systems. Nursing staff failed to file an event report of the incident, the discussion of the incident including miscommunication between staff and the physical effects subjected on Patient #1 when sent home with intravenous access and an indwelling catheter was not recognized as a systems related issue.</p> <p>In addition, the family representative had also notified the Quality Improvement Consultant regarding concerns related to possible ineffective pain management during Patient #1's hospitalization and the 5 day omission of 2 medications utilized by Patient #1 to manage his/her pain. One component of the grievance regarding Patient #1's medications was the family was referred to the attending physician practice at a non-hospital affiliated health care clinic. The family representative had expressed frustration that although a list of current medications were provided to the Emergency Department staff, the physician failed to utilize the current list but referred to an outdated list of medications from a previous hospital admission to determine admission orders. This resulted in Patient #1 not being maintained while hospitalized on 2 medications used successfully at home to manage pain issues.</p> <p>The Quality Improvement Manager confirmed it was his/her impression the grievance was resolved without any systemic review or consideration for opportunities for improvement.</p>	A 118		

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A 118	Continued From page 3 A letter was not generated by a department manager or by the Quality Improvement Consultant (as per hospital policy) to the family representative addressing steps taken on behalf of the patient to resolve the identified concerns. Per interview on 4/10/14 at 1:45 PM, the family caregiver for Patient #1 expressed frustration over the poor communication among nursing staff and the attending physicians from the health care center. As a result, Patient #1 was subjected to prolonged use of a urinary catheter and intravenous saline lock along with poor management of pain symptoms.	A 118		
A 130	482.13(b)(1) PATIENT RIGHTS: PARTICIPATION IN CARE PLANNING The patient has the right to participate in the development and implementation of his or her plan of care. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to determine if a patient with significant physical deficits was given the opportunity to participate in the development of his/her care plan to include addressing pain issues and psychosocial needs for 1 applicable patient. (Patient #1) Findings include: Per record review, Patient #1 is a 60 year old individual with a history of a CVA (stroke) with right sided hemiparesis (paralysis of one side of the body) and expressive aphasia (inability to express oneself through speech) and dysphagia (difficulty swallowing) who was admitted to the hospital on 3/12/14 after experiencing a respiratory event with possible aspiration while at	A 130	See Plan of Correction	5/30/14

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A 130	<p>Continued From page 4</p> <p>home. Per the History and Physical note dated 3/12/14 one of Patient #1's attending physicians states: " Past history of depression. It is difficult to assess him/her, but s/he is frequently irritable and angry and quite easily frustrated which is understandable."</p> <p>Per review of nursing notes, Patient #1 was described as "...unable to communicate effectively"; "...at times hard to understand"; "Pt tries to communicate but his/her speech is very unclear and hard to understand"; "...at times a bit angry appearing possible due to communication deficits". As per hospital policy the plan of care is initially determined by the Admission Data Base assessment. Patient #1's actual and potential health problems identified by nursing included: Airway issues, aspiration risk, knowledge deficits, self care deficits and impaired skin integrity. During hospitalization from 3/12 - 3/17/14 Patient #1 refused most meals or consumed only 25 % of a meal when accepted. Patient #1 developed pain symptoms especially with movement and demonstrated anger towards staff during attempts to communicate or during the provision of care.</p> <p>Despite the identified physical deficits, Patient #1 was not considered mentally incapacitated and remained responsible for directing his/her own care with guidance from family. However, there was no evidence either the patient and/or family were included or consulted in the formulation and direction of the patient's plan of care. Although the challenges were evident with verbal and cognition deficits, nursing staff failed to develop a plan to facilitate alternative forms of communication and nursing interventions that enabled and assisted Patient #1 with the</p>	A 130			

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A 130	<p>Continued From page 5</p> <p>management of his/her health care issues and direction of care while hospitalized. During the patient's hospitalization, pain became an issue for Patient #1, however there was no indication there was a discussion with the patient regarding alternative methods to assess for pain or medications that were more effective. Subsequently, the 2 medications that Patient #1 utilized for pain had been excluded at the time of admission, resulting in Patient #1 experiencing leg pain and pain when moved. Over a 5 day period, Patient #1 refused to eat or consumed only 25 % of a meal when accepted. Being his/her own guardian the patient had refused to accept an aspiration diet, refusing ground food or thickened liquids as per recommendations of speech therapy and dietician and would only accept minimal food intake however there was no evidence of discussing what the patient would accept or prefer to eat or why s/he was not eating.</p> <p>The opportunity to assist Patient #1 with the ongoing psychosocial issues related to the significant disabilities s/he was experiencing and the dependency it had created was also not addressed. Per interview on 4/15/14 at 10:30 AM a staff nurse stated s/he had a conversation with the physician who was discharging Patient #1 who commented about the patient: "S/He wants to die, wouldn't you want to die?" There was no evidence either from the Care Management Department, attending physicians or nursing to suggest offering counseling or an assessment by the Palliative Care Department to assist Patient #1 in his/her determining life choices and direction of his/her inpatient and outpatient treatment plan.</p>	A 130		

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A 385 A 385	<p>Continued From page 6</p> <p>482.23 NURSING SERVICES</p> <p>The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.</p> <p>This CONDITION is not met as evidenced by: The Condition of Participation: Nursing Services was not met as evidenced by the failure of nursing staff to assure the nursing care needs were evaluated and resolved prior to discharge from the hospital and failed to effectively reassess and meet pain management needs for 1 applicable patient in accordance with accepted standards of nursing practice and hospital policy.</p>	A 385 A 385	See Plan of Correction	5/30/14
A 395	<p>Refer to Tags: A-0395 & A-0396</p> <p>482.23(b)(3) RN SUPERVISION OF NURSING CARE</p> <p>A registered nurse must supervise and evaluate the nursing care for each patient.</p> <p>This STANDARD is not met as evidenced by: Based on family and staff interview and record review, nursing staff failed to assure the nursing care needs were evaluated and resolved prior to discharge from the hospital for 1 applicable patient and failed to effectively reassess and meet pain management needs for 1 applicable patient in accordance with accepted standards of nursing practice and hospital policy. (Patient #1) Findings include:</p> <p>1. Per record review, Patient #1 is a 60 year old individual with a history of a CVA (stroke) with right sided hemiparesis (paralysis of one side of</p>	A 395	See Plan of Correction	5/30/14

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A 395	<p>Continued From page 7</p> <p>the body) and expressive aphasia (inability to express oneself through speech) and dysphagia (difficulty swallowing) was admitted to the hospital on 3/12/14 after experiencing a respiratory event with possible aspiration while at home. During the 5 days of hospitalization Patient #1 required intermittent IV (intravenous) fluids and antibiotics which were infused via a peripheral intravenous catheter device (saline lock). Due to urinary retention, Patient #1 was catheterized and an indwelling catheter was inserted and remained during hospitalization to facilitate drainage of urine.</p> <p>During hospitalization, a discharge plan was developed to return Patient #1 back to his/her home where s/he is totally dependent on family to meet and provide all necessary care needs with the assistance of home health services. A Care Management note for 3/17/14 at 1134 states Patient #1's family and home health agency hospital liaison nurse were notified of the patient's pending discharge for 3/17/14. Patient #1's attending physician wrote orders for discharge however did not address whether the patient required the indwelling urinary catheter. Per review of "Provider Order Summary" the attending physician did order at 0951 on 3/17/14 to "discontinue saline lock". Per hospital policy Discharge Planning and Patient Discharge effective 7/8/13 states: "Responsibilities of Nursing: 5. On the day of discharge, the nursing staff will: C. Review Discharge Instructions sheet and Discharge Checklist to ensure all arrangements have been made.....Patient cannot be discharged from the organization until all outstanding items have been resolved and documentation is complete on the Discharge Checklist." Two outstanding items that were not addressed on the Discharge Check List or by</p>	A 395		

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A 395	Continued From page 8 nursing staff prior to Patient #1's discharge included the removal of Patient #1's indwelling urinary catheter and the saline lock. Per interview on 4/15/14 at 10:33 AM Nurse #1, who was assigned to Patient #1's care on 3/17/14, confirmed s/he was aware Patient #1 had the indwelling catheter and saline lock and his/her plan was to remove both prior to discharge after discussing the need for the urinary catheter with the patient's family and following up by obtaining a physician order for the removal of the catheter if indicated. However, at approximately 4:00 PM ambulance transport arrived and Patient #1 was transported back home with the indwelling catheter and saline lock still in place. Minutes after arrival home, family noted both the catheter and the saline lock had not been removed prior to Patient #1's discharge and immediately contacted the hospital with their concerns. Nurse #1 further stated that at the time of Patient #1's discharge, s/he was preoccupied with another patient discharge and acknowledged Patient #1 had not been appropriately prepared for discharge. Per interview on 4/15/14 at 11:05 AM the charge nurse on 3/17/14 for the Medical/Surgical Unit stated s/he had revived and signed off on the Discharge Checklist for Patient #1, noting it "...looked complete". S/he confirmed not being aware the catheter and saline lock had not been removed prior to discharge until after the family contacted Nurse #1. S/he then became involved in a discussion with Nurse #1 and the Interim Nurse Manager about miscommunication between staff. The charge nurse also acknowledged earlier planning should have occurred for the removal of the indwelling catheter in order to assess if Patient #1's bladder function would resume without further intervention prior to discharge. Per interview at 4/14/14 at 3:39	A 395		

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A 395	<p>Continued From page 9</p> <p>PM the Interim Nurse Manager also confirmed if a urinary catheter was removed and the patient was slated for discharge nursing would want to assure voiding prior to the patients discharge. In addition, s/he also confirmed there was no order to discontinue the catheter but there was an order for discharge, but not an order to discharge home with a urinary catheter. After Nurse #1 informed Patient #1's physician of the circumstances of the patient's discharge, an order was received to have the home health agency visit the patient on 3/18/14 and remove both the indwelling catheter and saline lock.</p> <p>2. At the time of Patient #1's admission on 3/12/14 to the Emergency Department (ED) his/her family brought a current list of medications Patient #1 receives at home. Included in the medication list was Relafen (Nabumetone) 500 mg orally x 2 once daily used to relieve arthritic pain, stiffness, swelling and Neurontin (Gabapentin) 300 mg 4 tablets orally 2 x daily. Per interview on 3/15/14 at 8:11 AM the ED nurse manager confirmed ED Triage staff are responsible for reconciling patient's medications using the list brought in from home and what the patient may have received during a prior hospitalization. The attending physician and/or hospitalist will review and confirm what medications will be continued and/or discontinued. Per review of the reconciled medications completed by ED staff, both Relafen and Neurontin were included.</p> <p>Per review of the History and Physical for 3/12/14, the attending physician does not reconcile the medication list but references a previous medication list from a discharge summary completed on 2/12/14 which does not include Relafen and Neurontin. Neither of these medications were later included in the patient's</p>	A 395		

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A 395	<p>Continued From page 10</p> <p>medication orders nor was there evidences they had been discontinued at the time of admission. Per nursing notes for 3/12/14 at 2306 states "medicated with 650 mg PO Tylenol for discomfort when moved/turned in bed". Follow up nursing note for 3/13/14 at 0555 states "PT. awake most of the night at times a bit angry appearing possibly due to communication deficit. Pt. appears to have pain in his/her legs and medicated with Tylenol x 1 during the night with no change". Per review of the MAR (Medication Administration Record) for 3/14/14 at 1947 Patient #1 was administered Tylenol 650 mg orally. A nursing note on 3/14/14 at 1547 " Appears uncomfortable with any touch of his legs, hollers out". On 3/15/14 at 1853 a nursing note states " Not interactive this morning, except to yell "No, No, No" and pushing staff away when attempting AM care.....c/o leg discomfort with repositioning. Medicated with Tylenol 650 mg orally with good effect". On 3/17/14 at 0025 Patient #1 again c/o of leg pain and received Tylenol. Per interview on 4/10/14 at 1:45 PM a family member of Patient #1 acknowledged although Patient #1 is unable to express himself/herself effectively s/ he was clearly in pain when discharged to home on 3/17/14 stating "S/he was hard to touch or move..could not tolerate physical contact". Upon review of the discharge documentation sent by the hospital, the family member noted Patient #1 had not received his/her prescribed medications used previously at home to effectively manage Patient #1's pain. Per hospital policy Pain Assessment and Management Standard of Practice revised 2/21/13 identifies multiple tools and assessment criteria for evaluating and treating patient pain. However, besides the administration of Tylenol and acknowledging the patient had difficulty with</p>	A 395		
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(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 395	Continued From page 11 communication due to physical deficits, there is a lack of evidence nursing staff made every effort to effectively evaluate the source of pain, inform the physician and advocate for a possible change or request additional pain medication orders, attempt to utilize alternative interventions or seek consultation with Patient #1's family/caregivers how to effectively communicate with Patient #1 in an effort to assure the patient's care needs were being met. Per Vermont Title 26: Professions and Occupations, Chapter 28: Nursing "Registered nursing" means the practice of nursing which includes: (A) Assessing the health status of individuals and groups; (H) Maintaining safe and effective nursing care rendered directly or indirectly (I) Evaluating responses to interventions; (L) Collaborating with other health professionals in the management of health care and (M) Addressing patient pain.	A 395		
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan This STANDARD is not met as evidenced by: Based on staff interview and record review, nursing staff failed to develop and address an effective care plan related to communication and psychosocial needs for 1 applicable patient. (Patient #1) Findings include: Per record review, Patient #1 is a 60 year old individual with a history of a CVA (stroke) with right sided hemiparesis (paralysis of one side of the body) and expressive aphasia (inability to	A 396	See Plan of Correction	5/30/14

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

PRINTED: 04/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2014
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NAME OF PROVIDER OR SUPPLIER CENTRAL VERMONT MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE BOX 547 BARRE, VT 05641
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(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 396	<p>Continued From page 12</p> <p>express oneself through speech) and dysphagia (difficulty swallowing) was admitted to the hospital on 3/12/14 after experiencing a respiratory event with possible aspiration while at home. Upon admission to the hospital and as per hospital policy the plan of care is initially determined by the Admission Data Base assessment. Actual and potential health problems identified by nursing included in the care plan included: Airway issues, aspiration risk, knowledge deficits, self care deficits and impaired skin integrity. During hospitalization from 3/12 - 3/17/14 nursing notes described Patient #1 as "...unable to communicate effectively"; "...at times hard to understand"; "Pt tries to communicate but his/her speech is very unclear and hard to understand"; "...at times a bit angry appearing possible due to communication deficits". The patient's difficulties with communicating effectively were not specifically addressed. No nursing interventions were incorporated within the care plan to assist staff and patient to clarify needs, adjust medications, seek alternative food requests or create diversions during the days of hospitalization.</p> <p>The care plan also failed to address the psychosocial needs and potential interventions. Per the History and Physical note dated 3/12/14 one of Patient #1's attending physicians states: "Past history of depression. It is difficult to assess him/her, but s/he is frequently irritable and angry and quite easily frustrated which is understandable." However, the interdisciplinary team to include the physician, nursing, dietician, social services/care management, or physical or occupational therapy failed to identify within the care plan the potential opportunity to offer services and/or consultation to Patient #1 to</p>	A 396		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2014
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NAME OF PROVIDER OR SUPPLIER CENTRAL VERMONT MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE BOX 547 BARRE, VT 05641
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(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 396	Continued From page 13 assist in addressing psychosocial factors or need for assistance with coping mechanisms related to his/her disabilities and dependence on others for all care needs.	A 396		

PLAN OF CORRECTION

A000 INITIAL COMMENTS

An unannounced on-site complaint survey was conducted by the Division of Licensing and Protection on 4/14/14 through 4/15/14, as authorized by the Centers for Medicare and Medicaid Services. It was determined at the time of the complaint survey the Condition of Participation for Patient Rights and Nursing Services were not met. The following regulatory violations were identified related to Complaint # 00011469.

A115 482.13 PATIENT RIGHTS

The hospital must protect and promote each patient's rights.

This CONDITION is not met as evidenced by: The Condition of Participation: Patient Rights was not met as evidenced by the hospital's failure to recognize concerns brought by a patient's family to be a grievance, and failed to follow hospital policy and process to effectively investigate the grievance to determine if opportunities for improvement existed as result of the grievance.

- Central Vermont Medical Center formally responded to the standard level deficiencies referenced in the above text at the standard level.
- The survey deficiencies and accompanying action plans will be presented by the Vice President of Quality or designee to the Performance Improvement Committee (PIC). This will be complete as 5/30/2014. The PIC provides oversight for performance improvement and patient safety activities for the organization. This is a multidisciplinary committee Chaired by the CEO with membership that includes senior management, physician and operational leaders from across the organization. The committee reports directly to the CVMC Board Quality and Risk Committee.
- The survey deficiencies and accompanying action plans will be presented by the Vice President of Quality or designee to the Standards of Operation Committee. This will be complete as of 5/30/2014. This committee provides oversight for compliance with associated regulatory standards and related operations. This is a multidisciplinary committee chaired by the CEO with membership that includes senior management and key leadership from across the enterprise.
- The survey deficiencies and accompanying action plans will be presented by the Vice President of Medical Affairs to the Medical Executive Committee. This will be complete as of 5/30/2014.
- The survey deficiencies and accompanying action plans will be reviewed with the Executive Committee of the CVMC Board of Trustees by 5/30/14.

Refer to Tags: A-0118 & A-0130

A118 482.13(a)(2) PATIENT RIGHTS: GRIEVANCES

The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.

This STANDARD is not met as evidenced by: Based on family and staff interview and record review, the hospital failed to recognize concerns brought by a patient's family to be a grievance, and failed to follow hospital policy and process to effectively investigate the grievance to determine if opportunities for improvement existed as result of the grievance for 1 applicable patient. (Patient #1) Findings include:

Per hospital policy Resolution of Patient or Visitor Complaint Grievance last revised 12/16/11 states: " When a patient care complaint cannot be resolved at the time of the complaint by staff present, is postponed for later resolution, is referred to another staff member for later resolution, requires investigation, and/or requires further actions for resolution then the complaint is a grievance." The policy also states regarding processing a grievance: "All formal and informal grievances will be investigated to determine if opportunities exist to improve processes and systems related to issues reported."

Per interview on 4/14/14 at 10:30 AM the Quality Improvement Consultant who provides oversight and receives Patient/Visitor complaints and/or grievances acknowledged s/he was made aware of an incident involving a patient who was inappropriately discharged to home from the Medical/Surgical Unit on 3/17/14. The Quality Improvement Consultant stated on 3/18/14 s/he received a telephone call from Patient #1's family representative regarding the failure of nursing staff to remove both an indwelling urinary catheter and a saline lock (peripheral intravenous catheter device) prior to discharging Patient #1 from the hospital on 3/17/14. Nursing Staff on the Medical/Surgical unit involved in the incident had not informed the Quality Improvement Consultant of a complaint raised by the family representative shortly after the patient arrived home on 3/17/14. Upon investigation and discussion of the event on 3/18/14 with nursing staff about the omissions at the time of discharge, it was determined by both nursing staff and the Quality Improvement Consultant the issues were discussed and resolved. The Quality Improvement Consultant stated s/he felt no further action was necessary to determine if opportunities existed to improve processes and systems. Nursing staff failed to file an event report of the incident, the discussion of the incident including miscommunication between staff and the physical effects subjected on Patient #1 when sent home with intravenous access and an indwelling catheter was not recognized as a systems related issue.

In addition, the family representative had also notified the Quality Improvement Consultant regarding concerns related to possible ineffective pain management during Patient #1's hospitalization and the 5 day omission of 2 medications utilized by Patient #1 to manage his/her pain. One component of the grievance regarding Patient #1's medications was the family was referred to the attending physician practice at a non-hospital affiliated health care clinic. The family representative had expressed frustration that although a list of current medications were provided to the Emergency Department staff, the physician failed to utilize the current list but referred to an outdated list of medications from a previous hospital admission to determine admission orders. This resulted in Patient #1 not being maintained while hospitalized on 2 medications used successfully at home to manage pain issues. The Quality Improvement Manager confirmed it was his/her impression the grievance was resolved without any systemic review or consideration for opportunities for improvement.

A letter was not generated by a department manager or by the Quality Improvement Consultant (as per hospital policy) to the family representative addressing steps taken on behalf of the patient to resolve the identified concerns.

Per interview on 4/10/14 at 1:45 PM, the family caregiver for Patient #1 expressed frustration over the poor communication among nursing staff and the attending physicians from the health care center. As a result, Patient #1 was subjected to prolonged use of a urinary catheter and intravenous saline lock along with poor management of pain symptoms.

Action Plan

- The Central Vermont Medical Center (CVMC) policies entitled Resolution of Patient and Visitor Complaint Policy and Adverse Event Reporting Policy were reviewed to assure alignment with best practice and regulatory requirements. This review was completed by a multidisciplinary team comprised of the Vice President of Quality, the Vice President of the James Jeffords Institute for Quality, the Director of Quality for CVMC and the Director of Accreditation and Regulatory Affairs at Fletcher Allen. This review was complete on 5/2/2014.
- The Resolution of Patient and Visitor Complaint Policy was updated and renamed the Patient Complaint and Grievance Policy to provide increased clarity for staff actions. This was complete on 5/5/2014.

- Staff will be educated regarding the processes of both the Patient Complaint and Grievance Policy, and Adverse Event Reporting Policy. A web based education and competency module has been developed by the lead Nurse Educator in collaboration with the Vice President and Director of Quality at CVMC. All actions will be completed on 5/30/2014.
- The expectations set forth in the CVMC Patient Complaint and Grievance Policy, and Adverse Event Reporting Policy will be communicated by the Vice President of Medical Affairs to the medical staff. This will be complete as of 5/30/2014.
- The Medication Reconciliation Policy was reviewed and revised by the Vice President of Medical Affairs on 5/5/2014 to assure alignment with regulatory requirements and best practice. The revised policy will be distributed and communicated to the Medical Staff by 5/23/14. Physician compliance with the policy will be monitored by the Vice President of Medical Affairs using an electronic compliance reporting process beginning on 5/30/14.
- Patient complaints and adverse event reports will be reviewed collectively by the Quality Consultant for Patient Advocacy, Director of Quality Management, and the Vice President of Quality on a bi-weekly basis to determine appropriate action and follow up. Compliance with the CVMC Patient Complaint and Grievance Policy will be reviewed at the bi-weekly meeting. Attention will be made to whether opportunities exist to improve systems and processes using the appropriate performance improvement methodology. Cases requiring action will be reported through to the Performance Improvement Committee (PIC). The PIC provides oversight for performance improvement, regulatory and patient safety functions of the organization. The PIC is a multidisciplinary committee chaired by the CEO with membership that includes senior management, physician and operational leaders from across the organization. The committee reports directly to the CVMC Board Quality and Risk Committee.
- All action plans will be completed as of 5/30/2014.

A130 482.13(b)(1) PATIENT RIGHTS: PARTICIPATION IN CARE PLANNING

The patient has the right to participate in the development and implementation of his or her plan of care.

This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to determine if a patient with significant physical deficits was given the opportunity to participate in the development of his/her care plan to include addressing pain issues and psychosocial needs for 1 applicable patient. (Patient #1) Findings include:

Per record review, Patient #1 is a 60 year old individual with a history of a CVA (stroke) with right sided hemiparesis (paralysis of one side of the body) and expressive aphasia (inability to express oneself through speech) and dysphagia (difficulty swallowing) who was admitted to the hospital on 3/12/14 after experiencing a respiratory event with possible aspiration while at home. Per the History and Physical note dated 3/12/14 one of Patient #1's attending physicians states: "Past history of depression. It is difficult to assess him/her, but s/he is frequently irritable and angry and quite easily frustrated which is understandable."

Per review of nursing notes, Patient #1 was described as "...unable to communicate effectively"; "...at times hard to understand" "Patient tries to communicate but his/her speech is very unclear and hard to understand"....at times a bit angry appearing possible due to communication deficits". As per hospital policy the plan of care is initially determined by the Admission Data Base assessment. Patient #1's actual and potential health problems identified by nursing included: Airway issues, aspiration risk, knowledge deficits, self-care deficits and impaired skin integrity. During hospitalization from 3/12 - 3/17/14 Patient #1 refused most meals or consumed only 25 % of a meal when accepted. Patient #1 developed pain symptoms especially

with movement and demonstrated anger towards staff during attempts to communicate or during the provision of care.

Despite the identified physical deficits, Patient #1 was not considered mentally incapacitated and remained responsible for directing his/her own care with guidance from family. However, there was no evidence either the patient and/or family were included or consulted in the formulation and direction of the patient's plan of care. Although the challenges were evident with verbal and cognition deficits, nursing staff failed to develop a plan to facilitate alternative forms of communication and nursing interventions that enabled and assisted Patient #1 with the management of his/her health care issues and direction of care while hospitalized. During the patient's hospitalization, pain became an issue for Patient #1, however there was no indication there was a discussion with the patient regarding alternative methods to assess for pain or medications that were more effective. Subsequently, the 2 medications that Patient #1 utilized for pain had been excluded at the time of admission, resulting in Patient #1 experiencing leg pain and pain when moved. Over a 5 day period, Patient #1 refused to eat or consumed only 25 % of a meal when accepted. Being his/her own guardian the patient had refused to accept an aspiration diet, refusing ground food or thickened liquids as per recommendations of speech therapy and dietician and would only accept minimal food intake however there was no evidence of discussing what the patient would accept or prefer to eat or why s/he was not eating.

The opportunity to assist Patient #1 with the ongoing psychosocial issues related to the significant disabilities s/he was experiencing and the dependency it had created was also not addressed. Per interview on 4/15/14 at 10:30 AM a staff nurse stated s/he had a conversation with the physician who was discharging Patient #1 who commented about the patient: "S/He wants to die, wouldn't you want to die?" There was no evidence either from the Care Management Department, attending physicians or nursing to suggest offering counseling or an assessment by the Palliative Care Department to assist Patient #1 in his/her determining life choices and direction of his/her inpatient and outpatient treatment plan.

Action Plan

- The CVMC Discharge Planning and Patient Discharge Policy was reviewed and revised on 5/2/2014 by the Vice President of Quality, the Chief Nursing Officer and the Vice President of Medical Affairs in collaboration with the Care Management Program Manager. An additional prompt was added to the relevant documentation tools to include the requirement to verify lines, drains and tube removal.
- The discharge checklist was revised on 5/1/2014 by the Care Management Program Manager to include a prompt for the removal of lines, drains or tubes and a prompt to indicate that if they are not to be removed, and the necessary steps required to be taken. The checklist supports the Discharge Planning and Patient Discharge policy and process. Appropriate members of the treatment team contribute to the process of discharge planning and utilize the Discharge Checklist for documentation. The Charge Nurse is responsible for final review of the checklist prior to the patient's discharge. The final review serves as a hard stop to ensure that appropriate services have been addressed prior to the patient's discharge.
- A web based education module and competency were developed by the lead Nurse Educator to support the Discharge Planning and Discharge Policy and accompanying Discharge Checklist. The revised education module and Discharge Checklist was approved by the Chief Nursing Officer. Nursing staff that have accountability for the discharge of patients will be required to complete the education and competency by 5/30/2014.
- Compliance with the CVMC Discharge Planning and Patient Discharge Policy will be monitored through practice observations and interviews in conjunction with discharge documentation audits performed by the Nurse Managers. Performance feedback will be given to Chief Nursing Officer and will be reported through the Performance Improvement Committee (PIC).

- The CVMC Nursing Assessment and Care Planning policies and existing documentation tools have been reviewed and revised by the Nurse Managers and the Chief Nursing Officer. The referenced policies and documentation tools were revised to include psychosocial assessments and interventions. In addition, specific assessments and interventions for care planning for the special needs population were addressed. The revised policies and documentation tools were approved by the Chief Nursing Officer on 5/5/2014.
- A web based education module and competency was developed by the lead Nurse Educator to support the Nursing Assessment and Care Planning policies and practice. Education on the accompanying documentation tools will focus on the assessment and care planning for the special needs patient. The revised education module was approved by the Chief Nursing Officer. Nursing staff will be required to complete the education and competency by 5/30/2014.
- The CVMC Pain Assessment and Management Standard of Practice policy was reviewed and revised by the Chief Nursing Officer on 5/5/2014. Revisions include standardization of pain assessment tools that are population specific. Revisions to the pain assessment tools will be made in the electronic medical record to allow for selection of the appropriate pain assessment tool for the individual patient.
- A web based education module and competency was developed by the lead Nurse Educator to support the CVMC Pain Assessment and Management Standard of Practice Policy. Education will focus on the assessment and treatment of pain for the special needs patient. In addition, education will address the use of Palliative Care referrals for patients with uncontrolled or chronic pain. Nursing staff will complete the education and accompanying competencies by 5/30/2014.
- Compliance with the CVMC Nursing Assessment and Care Planning policies and CVMC Pain Assessment Standard of Practice policy will be monitored by the by the Chief Nursing Officer. Feedback for identified performance improvement opportunities will be given to the appropriate Nursing Manager for follow up and action. Oversight for this process will be the responsibility of the Chief Nursing Officer. Performance data will be shared at the Performance Improvement Committee (PIC) by the Chief Nursing Officer.
- The Medication Reconciliation Policy was reviewed and revised by the Vice President of Medical Affairs on 5/5/2014 to assure alignment with regulatory requirements and best practice. The revised policy will be distributed and communicated to the Medical Staff by 5/23/14. Physician compliance with the policy will be monitored by the Vice President of Medical Affairs using an electronic compliance reporting process beginning on 5/30/14.
- All action plans will be completed as of 5/30/2014.

A385 482.23 NURSING SERVICES

The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.

This CONDITION is not met as evidenced by: The Condition of Participation: Nursing Services was not met as evidenced by the failure of nursing staff to assure the nursing care needs were evaluated and resolved prior to discharge from the hospital and failed to effectively reassess and meet pain management needs for 1 applicable patient in accordance with accepted standards of nursing practice and hospital policy.

Action Plan

Central Vermont Medical Center formally responded to the standard level deficiencies referenced in the above text at the standard level finding level.

Refer to Tags: A-0395 & A-0396

A395 482.23(b)(3) RN SUPERVISION OF NURSING CARE

A registered nurse must supervise and evaluate the nursing care for each patient.

This STANDARD is not met as evidenced by: Based on family and staff interview and record review, nursing staff failed to assure the nursing care needs were evaluated and resolved prior to discharge from the hospital for 1 applicable patient and failed to effectively reassess and meet pain management needs for 1 applicable patient in accordance with accepted standards of nursing practice and hospital policy. (Patient #1) Findings include:

1. Per record review, Patient #1 is a 60 year old individual with a history of a CVA (stroke) with right sided hemiparesis (paralysis of one side of the body) and expressive aphasia (inability to express oneself through speech) and dysphagia (difficulty swallowing) was admitted to the hospital on 3/12/14 after experiencing a respiratory event with possible aspiration while at home. During the 5 days of hospitalization Patient #1 required intermittent IV (intravenous) fluids and antibiotics which were infused via a peripheral intravenous catheter device (saline lock). Due to urinary retention, Patient #1 was catheterized and an indwelling catheter was inserted and remained during hospitalization to facilitate drainage of urine.

During hospitalization, a discharge plan was developed to return Patient #1 back to his/her home where s/he is totally dependent on family to meet and provide all necessary care needs with the assistance of home health services. A Care Management note for 3/17/14 at 1134 states Patient #1's family and home health agency hospital liaison nurse were notified of the patient's pending discharge for 3/17/14. Patient #1's attending physician wrote orders for discharge however did not address whether the patient required the indwelling urinary catheter. Per review of "Provider Order Summary" the attending physician did order at 0951 on 3/17/14 to "discontinue saline lock". Per hospital policy Discharge Planning and Patient Discharge effective 7/8/13 states: "Responsibilities of Nursing: 5. On the day of discharge, the nursing staff will: C. Review Discharge Instructions sheet and Discharge Checklist to ensure all arrangements have been made. Patient cannot be discharged from the organization until all outstanding items have been resolved and documentation is complete on the Discharge Checklist." Two outstanding items that were not addressed on the Discharge Check List or by nursing staff prior to Patient #1's discharge included the removal of Patient #1's indwelling urinary catheter and the saline lock. Per interview on 4/15/14 at 10:33 AM Nurse #1, who was assigned to Patient #1's care on 3/17/14, confirmed s/he was aware Patient #1 had the indwelling catheter and saline lock and his/her plan was to remove both prior to discharge after discussing the need for the urinary catheter with the patient's family and following up by obtaining a physician order for the removal of the catheter if indicated. However, at approximately 4:00 PM ambulance transport arrived and Patient #1 was transported back home with the indwelling catheter and saline lock still in place. Minutes after arrival home, family noted both the catheter and the saline lock had not been removed prior to Patient #1's discharge and immediately

contacted the hospital with their concerns. Nurse #1 further stated that at the time of Patient #1's discharge, s/he was preoccupied with another patient discharge and acknowledged Patient #1 had not been appropriately prepared for discharge. Per interview on 4/15/14 at 11:05 AM the charge nurse on 3/17/14 for the Medical/Surgical Unit stated s/he had revived and signed off on the Discharge Checklist for Patient #1, noting it "...looked complete". S/he confirmed not being aware the catheter and saline lock had not been removed prior to discharge until after the family contacted Nurse #1. S/he then became involved in a discussion with Nurse #1 and the Interim Nurse Manager about miscommunication between staff. The charge nurse also acknowledged earlier planning should have occurred for the removal of the indwelling catheter in order to assess if Patient #1's bladder function would resume without further intervention prior to discharge. Per interview at 4/14/14 at 3:39 PM the Interim Nurse Manager also confirmed if a urinary catheter was removed and the patient was slated for discharge nursing would want to assure voiding prior to the patient's discharge. In addition, s/he also confirmed there was no order to discontinue the catheter but there was an order for discharge, but not an order to discharge home with a urinary catheter. After Nurse #1 informed Patient #1's physician of the circumstances of the patient's discharge, an order was received to have the home health agency visit the patient on 3/18/14 and remove both the indwelling catheter and saline lock.

2. At the time of Patient #1's admission on 3/12/14 to the Emergency Department (ED) his/her family brought a current list of medications Patient #1 receives at home. Included in the medication list was Relafen (Nabumetone) 500 mg orally x 2 once daily used to relieve arthritic pain, stiffness, swelling and Neurontin (Gabapentin) 300 mg 4 tablets orally 2 x daily. Per interview on 3/15/14 at 8:11 AM the ED nurse manager confirmed ED Triage staff are responsible for reconciling patient's medications using the list brought in from home and what the patient may have received during a prior hospitalization. The attending physician and/or hospitalist will review and confirm what medications will be continued and/or discontinued. Per review of the reconciled medications completed by ED staff, both Relafen and Neurontin were included.

Per review of the History and Physical for 3/12/14, the attending physician does not reconcile the medication list but references a previous medication list from a discharge summary completed on 2/12/14 which does not include Relafen and Neurontin. Neither of these medications were later included in the patient's medication orders nor was there evidence they had been discontinued at the time of admission. Per nursing notes for 3/12/14 at 2306 states "medicated with 650 mg PO Tylenol for discomfort when moved/turned in bed". Follow up nursing note for 3/13/14 at 0555 states "PT. awake most of the night at times a bit angry appearing possibly due to communication deficit. Pt. appears to have pain in his/her legs and medicated with Tylenol x 1 during the night with no change". Per review of the MAR (Medication Administration Record) for 3/14/14 at 1347 Patient #1 was administered Tylenol 650 mg orally. A nursing note on 3/14/14 at 1547 "Appears uncomfortable with any touch of his legs, hollers out". On 3/15/14 at 1853 a nursing note states "Not interactive this morning, except to yell "No, No, No" and pushing staff away when attempting AM care c/o leg discomfort with repositioning. Medicated with Tylenol 650 mg orally with good effect". On 3/17/14 at 0025 Patient #1 again c/o of leg pain and received Tylenol. Per interview on 4/10/14 at 1:45 PM a family member of Patient #1 acknowledged although Patient #1 is unable to express himself/herself effectively s/he was clearly in pain when discharged to home on 3/17/14 stating "S/he was hard to touch or move could not tolerate physical contact". Upon review of the discharge documentation sent by the hospital, the family member noted Patient #1 had not received his/her prescribed medications used previously at home to effectively manage Patient #1's pain. Per hospital policy Pain Assessment and Management Standard of Practice revised 2/21/13 identifies multiple tools and assessment criteria for evaluating and treating patient pain. However, besides the administration of Tylenol and acknowledging the patient had difficulty with communication due to physical deficits, there is a lack of evidence nursing staff made every effort to effectively evaluate the source of pain, inform the physician and advocate for a possible change or request additional pain medication orders, attempt to utilize alternative interventions or seek consultation with Patient #1's family/caregivers how to effectively communicate with Patient #1 in an effort to assure the patient's care needs were being met.

Per Vermont Title 26: Professions and Occupations, Chapter 28: Nursing "Registered nursing" means the practice of nursing which includes: (A) Assessing the health status of individuals and groups; (H) Maintaining safe and effective nursing care rendered directly or indirectly (I) Evaluating responses to interventions; (L) Collaborating with other health professionals in the management of health care and (M) Addressing patient pain.

Action Plan

- The CVMC Discharge Planning and Patient Discharge Policy was reviewed and revised on 5/2/2014 by the Vice President of Quality, the Chief Nursing Officer and the Vice President of Medical Affairs in collaboration with the Care Management Program Manager. An additional prompt was added to the relevant documentation tools to include the requirement to verify lines, drains and tube removal.
- The discharge checklist was revised on 5/1/2014 by the Care Management Program Manager to include a prompt for the removal of lines, drains or tubes and a prompt to indicate that if they are not to be removed, and the necessary steps required to be taken. The checklist supports the Discharge Planning and Patient Discharge policy and process. Appropriate members of the treatment team contribute to the process of discharge planning and utilize the checklist for documentation. The Charge Nurse is responsible for final review of the checklist prior to the patient's discharge. The final review serves as a hard stop to ensure that appropriate services have been addressed prior to the patient's discharge.
- A web based education module and competency were developed by the lead Nurse Educator to support the Discharge Planning and Discharge Policy and accompanying Discharge Checklist. The revised education module and Discharge Checklist were approved by the Chief Nursing Officer. Nursing staff that have accountability for the discharge of patients will be required to complete the education and competency by 5/30/2014.
- Compliance with the CVMC Discharge Planning and Patient Discharge Policy will be monitored through practice observations and interviews in conjunction with discharge documentation audits performed by the Nurse Managers. Performance feedback will be given to Chief Nursing Officer and will be reported through the Performance Improvement Committee (PIC).
- The CVMC Nursing Assessment and Care Planning policies and existing documentation tools have been reviewed and revised by the Nurse Managers and the Chief Nursing Officer. The referenced policies and documentation tools were revised to include psychosocial assessments and interventions. In addition, specific assessments and interventions for care planning for the special needs population were addressed. The revised policies and documentation tools were approved by the Chief Nursing Officer on 5/5/2014.
- A web based education module and competency was developed by the lead Nurse Educator to support the Nursing Assessment and Care Planning policies and practice. Education on the accompanying documentation tools will focus on the assessment and care planning for the special needs patient. The revised education module was approved by the Chief Nursing Officer. Nursing staff will be required to complete the education and competency by 5/30/2014.
- The CVMC Pain Assessment and Management Standard of Practice policy was reviewed and revised by the Chief Nursing Officer on 5/5/2014. Revisions include standardization of pain assessment tools that are population specific. Revisions to the pain assessment tool set will be made in the electronic medical record to allow for selection of the appropriate pain assessment tool for the individual patient.
- A web based education module and competency was developed by the lead Nurse Educator to support the CVMC Pain Assessment and Management Standard of Practice Policy. Education will

focus on the assessment and treatment of pain for the special needs patient. In addition, education will address the use of Palliative Care referrals for patients with uncontrolled or chronic pain. Nursing staff will complete the education and accompanying competencies by 5/30/2014.

- Compliance with the CVMC Nursing Assessment and Care Planning policies and CVMC Pain Assessment Standard of Practice policy will be monitored by the by the Chief Nursing Officer. Feedback for identified performance improvement opportunities will be given to the appropriate Nursing Manager for follow up and action. Oversight for this process will be the responsibility of the Chief Nursing Officer. Performance data will be shared at the Performance Improvement Committee (PIC) by the Chief Nursing Officer.
- The Medication Reconciliation Policy was reviewed and revised by the Vice President of Medical Affairs on 5/5/2014 to assure alignment with regulatory requirements and best practice. The revised policy will be distributed and communicated to the Medical Staff by 5/23/14. Physician compliance with the policy will be monitored by the Vice President of Medical Affairs using an electronic compliance reporting process beginning on 5/30/14.
- All action plans will be completed as of 5/30/2014.

A396 482.23(b)(4) NURSING CARE PLAN

The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan

This STANDARD is not met as evidenced by: Based on staff interview and record review, nursing staff failed to develop and address an effective care plan related to communication and psychosocial needs for 1 applicable patient. (Patient #1) Findings include:

Per record review, Patient #1 is a 60 year old individual with a history of a CVA (stroke) with right sided hemiparesis (paralysis of one side of the body) and expressive aphasia (inability to the body) and expressive aphasia (inability to express oneself through speech) and dysphagia (difficulty swallowing) was admitted to the hospital on 3/12/14 after experiencing a respiratory event with possible aspiration while at home. During the 5 days of hospitalization Patient #1 required intermittent IV (intravenous) fluids and antibiotics which were infused via a peripheral intravenous catheter device (saline lock). Due to urinary retention, Patient #1 was catheterized and an indwelling catheter was inserted and remained during hospitalization to facilitate drainage of urine.

During hospitalization, a discharge plan was developed to return Patient #1 back to his/her home where s/he is totally dependent on family to meet and provide all necessary care needs with the assistance of home health services. A Care Management note for 3/17/14 at 1134 states Patient #1's family and home health agency hospital liaison nurse were notified of the patient's pending discharge for 3/17/14. Patient #1's attending physician wrote orders for discharge however did not address whether the patient required the indwelling urinary catheter. Per review of "Provider Order Summary" the attending physician did order at 0951 on 3/17/14 to "discontinue saline lock". Per hospital policy Discharge Planning and Patient Discharge effective 7/8/13 states: "Responsibilities of Nursing: 5. On the day of discharge, the nursing staff will: C. Review Discharge Instructions sheet and Discharge Checklist to ensure all arrangements have been made Patient cannot be discharged from the organization until all outstanding items have been resolved and documentation is complete on the Discharge Checklist." Two outstanding items that were not addressed on the Discharge Check List or by nursing staff prior to Patient #1's discharge included the removal of Patient #1's indwelling urinary catheter and the saline lock. Per interview on 4/15/14 at 10:33 AM Nurse #1, who was assigned to Patient #1's care on 3/17/14, confirmed s/he was aware Patient #1 had the indwelling catheter and saline lock and his/her plan was to remove both prior to discharge after discussing the need for the urinary catheter with the patient's family and following up by obtaining a physician order for the removal of the catheter if indicated. However, at approximately 4:00 PM ambulance transport arrived and Patient #1 was transported back home with the indwelling catheter and saline lock still in place. Minutes after arrival home, family noted both the catheter and the saline lock had not been removed prior to Patient #1's discharge and immediately

contacted the hospital with their concerns. Nurse #1 further stated that at the time of Patient #1's discharge, s/he was preoccupied with another patient discharge and acknowledged Patient #1 had not been appropriately prepared for discharge. Per interview on 4/15/14 at 11:05 AM the charge nurse on 3/17/14 for the Medical/Surgical Unit stated s/he had reviewed and signed off on the Discharge Checklist for Patient #1, noting it "...looked complete". S/he confirmed not being aware the catheter and saline lock had not been removed prior to discharge until after the family contacted Nurse #1. S/he then became involved in a discussion with Nurse #1 and the Interim Nurse Manager about miscommunication between staff. The charge nurse also acknowledged earlier planning should have occurred for the removal of the indwelling catheter in order to assess if Patient #1's bladder function would resume without further intervention prior to discharge. Per interview at 4/14/14 at 3:39 PM the Interim Nurse Manager also confirmed if a urinary catheter was removed and the patient was slated for discharge nursing would want to assure voiding prior to the patient's discharge. In addition, s/he also confirmed there was no order to discontinue the catheter but there was an order for discharge, but not an order to discharge home with a urinary catheter. After Nurse #1 informed Patient #1's physician of the circumstances of the patient's discharge, an order was received to have the home health agency visit the patient on 3/18/14 and remove both the indwelling catheter and saline lock.

2. At the time of Patient #1's admission on 3/12/14 to the Emergency Department (ED) his/her family brought a current list of medications Patient #1 receives at home. Included in the medication list was Relafen (Nabumetone) 500 mg orally x 2 once daily used to relieve arthritic pain, stiffness, swelling and Neurontin (Gabapentin) 300 mg 4 tablets orally 2 x daily. Per interview on 3/15/14 at 8:11 AM the ED nurse manager confirmed ED Triage staff are responsible for reconciling patient's medications using the list brought in from home and what the patient may have received during a prior hospitalization. The attending physician and/or hospitalist will review and confirm what medications will be continued and/or discontinued. Per review of the reconciled medications completed by ED staff, both Relafen and Neurontin were included.

Per review of the History and Physical for 3/12/14, the attending physician does not reconcile the medication list but references a previous medication list from a discharge summary completed on 2/12/14 which does not include Relafen and Neurontin. Neither of these medications were later included in the patient's medication orders nor was there evidence they had been discontinued at the time of admission. Per nursing notes for 3/12/14 at 2306 states "medicated with 650 mg PO Tylenol for discomfort when moved/turned in bed". Follow up nursing note for 3/13/14 at 0555 states "PT. awake most of the night at times a bit angry appearing possibly due to communication deficit. Pt. appears to have pain in his/her legs and medicated with Tylenol x 1 during the night with no change".

Per review of the MAR (Medication Administration Record) for 3/14/14 at 1347 Patient #1 was administered Tylenol 650 mg orally. A nursing note on 3/14/14 at 1547 "Appears uncomfortable with any touch of his legs, hollers out". On 3/15/14 at 1853 a nursing note states "Not interactive this morning, except to yell "No, No, No" and pushing staff away when attempting AM care/c/o leg discomfort with repositioning. Medicated with Tylenol 650 mg orally with good effect". On 3/17/14 at 0025 Patient #1 again c/o of leg pain and received Tylenol. Per interview on 4/10/14 at 1:45 PM a family member of Patient #1 acknowledged although Patient #1 is unable to express himself/herself effectively s/he was clearly in pain when discharged to home on 3/17/14 stating "S/he was hard to touch or move could not tolerate physical contact". Upon review of the discharge documentation sent by the hospital, the family member noted Patient #1 had not received his/her prescribed medications used previously at home to effectively manage Patient #1's pain. Per hospital policy Pain Assessment and Management Standard of Practice revised 2/21/13 identifies multiple tools and assessment criteria for evaluating and treating patient pain. However, besides the administration of Tylenol and acknowledging the patient had difficulty with communication due to physical deficits, there is a lack of evidence nursing staff made every effort to effectively evaluate the source of pain, inform the physician and advocate for a possible change or request additional pain medication orders, attempt to utilize alternative interventions or seek consultation with Patient #1's family/caregivers how to effectively communicate with Patient #1 in an effort to assure the patient's care needs were being met.

Per Vermont Title 26: Professions and Occupations, Chapter 28: Nursing "Registered nursing" means the practice of nursing which includes: (A) Assessing the health status of individuals and groups; (B) Maintaining safe and effective nursing care rendered directly or indirectly (C) Evaluating responses to interventions; (D) Collaborating with other health professionals in the management of health care and (E) Addressing patient pain.

Action Plan

- The CVMC Discharge Planning and Patient Discharge Policy was reviewed and revised on 5/2/2014 by the Vice President of Quality, the Chief Nursing Officer and the Vice President of Medical Affairs in collaboration with the Care Management Program Manager. An additional prompt was added to the relevant documentation tools to include the requirement to verify lines, drains and tube removal.
- The discharge checklist was revised on 5/1/2014 by the Care Management Program Manager to include a prompt for the removal of lines, drains or tubes and a prompt to indicate that if they are not to be removed, and the necessary steps required to be taken. The checklist supports the Discharge Planning and Patient Discharge policy and process. Appropriate members of the treatment team contribute to the process of discharge planning and utilize the checklist for documentation. The Charge Nurse is responsible for final review of the checklist prior to the patient's discharge. The final review serves as a hard stop to ensure that appropriate services have been addressed prior to the patient's discharge.
- A web based education module and competency were developed by the lead Nurse Educator to support the Discharge Planning and Discharge Policy and accompanying Discharge Checklist. The revised education module was approved by the Chief Nursing Officer. Nursing staff that have accountability for the discharge of patients will be required to complete the education and competency by 5/30/2014.
- Compliance with the CVMC Discharge Planning and Patient Discharge Policy will be monitored through practice observations and interviews in conjunction with discharge documentation audits performed by the Nurse Managers. Performance feedback will be given to Chief Nursing Officer and will be reported through the Performance Improvement Committee (PIC).
- The CVMC Nursing Assessment and Care Planning policies and existing documentation tools have been reviewed and revised by the Nurse Managers and the Chief Nursing Officer. The referenced policies and documentation tools were revised to include psychosocial assessments and interventions. In addition, specific assessments and interventions for care planning for the special needs population were addressed. The revised policies and documentation tools were approved by the Chief Nursing Officer on 5/5/2014.
- A web based education module and competency was developed by the lead Nurse Educator to support the Nursing Assessment and Care Planning policies and practice. Education on the accompanying documentation tools will focus on the assessment and care planning for the special needs patient. The revised education module and Discharge Checklist were approved by the Chief Nursing Officer. Nursing staff will be required to complete the education and competency by 5/30/2014.
- The CVMC Pain Assessment and Management Standard of Practice policy was reviewed and revised by the Chief Nursing Officer on 5/5/2014. Revisions include standardization of pain assessment tools that are population specific. Revisions to the pain assessment tool will be made in the electronic medical record to allow for selection of the appropriate pain assessment tool for the individual patient.
- A web based education module and competency was developed by the lead Nurse Educator to support the CVMC Pain Assessment and Management Standard of Practice Policy. Education will focus on the assessment and treatment of pain for the special needs patient. In addition, education

will address the use of Palliative Care referrals for patients with uncontrolled or chronic pain. Nursing staff will complete the education and accompanying competencies by 5/30/2014.

- Compliance with the CVMC Nursing Assessment and Care Planning policies and CVMC Pain Assessment Standard of Practice Policy will be monitored by the Chief Nursing Officer. Feedback for identified performance improvement opportunities will be given to the appropriate Nursing Manager for follow up and action. Oversight for this process will be the responsibility of the Chief Nursing Officer. Performance data will be shared at the Performance Improvement Committee (PIC) by the Chief Nursing Officer.
- The Medication Reconciliation Policy was reviewed and revised by the Vice President of Medical Affairs on 5/5/2014 to assure alignment with regulatory requirements and best practice. The revised policy will be distributed and communicated to the Medical Staff by 5/23/14. Physician compliance with the policy will be monitored by the Vice President of Medical Affairs using an electronic compliance reporting process beginning on 5/30/14.
- All action plans will be completed as of 5/30/2014.

A396 482.23(B)(4) NURSING CARE PLAN

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Per record review, Patient #1 is a 60 year old individual with a history of a CVA (stroke) with right sided hemiparesis (paralysis of one side of the body) and expressive aphasia (inability to express oneself through speech) and dysphagia (difficulty swallowing) was admitted to the hospital on 3/12/14 after experiencing a respiratory event with possible aspiration while at home. Upon admission to the hospital and as per hospital policy the plan of care is initially determined by the Admission Data Base assessment. Actual and potential health problems identified by nursing included in the care plan included: Airway issues, aspiration risk, knowledge deficits, self care deficits and impaired skin integrity. During hospitalization from 3/12 - 3/17/14 nursing notes described Patient #1 as "...unable to communicate effectively"; "...at times hard to understand"; "Pt tries to communicate but his/her speech is very unclear and hard to understand". "...at times a bit angry appearing possible due to communication deficits". The patient's difficulties with communicating effectively were not specifically addressed. No nursing interventions were incorporated within the care plan to assist staff and patient to clarify needs, adjust medications, seek alternative food requests or create diversions during the days of hospitalization.

The care plan also failed to address the psychosocial needs and potential interventions. Per the History and Physical note dated 3/12/14 one of Patient #1's attending physicians states: "Past history of depression. It is difficult to assess him/her, but s/he is frequently irritable and angry and quite easily frustrated which is understandable." However, the interdisciplinary team to include the physician, nursing, dietician, social services/care management, or physical or occupational therapy failed to identify within the care plan the potential opportunity to offer services and/or consultation to Patient #1 to assist in addressing psychosocial factors or need for assistance with coping mechanisms related to his/her disabilities and dependence on others for all care needs

Action Plan

- The CVMC Nursing Assessment and Care Planning policies and existing documentation tools have been reviewed and revised by the Nurse Managers and the Chief Nursing Officer. The referenced policies and documentation tools were revised to include psychosocial assessments and interventions. In addition, specific assessments and interventions for care planning for the special needs population were addressed. The revised policies and documentation tools were approved by the Chief Nursing Officer on 5/5/2014.
- A web based education module and competency was developed by the lead Nurse Educator to support the Nursing Assessment and Care Planning policies and practice. Education on the accompanying documentation tools will focus on the assessment and care planning for the special needs patient. The revised education module was approved by the Chief Nursing Officer. Nursing staff will be required to complete the education and competency by 5/30/2014.
- The CVMC Pain Assessment and Management Standard of Practice policy was reviewed and revised by the Chief Nursing Officer on 5/5/2014. Revisions include standardization of pain assessment tools that are population specific. Revisions to the pain assessment tools will be made in the electronic medical record to allow for selection of the appropriate pain assessment tool for the individual patient.
- A web based education module and competency was developed by the lead Nurse Educator to support the CVMC Pain Assessment and Management Standard of Practice Policy. Education will focus on the assessment and treatment of pain for the special needs patient. In addition, education will address the use of Palliative Care referrals for patients with uncontrolled or chronic pain. Nursing staff will complete the education and accompanying competencies by 5/30/2014.
- Compliance with the CVMC Nursing Assessment and Care Planning policies and CVMC Pain Assessment Standard of Practice Policy will be monitored by the by the Chief Nursing Officer. Feedback for identified performance improvement opportunities will be given to the appropriate Nursing Manager for follow up and action. Oversight for this process will be the responsibility of the Chief Nursing Officer. Performance data will be shared at the Performance Improvement Committee (PIC) by the Chief Nursing Officer.
- All action plans will be completed as of 5/30/2014.